

Contextualizing the Physician Charter on Professionalism in Qatar: From Patient Autonomy to Family Autonomy

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ABSTRACT

Background The Physician Charter on medical professionalism has been endorsed by professional organizations worldwide, yet it is unclear if this Western framework of professionalism is applicable in non-Western countries.

Objective This study examines how physicians practicing in a Middle Eastern context perceive the terms, principles, and commitments outlined in the charter.

Methods In May 2013, the authors conducted 6 focus groups with 43 clinician-educators practicing at Hamad Medical Corporation in Doha, Qatar, to discuss the applicability of the Physician Charter in a local context. The research team coded and analyzed transcripts to identify sociocultural influences on professionalism.

Results Participants generally expressed agreement with the applicability of the charter's principles to physician professionalism in Qatar. However, 3 contextual factors (religious beliefs and practices, family-centered decision making, and multinationality) complicated the application of the core principles of patient autonomy and social justice. Islamic beliefs reinforced the importance of professional values such as altruism, but presented a barrier to the principle of self-determination for female patients. The family-centered culture in Qatar called for enlarging the scope of patient-centered decision making to include the patient's family. Qatar's multinational population prompted debate over equal treatment and how to conceptualize and implement the principle of social justice.

Conclusions Several sociocultural contexts influence the conceptualization of the principles of medical professionalism in Qatar. The findings suggest that contextual factors should be considered when developing or adopting a professionalism framework in an international setting and context.

Introduction

The concept and principles of physician professionalism have gained significant attention in the past 2 decades. Efforts to define professional values and establish standards in medical education culminated in the development of the Physician Charter in 2002 by the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine.¹ The charter defines 3 principles—primacy of patient welfare, patient autonomy, and social justice—and 10 commitments of professionalism serving as fundamental guidelines for physicians and medical educators worldwide.¹ The charter has been endorsed by more than 130 professional organizations across the globe, and was translated into 12 languages.²

Professionalism is increasingly understood by the medical profession as being a social construct, context dependent, and reflecting values of the society in which medicine is practiced.³ With the globalization

of medical practice and education, and with it physician professionalism, cross-cultural research is imperative.⁴ Studies have shown that cultural background plays a crucial role in shaping how professionalism is perceived and defined.^{5,6} For example, research in Taiwan found that Confucian values influenced the conception of professionalism in that nation.^{7,8} Other studies have revealed differing values of professionalism not present in the Western framework. For example, physicians in Japan perceive a professional obligation to accept responsibility for a subordinate's mistake,⁹ and physicians in Saudi Arabia conceptualize physician autonomy as part of professionalism.¹⁰ However, published literature on the conceptualizations of professionalism across different nations and cultures is sparse.

Current literature on professionalism is dominated by voices from North America and Europe,¹¹ and there is insufficient research to support the contention that professionalism concepts and attributes from Western nations are fully translatable to other cultural groups.³ Recent studies have called into question the universal applicability of the Western

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framework of professionalism in non-Western contexts.^{3,8,12–15} To date, few studies have investigated the perception and implementation of the Physician Charter in non-Western cultures. This study aims to examine the charter's applicability in Qatar and the influence of sociocultural context on how clinician-educators perceive and apply its principles.

Methods

Context

As an Arab country with Islam as its dominant religion, the nation with 1 of the highest per capita gross domestic product,¹⁶ and a country with a high migrant-to-local population ratio, Qatar is an ideal site to study how sociocultural features may impact societal expectations of medical professionalism. At Hamad Medical Corporation (HMC), the main teaching hospital system for Weill Cornell Medical College in Qatar (WCM-Q) and a major sponsor of graduate medical education programs in the region, medical treatment is provided free for all Qatari nationals, and is government subsidized for foreign nationals with citizenship from other parts of the world.¹⁷ HMC trains more than 600 residents and fellows and has programs in 14 specialties accredited through the Accreditation Council for Graduate Medical Education–International. All participants in this study were employees of HMC and were voluntarily recruited.

Data Collection

We conducted 6 focus groups, each of which had approximately 8 participants representing different specialties, including surgical and nonsurgical, pediatrics, and adult specialties. We used purposive sampling¹⁸ to collect data until we reached thematic saturation.¹⁹ One author (A.A.) recruited the focus group participants from among the HMC faculty, and participation was voluntary and based on faculty members' availability for the focus group times. The overall sample consisted of 43 participants (34 men, 9 women) with an average age of 45. Approximately a third of participants were native to Qatar, and the remaining physicians were from various Arab states (Palestine, Jordan, Iraq, Sudan, Egypt, Libya) and non-Arab countries (Pakistan, India). The majority had practiced more than 10 years in Qatar, and held Arab Board certification. About half of the participants had more than 1 year of experience practicing in a foreign country, most commonly in the United Kingdom, United States, Ireland, and Jordan. Focus group participation was stratified according to professional rank (specialists, consultants, and program directors, from junior to senior) to limit power

What was known and gap

While Western professionalism frameworks have received worldwide endorsement, their relevance to professionalism education and practice in non-Western nations has not been studied.

What is new

Clinician educators in Qatar endorsed much of the Western professionalism framework, but highlighted 3 factors—religious beliefs and practices, family-centered decision making, and Qatar's multinational population—that complicated its application.

Limitations

Small sample, single institution study reduces generalizability.

Bottom line

Sociocultural differences need to be considered in adapting Western professionalism frameworks in an international context.

differentials among participants. The 6 groups were junior specialists, senior specialists, junior consultants, senior consultants, junior program directors, and senior program directors.

The first author (M.J.H.), who had no affiliation with HMC and WCM-Q at the time of the study, facilitated the focus group discussions. Focus group sessions were audiotaped with participants' consent, then transcribed and anonymized. Recordings and transcripts contained no identifiable information and were stored in a secure database only accessible to the researchers. Focus groups lasted approximately 1 to 1½ hours.

The following questions were asked in the focus groups:

1. What do you think about the principles and commitments of the Physician Charter?
2. Can each of the principles and commitments developed in the West be applied in different cultural contexts?
3. Are there cases from your experience or your colleagues' experiences that illustrate that certain principles or responsibilities are difficult to apply in Qatar?
4. What are your roles in the professional formation of trainees?
5. Are there times when what you believe is in conflict with what is expected in the role of a physician?
6. What are your recommendations for adapting the Physician Charter to be globally applicable?

The study was approved for waiver of signed informed consent by the Ethics Committee of HMC.

Data Analysis

Following a constructivist methodology,²⁰ a team of researchers (J.S., K.S., C.W.) not affiliated with HMC performed the thematic analysis of the data.²¹ Two authors (J.S. and K.S.) independently conducted open coding using NVivo 9 (QSR International Pty Ltd, Doncaster, Victoria, Australia). Intercoder agreement was established by iterative comparisons. The team then developed a thematic outline based on themes that emerged from the initial codes and confirmed these themes with the principal investigators (M.H. and L.K.). Codes from open coding were categorized into the thematic outline, and the team audited each other's coding to ensure consistency and quality. Lastly, the research team identified themes relevant to the study's exploration of sociocultural contexts for professionalism in Qatari physicians.

Results

Participants generally affirmed the importance of the principles and commitments outlined in the Physician Charter, but acknowledged challenges facing its implementation. In 1 focus group, physicians discussed examples of professional dilemmas relating to the principle of patient welfare—such as whether to see a late patient past closing time, how the scenario might change if the patient were a child brought in by a parent, and how altruism can be influenced by practice environment, such as an organizational culture where clinic staff do not stay past regular hours.

While the applicability of patient welfare was undisputed, participants cited cultural differences moderating the implementation and understanding of the principles of patient autonomy and social justice. Physicians discussed at length contextual differences between Qatar and the West, highlighting differences between Western medical practices and their current cultural setting. Three themes were identified: (1) the strong family orientation of Qatari citizens; (2) Islamic religious beliefs and practices; and (3) the country's multinational context. Supporting quotations will be referenced by focus group type and number (eg, consultants [C], program directors [D], and specialists [S], and speaker number).

Family-Centered Decision Making

In all interviews, the Qatari cultural concept of strong family ties was a prominent theme. Participants cited challenges concerning decision making, informed consent, and confidentiality when working with patients' families in the process of care.

Culturally, it is common for families to be integrally involved in decision making on the patient's behalf: "In our society in general and in Arab countries, the family has major roles in taking decision for the patient" (1D, 6). The cultural norm of decision making as a family unit complicates the charter's emphasis on patient autonomy focused on the individual, and physicians expressed a need to "educate the family about what is patient autonomy" (1D, 6).

Patients' relatives are often highly involved in the treatment process, influencing physicians' treatment decisions and sometimes overriding the patient's wishes. One physician described the dilemma physicians face caring for patients: "Maybe the patient's interest is not to do something, but you are pushed by the family. . . . The family insists against our wishes to transfer them to intensive care and do all kinds of things which are disastrous, so we are under pressure" (2C, 8).

While 1 of the charter's commitments concerns honesty with patients, physicians spoke of being pressured by families to withhold diagnoses from patients, especially in the case of terminal illnesses or serious conditions such as cancer. A physician who informs the patient without the consent of the family risks enraging the relatives. As a participant stated, in some cases, "you cannot tell [the patient] the diagnosis . . . If you do that, you might be even beaten by the family" (2C, 1).

Participants also discussed how their commitment to patient confidentiality is complicated by a cultural difference in the understanding of confidentiality. Relatives believe they have a right to know a patient's diagnosis and think a physician is wrong to withhold information from them. As 1 participant described:

It would be odd if you start telling the family . . . sorry I cannot give you any information, and this what we see on a daily basis . . . you provide the care for the patient, and in between the whole family would come one by one . . . and everyone thinks they have the right to ask about the patient. If you don't give them the proper information they need, they will get angry and think this is malpractice, and some of them will go on to complain (2D, 5).

Physicians proposed resolutions to the challenges by enlarging the scope of the patient to include the patient's family, rephrasing the charter's principles to "family autonomy" (1C, 10) in order to "serve also the interest of the family" (1D, 1). One participant reasoned: "If you consider the family as an integral

part of the patient . . . then you are informing . . . the patient, one part of it” (2D, 1).

Although family involvement can complicate patient autonomy and confidentiality, physicians also acknowledged the psychological benefits of strong family ties: “We feel more secure inside . . . [we] all . . . need families to . . . share the decision” (1S, 9). One specialist stressed that it is in the interest of the patient: “Many times when it comes to taking important decisions, [the patients] don’t want to take them on their own. They want their brothers, mothers, sisters to share” (1S, 7).

Religious Beliefs and Practices

The individual interpretation of Islamic values may complicate the implementation of patient autonomy. Some participants discussed how men’s guardianship of women in Muslim society posed a challenge to respecting female patient autonomy. One physician stated, “When it comes to the women population . . . they are always guided by someone superior to them” (1C, 5). According to another participant, a husband can override his wife’s right to reproductive medical procedures because “by religious law, women can’t ask for sterilization, such as tubal ligation, without consent from their husbands” (1S, 4).

At the same time, religious values were not always brought up as being in conflict with the charter. Of the principles outlined in the Physician Charter, the primacy of patient welfare was a value embraced by Qatari physicians and aligned with their religious beliefs: “here we are in a culture which is an Islamic country . . . [and through the] Quran and Hadith [the Prophet Muhammad’s sayings] . . . the primacy of the patient’s welfare is well integrated in our mentality . . . so regardless . . . if he’s your enemy or whatever, we have to treat him” (2D, 2).

Physicians referenced Islamic teachings supporting the values of altruism and honesty: “In Islam they teach you how . . . to be a professional . . . they teach about the honesty and about how to help other people above your interest” (1D, 1).

Qatar’s Multinational Context

Physicians cited Qatar’s large multinational population, with a large nonnational workforce of a lower socioeconomic status, as another challenge to the charter’s implementation, especially concerning the principle of social justice. Foreign laborers make up a large part of the population in Qatar, and while many have national health insurance, access to care of nonnationals was a subject of debate. Some physicians expressed that they wish to see all patients getting equal access to care, and at the same time

abide by bureaucratic requirements when caring for nonnationals and the uninsured. While all participants aspired to apply the principle of social justice, there was considerable disagreement over whether discrimination in the provision of health care was actually occurring or not and, if so, at what level. Some argued the nonnationals are discriminated against as physicians prioritize citizens for treatment, while others countered that nonnationals still receive the same level of health care and likely better care than they would receive in their home countries.

There was also debate over whether hospitals’ private rooms for national patients and common rooms for nonnational patients constituted discrimination; some claimed that room separation helps eliminate the pressure to discriminate. However, Qatari citizens are frequently admitted to common rooms because of a shortage of private rooms.

The nonnational labor workforce, which is often less educated and of lower socioeconomic status, also presents physicians with challenges regarding informed consent and communication. A physician expressed concern that when less educated patients are informed of risks “they will start to think about [the complications] and many times they refuse [care]” and argued that “patient autonomy should be implemented only when . . . the general background [of the patient] will allow good understanding of what you are explaining and why you are allowing them to share the decision” (1D, 5).

Language barriers pose another challenge, and 1 consultant reported the difficulty of working with Qatar’s multinational population: “I’ve seen at least 3 or 6 nationalities [in 1 day], and some of them don’t know any language [that I know] . . . how can I discuss [care] with them?” (2C, 3). Physicians believed in “empowering the patient to decide the course of therapy by . . . giving him options, and tell[ing] him to choose” (2D, 1). However, they also noted that nonnationals would sometimes defer to the authority of the physician, saying “You are the doctor; you tell me” (2D, 1).

Discussion

Physician interviews revealed the modifying effects of religion, family-centered culture, and Qatar’s multinational population on the implementation and interpretation of the charter in Qatar. Among the 3 principles of the charter, the principle of patient welfare is culturally applicable and well-understood by physicians practicing in Qatar, with values such as altruism reinforced by Islamic teachings.²² Another principle, patient autonomy, calls for physicians to “be honest with their patients and empower them to

make informed decisions about their treatment.”¹ This principle is not universally applicable in different sociocultural contexts.

Exploring Themes

The first and most significant theme identified affecting patient autonomy is the family-centered culture of Islamic countries. Similar to this study, previous research in cultures with an emphasis on the family unit also reported challenges in applying the principle of patient autonomy.⁷ Nevertheless, patient autonomy continues to be promoted in medical education around the globe, despite not being fully translatable to different cultural contexts. In Islamic culture, a patient's family plays a central role in patient care and medical decision making.²³ Families might compromise patient autonomy when they prevent physicians from informing patients of their medical condition. Physicians in Qatar expressed that patients may themselves choose to have information entrusted to their family rather than be informed. Previous studies have examined the “high-context” culture in Qatar where communication relies on nonverbal cues and explicit information may not be desired.^{24,25} Other studies in Muslim countries have found that during terminal illness, many physicians disclose diagnoses to the relatives rather than to the patient.^{26,27} In the Middle East, these cultural norms reshape the conceptualization of informed consent and professionalism.

To date, studies examining cross-cultural professionalism have largely focused on the physician's perspective. Focus group participants emphasized that patients did not conceptualize autonomy in the same way as physicians. Disparities between patients' perception of professionalism and the perception of Western-trained physicians are an added source of tension that must be resolved.²⁸ For example, the principle of patient confidentiality faces tensions in the family-centered culture of Qatar. Relatives of patients often blame physicians for withholding patient information from them. This reflects a cultural difference in the conceptualization of confidentiality and a difference between provider and patient perceptions. As a solution, participants suggested redefining patient autonomy and expanding the scope of the patients to include their families. In other words, the autonomy of a patient is respected by the physicians in Qatar; however, they suggest enlarging the unit of patient from individual patient to patient's families.

The study identified religion as an added factor potentially complicating implementation of the principle of patient autonomy. While Islamic religion supports patient autonomy,²⁹ in Middle Eastern

culture, men may have a major role in the decision making on behalf of female family members.²³ Attitudes toward female autonomy may vary, and are shaped not only by religion, but also by complex and intersecting factors such as families (versus individuals) as the units of decision making, culture, ethnicity, and individual traditions and beliefs. In the focus group discussions, some physicians attributed their values to Islam, which encourages procreation.³⁰ Despite its influence on patient autonomy, religion has rarely been addressed in previous studies of professionalism. A study of Islamic medical students' perception of professionalism found that “God-fearing” was cited as a professional attribute,³¹ but this finding was not emphasized in the subsequent discussion or in other literature on the subject. Our findings suggest that religion is a crucial element affecting the conceptualization of professionalism, and should not be overlooked.

While participants expressed concurring views on the issue of patient autonomy, debate sparked over the principle of social justice. All participants agreed that social justice was an important tenet of professionalism, but views diverged over the practice of separating Qatari citizens and nonnationals into different hospital rooms. While some felt that this practice promoted unbiased treatment and better health care delivery to both groups, others objected to the practice and thought it discriminatory. This difference in the conceptualization of social justice and the complications involved in its implementation suggest the need to further explore physician and patient attitudes that provide context for the principles of professionalism.³²

A Proposed Framework

Based on the study's findings and existing literature, we propose a framework to understand and explore why Western conceptualizations of professionalism may not fit non-Western countries. Conflicts in implementing the charter's principles of professionalism can arise when there are differences in (1) the ethical teachings and/or spirituality of the local nation; (2) decision making around patient welfare; (3) local perceptions of social justice and individual and societal rights; and (4) societal expectations of the professional attributes of physicians. The literature has demonstrated differing societal expectations of physicians' professionalism in regards to responsibility⁹ and autonomy.¹⁰ Previous findings that Confucianism in Taiwan influenced conceptualizations of professionalism reflect potential conflicts with the charter in both the spirituality and societal expectations of the physician.^{7,8}

Our findings from Qatar reveal 3 important contextual factors influencing the conceptualization of professionalism not previously articulated in the literature. Differences in religious values, individual versus collective decision making, and perceptions of social justice fall within the proposed framework, and present additional challenges facing the adaptation of medical professionalism in non-Western countries. This framework can serve medical educators when teaching professionalism, and can be further modified and expanded as new insight on cross-cultural professionalism comes to light.

The cultural differences discussed by participants have implications for teaching and implementing professionalism in Qatar and the Middle East. Family involvement was cited as both a great benefit to patients and a challenge to patient autonomy, and the concept of patient autonomy should be reconsidered when establishing professional guidelines in family-centered cultures. Medical students in the Middle East report that the current curriculum is inadequate in nurturing professional behavior.³¹ Cross-cultural medical ethics courses introduced at Weill Cornell Medical College in Qatar have demonstrated promise in mediating cultural frictions by promoting trust and tolerance; engaging students in critical thinking; and helping them develop emergent, culturally sensitive professional identities.³³ With the globalization of medical education, efforts should be made to develop curricula that promote the development of context-specific professional values in non-Western countries.

Our study has several limitations. Although participants revealed a wealth of knowledge regarding Qatari culture and physician perception, the findings are limited by the small number of participants, and the even smaller number and lower than hospital/institutional ratio (21% versus 29%) of female physicians. While focus groups included physicians from diverse specialties, and were separated by seniority to reduce hierarchical pressure, participants represented only a single institution. Time restraints prevented groups from discussing every principle in detail. Additional studies are needed to examine the influence of Arab culture and Islamic religion on professionalism before the results can be generalized to other Muslim countries.

Conclusion

This study identified several significant sociocultural contexts influencing the conceptualization of professionalism in an Arabic context. Religion, family, and multinationality called for reconsideration of the applicability of the Physician Charter in Qatar.

References

1. American Board of Internal Medicine, American College of Physicians, American Society of Internal Medicine, et al. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002;136(3):243–246.
2. Cassel CK, Hood V, Bauer W. A *Physician Charter*: the 10th anniversary. *Ann Intern Med.* 2012;157(4):290–291.
3. Hodges BD, Ginsburg S, Cruess R, et al. Assessment of professionalism: recommendations from the Ottawa 2010 Conference. *Med Teach.* 2011;33(5):354–363.
4. Hodges BD, Maniate JM, Martimianakis MA, et al. Cracks and crevices: globalization discourse and medical education. *Med Teach.* 2009;31(10):910–917.
5. Cruess SR, Cruess RL, Steinert Y. Teaching professionalism across cultural and national borders: lessons learned from an AMEE workshop. *Med Teach.* 2010;32(5):371–374.
6. Hafferty FW. Definition of professionalism: a search for meaning and identity. *Clin Orthop Relat Res.* 2006;449:193–204.
7. Ho MJ, Lin CW, Chiu YT, et al. A cross-cultural study of students' approaches to professional dilemmas: sticks or ripples. *Med Educ.* 2012;46(3):245–256.
8. Ho MJ, Yu KH, Hirsh D, et al. Does one size fit all? Building a framework for medical professionalism. *Acad Med.* 2011;86(11):1407–1414.
9. Tsugawa Y, Tokuda Y, Ohbu S, et al. Professionalism mini-evaluation exercise for medical residents in Japan: a pilot study. *Med Educ.* 2009;43(10):968–978.
10. Al-Eraky MM, Chandratilake M. How medical professionalism is conceptualised in Arabian context: a validation study. *Med Teach.* 2012;34(suppl 1):90–95.
11. Castellani B, Hafferty F. The complexities of medical professionalism. In: Wear D, Aultman J, eds. *Professionalism in Medicine*. New York, NY: Springer; 2006:3–23.
12. Chandratilake M, McAleer S, Gibson J. Cultural similarities and differences in medical professionalism: a multi-region study. *Med Educ.* 2012;46(3):257–266.
13. Tsai S, Ho MJ, Hirsh D, et al. Defiance, compliance, or alliance? How we developed a medical professionalism curriculum that deliberately connects to cultural context. *Med Teach.* 2012;34(8):614–617.
14. Pan H, Norris JL, Liang YS, et al. Building a professionalism framework for healthcare providers in China: a nominal group technique study. *Med Teach.* 2013;35(10):1531–1536.
15. Ho MJ, Yu KH, Pan H, et al. A tale of two cities: understanding constructs of medical professionalism in two universities of different Chinese cultural contexts. *Acad Med.* 2014;89(6):944–950.

16. Central Intelligence Agency. The world factbook. <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2004rank.html>. Accessed August 31, 2016.
17. Policy Affairs Directorate; Supreme Council of Health. Qatar national health accounts—years 2009 & 2010. <http://www.nhsq.info/app/media/1148>. Accessed August 31, 2016.
18. Wright S, O'Brien BC, Nimmon L, et al. Research design considerations. *J Grad Med Educ*. 2016;8(1):97–98.
19. Teherani A, Martimianakis T, Stenfors-Hayes T, et al. Choosing a qualitative research approach. *J Grad Med Educ*. 2015;7(4):669–670.
20. Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. *Field Meth*. 2006;18(1):59–82.
21. Silverman D. *Interpreting Qualitative Data: Methods for Analysing Talk, Text, and Interaction*. London, UK: SAGE; 1993.
22. Padela AI. Islamic medical ethics: a primer. *Bioethics*. 2007;21(3):169–178.
23. Ho MJ. Culturally sensitive medical professionalism. *Acad Med*. 2013;88(7):1014.
24. Fins JJ, del Pozo PR. The hidden and implicit curricula in cultural context: new insights from Doha and New York. *Acad Med*. 2011;86(3):321–325.
25. Del Pozo PR, Fins JJ. Islam and informed consent: notes from Doha. *Camb Q Healthc Ethics*. 2008;17(3):273–279.
26. Mobeireek AF, Al-Kassimi FA, Al-Majid SA, et al. Communication with the seriously ill: physicians' attitudes in Saudi Arabia. *J Med Ethics*. 1996;22(5):282–285.
27. Halligan P. Caring for patients of Islamic denomination: critical care nurses' experiences in Saudi Arabia. *J Clin Nurs*. 2006;15(12):1565–1573.
28. Mobeireek AF, Al-Kassimi F, Al-Zahrani K, et al. Information disclosure and decision-making: the Middle East versus the Far East and the West. *J Med Ethics*. 2008;34(4):225–229.
29. Brockopp J, Eich T. *Muslim Medical Ethics: From Theory to Practice*. Columbia, SC: University of South Carolina Press; 2008.
30. Albar MA. An Islamic view on contraception and abortion. *JIMA*. 1989;21(2):79–82. http://scholarlyexchange.org/ojs/index.php/JIMA/article/download/5527/21_2-8. Accessed August 31, 2016.
31. Adkoli BV, Al-Umrani KU, Al-Sheikh M, et al. Medical students' perception of professionalism: a qualitative study from Saudi Arabia. *Med Teach*. 2011;33(10):840–845.
32. Monrouxe LV, Rees CE, Hu W. Differences in medical students' explicit discourses of professionalism: acting, representing, becoming. *Med Educ*. 2011;45(6):585–602.
33. Del Pozo PR, Fins JJ. The globalization of education in medical ethics and humanities: evolving pedagogy at Weill Cornell Medical College in Qatar. *Acad Med*. 2005;80(2):135–140.



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