Religion and Medical Professionalism: Moving Beyond Social and Cultural Nuances

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As medical practice becomes increasingly globalized, students, physicians, and patients move among different countries and, in doing so, may encounter existing local beliefs regarding professionalism.[1] An article in this issue of the *Journal of Graduate Medical Education* by Abdel-Razig and colleagues[2] that presents an initial consensus definition of professionalism for the United Arab Emirates (UAE), therefore, is timely. Drawing on concerns regarding the predominance of Western views in defining professionalism[3] and the need to consider it within a social and cultural context,[4,5] there have been recent pleas for medical educators to start a long overdue discussion about professionalism in a global context.[1]

The article identifies 9 core attributes of medical professionalism, of which 2, *Ihsan* and *Itqan*, are rooted in Islamic scripture. *Ihsan*, the act of displaying one's inner faith, is interpreted in terms of personal, social, and religious domains. In traditional Western definitions of professionalism, the personal and social determinants of professionalism are represented as well, such as the need to strive for benevolence and demonstrate non-discriminatory practices. However, the religious underpinning of accountability to a higher being is less clearly defined in Western frameworks. An overarching aim of professionalism frameworks is to provide guidance for physicians in training. The incorporation of *Ihsan*, which stems from belief in a higher being and the act of displaying one's inner faith, as a competency for training may prove challenging in a globalized workforce.

Itqan is described as an "ongoing effort" to improve behavior, perform beyond the call of duty, and reach a "perfect or complete state of being," notions that appear to be largely aspirational.[5] There appears to be no English language equivalent to *Itqan*. However, comparisons can be drawn with the concept of proto-professionalism suggested by Hilton and Slotnick.[6] In the description from Abdel-Razig and colleagues,[2] the development of professionalism is never complete, but rather something to which physicians should constantly aspire. Performance beyond the call of duty can, at least in medicine, be linked to the notion of altruism. The focus on altruism in Western nations appears to be declining, potentially due to a reduced perception of need, given societal affluence and access to care in many nations and the loss of incentives for this behavior, such as support from colleagues, public trust, and the social status accorded to medical professionals. The widely held belief of the importance of work-life balance, coupled with pressures to transform medicine into a business, further challenge the relevance of altruism as a core element of professionalism in the West.

The relationship between religion and culture is complex. It is sometimes impossible, and indeed inappropriate, to separate the 2 when considering beliefs, values, and behaviors of people functioning within a social and cultural context. Saroglou and Cohen[7] eloquently describe ways in which religion and culture interrelate and provide guidance for an evaluation of Abdel-Razig et al's consensus statement. Religion often is an integral part of culture, for example, Islam in the Arabic world or Hinduism and Buddhism in Asia. By defining norms, values, and beliefs, religion may also be seen as a form of culture itself, as it defines an individual's identity along with nationality, ethnicity, and socio-economic status. Religion can be influenced by culture, and it also shapes culture. This is evident when we compare differences in the way religious beliefs are expressed in different cultures and parts of the world. An example is the finding that the practice of Catholicism in the Mediterranean world is more conservative than in other parts of Western Europe. Religion shapes culture in terms of facilitating the socialization processes and influencing moral and ethical sensitivities. Religion also interacts with culture, influencing the way individuals think, behave, and consider issues such as morality and well-being. Finally, religion includes aspects of culture, such as traditions and local practices.

Saroglou[8] proposed a model to study the psychological aspect of religion. This model uses a cross-cultural perspective by identifying 4 psychological dimensions drawn from components that are universal to all religions. These dimensions—*believing, bonding, behaving, and belonging*—also can be applied to the study of professionalism. *Believing* relates to the set of beliefs that form the basic tenet of any religion. Professional behavior is often studied as a product of underpinning

DOI: http://dx.doi.org/10.4300/JGME-D-16-00104.1

beliefs.[9] In this respect, religion (with beliefs related to external transcendence) and professionalism (with beliefs related to behavioral outcomes, norms, and control) overlap. The inclusion of *Ihsan* as one of the domains in the UAE consensus illustrates how a religious belief in the existence of and accountability to a higher being can be linked to more secular beliefs such as the need to pursue social justice.

The notion of *bonding* is linked to the emotional component of religion, both in terms of being in awe of a superior being and conforming to rituals. This is defined by emotions such as guilt and shame related to transgressions involving religion and the notion of forgiveness for wrongdoings. The way we consider lapses of professionalism in medicine is not dissimilar, with demonstration of insight and expression of regret forming important components of how we deal with students and physicians who have not behaved appropriately. Despite this, the relationship between emotion and professionalism is less clearly defined; this could be an area for future research.

In the third dimension of *behaving*, it is argued that the concept of "good behavior" from a religious perspective often resonates with socially acceptable behavior. Religion imposes moral standards and taboos that guide followers' behaviors and practices. The behavior dimension aligns particularly well with medical professionalism, in which standards of professional behavior are imposed by regulatory bodies such as the General Medical Council (GMC) in the United Kingdom, and the Federation of State Medical Boards (FSMB) in the United States.

The fourth dimension entails *belonging*, the need for people to wish to belong to a group, society, or community. As with religion, medicine also reflects the need for practitioners to belong to the medical community and behave in accordance with norms laid down by the community in order to be accepted as part of the profession.

Abdel-Razig and colleagues[2] highlight 2 additional differences between their findings and traditional Western notions of professionalism. First, they discuss the need for physicians in the Arabic context to behave professionally not just in their professional but also in their private lives. In Western nations, this also is becoming increasingly recognized, with an overlap of rules regarding professional and personal behavior. However, these boundaries have become even less distinct during the use of social media. Professional bodies from the United Kingdom, Canada, Australia, and the United States have all released guidelines for physicians on the use of social media within the last decade.[10–13] These guidelines emphasize the need to separate professional life from personal life, in particular regarding professional boundaries in relationships with patients.

The second difference presented by Abdel-Razig and colleagues[2] concerns the emphasis on community welfare and social justice in the UAE, contrasted with physician autonomy in Western nations. However, in the West too, the traditional notion of physician autonomy and self-regulation no longer exists, with professional bodies such as the GMC in the United Kingdom and the FSMB in the United States providing much of the regulatory functions rather than physicians themselves through a peer network.

Abdel-Razig et al[2] describe how professional practice in the UAE deviates from Western principles with respect to family involvement in patient care. In the professional domain entitled "respect," there is reference to the Western notion of a patient's right to confidentiality and autonomy, but also an additional need for consideration of "cultural norms and family values." They describe the individual as an extension of family and the larger society. In the UAE, in situations where patient autonomy is in conflict with social justice, family, or the community, the latter will potentially be a stronger force. Western guidelines, such as the GMC's *Good Medical Practice,*[14] acknowledge the importance of family involvement and allow the assumption that close relatives would wish to be informed of medical issues if the patient does not have decisional capacity, but guidance rarely goes further than this.

Research into cultural influences on medical professionalism is still in an early stage. There are few comparative studies reporting differences in the attitudes, beliefs, and behaviors related to professionalism based on regional and socio-cultural variations.[15] A number of studies have discussed cultural nuances in individual nations. For example, Alkabba and colleagues[16] reported the challenge of accepting confidentiality and informed consent as major components of professionalism in Saudi Arabia. In Pakistan, Humayun et al[17] found that there was a striking lack of awareness of these principles, potentially due to the paternalistic model of patient care in many Asian cultures. Baingana and colleagues[18] reported that in Uganda, the community-centric Ubuntu philosophy ran contrary to the established Western notion of confidentiality. In Confucian-influenced societies, ideas are not considered to belong to the original author, but rather are part of society's collective knowledge, and reproducing ideas is perceived as being respectful to the owner rather than plagiarism.[19]

It would be interesting to explore the extent of overlap, as well as the differences between universal principles among religions and individuals' interpretation of these principles. This would help analyze individual physicians' intention to behave professionally depending on

their own (or their community, region, or country) interpretation of religious principles. We know that there is considerable overlap between the universal principles across the 4 main world religions: Christianity, Islam, Hinduism, and Buddhism. The decisions an individual makes regarding professional behavior may depend on how they interpret cultural nuances and religious codes, and thus needs to be studied.

In summary, the article by Abdel-Razig and colleagues[2] takes an important step toward defining medical professionalism in a secular manner for an Islamic country. Important differences between Western and Arabic viewpoints are highlighted. In producing this framework, workshop participants were drawn from 3 areas of medical education, which is appropriate for an exercise chiefly concerned with producing a document for physician training. However, expanded consultation from beyond the medical community—involving ethicists, legal experts, patients, and the public—would bolster the legitimacy of this document. We conclude that the complex relationship between religion, culture, and medical professionalism presents a rich field for future research.

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