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AUSTRALIA AND NEW ZEALAND

Professionalism and professional identity of our future doctors

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1. Executive Summary

Doctors are expected to demonstrate professionalism throughout their careers, but defining, teaching, assessing professionalism, and effectively remediating unprofessional behaviours can be challenging at the best of times. With the rapid changes, ongoing uncertainties, and new teaching approaches driven by the COVID-19 pandemic, the task became immense but was never more important.

To support the medical educators[1] and clinical supervisors at our member schools, the Medical Education Collaborative Committee (MECC) of Medical Deans Australia and New Zealand (Medical Deans) established a working group who was tasked to develop practical and relevant advice and guidance when considering and navigating these changes and challenges. Membership of the working group comprised academic leads from 20 member schools and a Medical Deans' Senior Policy Officer.

This Report is the outcome of in-depth consultation with medical schools, review of the literature and evidence in this area, and a collaborative approach to developing guidance on this complex but central aspect to a doctor's professional identity and clinical practice. As well as a set of recommendations for medical schools – see section 2 for a summary of these – the Report sets out:

- An overview of the current approaches taken across Australian and New Zealand medical schools;
- Common challenges and systemic issues on how professionalism is defined, taught, assessed, and remediated;
- Suggestions on potential areas for future collaboration and further research; and
- Suggested useful resources.

The findings in this Report reflect the importance and complexity of the term 'professionalism'. It is recognised as a central component to the medical program, and medical schools have implemented a wide range of methods across their curriculum to embed a solid understanding, the necessary skillset, and a strong commitment to professionalism among their students.

Key to the working group's findings was the central importance of having a clear definition of professionalism, that is common to and threads through the entirety of the medical program and in all learning environments. Consistency was also noted as fundamental, for both staff and students; from what is expected, to how it is role-modelled, the way it is taught and measured, through to remediation where necessary; with remediation seen as part of the learning journey rather than taking a solely punitive approach.

This Report also highlights that all this work can only be effective when embedded within a strong culture of professionalism. Culture provides the unspoken evidence of what's really important in an organisation. The impact of the teaching occurring within an environment with a strong culture of professionalism – expected from students, educators, and professional staff alike – is the foundation that makes all the resources, systems, and processes meaningful, valued, and effective.

The disruption caused by COVID-19 brought the importance of professionalism to the forefront. However, as this Report highlights, it also created a range of opportunities to improve the teaching of professionalism to take better account of the different learning environments – virtual, on-campus and clinical.

As Australian and New Zealand health systems continue to grapple with the changes and constraints caused by the pandemic, it is especially important that our future doctors understand what professionalism means – for

[1] By referring to 'medical educators', we include program leads within medical schools responsible for delivering professionalism teaching, assessment, and remediation, as well as teachers, clinicians, Faculty staff, and Deans.

their professional identify as a doctor, their connection with their colleagues, and their service to their patients and community.

2. Summary of Recommendations

The Working Group developed a set of specific recommendations to aid medical schools in reflecting on how professionalism is defined, taught, understood, and assessed within the context of their medical school. They include recommendations about how professionalism is 'lived' in helping students form their professional identity as they progress through the medical program.

A clear and consistent definition

- Ensure a definition of professionalism that applies to both staff and students. It should be: explicit about its components; applicable to different stages of the medical program; and relate to the teaching, learning, assessment activities and remediation processes. It needs to incorporate a strong understanding of cultural sensitivity and cultural safety.
- Ensure expectations of professional behaviour for both students and staff are clearly expressed and consistently monitored.
- Advocate for the definition to be endorsed, or if possible adopted, in the health service setting.
- Make explicit the alignment between the components that make up the definition of professionalism, and the associated teaching, learning and assessment activities and remediation processes.
- Have a glossary of terms to help reduce confusion about the use of terms such as professional competence, professional behaviour, and professional identity.

Teaching and Learning

- Ensure a range of learning opportunities on professionalism are embedded in the curriculum and are made explicit, particularly in the transition into clinical settings as this represents an opportunity for specific teaching regarding expectations.
- Work with health service providers to ensure the medical school's professionalism definitions are enacted in their placement teaching programs.
- Provide learning opportunities related explicitly to professional identity formation, to foster an understanding of the direct connection between the two
- Build a positive culture around professionalism, empowering students to act professionally and embrace and learn about professionalism rather than having the focus on penalising bad behaviour (e.g. empower students to inform of absences rather than marking a roll and penalising non-attendance). This may be through creation of a safe space to enable students to explore and make mistakes and learn from them.
- Ensure expectations of role models for students are consistent with the expectations of students.
- Explore opportunities to share teaching and learning resources, including further consultation with the Medical Board of Australia about the development of professionalism modules for students.

Assessment

- Further explore the value of methods to longitudinally track students' behaviours within and across years. Any such system needs to recognise that professionalism is developmental and ensure that students are supported as they progress through the program and develop their professional identity. Positive re-enforcement is as important as correcting unwanted behaviour.
- Assess professionalism as part of a general assessment of a student, being explicit about what attributes or components of professionalism are being assessed and sharing any rating forms.

Remediation

- Focus on the desired outcome from remediation considering what works well or less well with students and for which professional behaviours, ensuring student perspectives inform this. This could be an area for further research.
- Make clear to students, role models[2] and health services (i.e. all parties involved), the processes for identifying and remedying lapses in professional behaviour. Processes and discussions should be documented and 'handed over', to improve the ongoing support of the learner who experiences a lapse in professional behaviour.
- Communicate channels of reporting and notification of both minor and serious concerns between the different teams and staff involved in medical program delivery and students. For example, do clinical supervisors know with whom to speak if they notice an incident that may be considered minor but possibly worth further discussion?

3. Background

"Medical Professionalism signifies a set of values, behaviours and relationships that underpins that trust the public has in doctors" (Royal College of Physicians, 2005). Supporting and sustaining the learning of professionalism among medical students is central to embedding professionalism within the medical profession culture and assisting the formation of an individual's professional identity – which are separate but related concepts. However, it is important to recognise that what is considered 'professional' needs to develop in line with society's changing expectations and may depend greatly on the context. This presents a challenge for educators in equipping medical students with the decision-making skills to navigate complex seemingly contradictory situations, where the right decision in one context would not be considered the appropriate decision in another.

The COVID-19 pandemic caused substantial disruption and change to the medical education environment and brought to light many challenges – both existing and new – in how professionalism is taught and assessed, and how lapses in professionalism are remediated. Medical schools rapidly moved from on-campus learning to online, triggering questions about what professionalism looks like in a virtual world, how to articulate and identify it, and how to intervene without the usual in-person context and opportunity. Medical schools had to explore how students' behaviour online could be assessed and evaluated, expanding the domains of where professionalism is expected to be demonstrated and the remediation processes for inappropriate behaviours in this new context.

The reduced access to clinical placements for some students – primarily those in earlier years – and the pressures on supervisors also affected, and at times limited, the ability to observe and assess students in a workplace environment. This impacted the early detection and timely intervention for any unprofessional behaviours that has been a staple aspect of immersive, experiential learning. In addition, the highly charged and highly volatile COVID-impacted clinical environment in which students and their healthcare colleagues were working in added further complications and required thoughtful consideration and adaptation.

All these changes took place incredibly rapidly, in a continually evolving and uncertain landscape, with considerable pressure on medical schools to continue their delivery of high-quality education and meet the needs of the curriculum, students, and healthcare services alike, whilst simultaneously pivoting their delivery models to align with the necessary restrictions.

It is hard to overstate the level of disruption to medical education and training caused by the COVID-19 pandemic, and it brought into sharp relief the challenges of teaching such a complex and changing concept as professionalism within a system that is based on highly diverse and disseminated learning environments and teachers. With the rapid adoption of new technologies, models of care, student placements, and teaching

[2] The term 'role models' in this context applies to university academics, clinicians, supervisors or other staff that are involved in the delivery of the medical program.

mechanisms to deal with the disruption, there has also emerged opportunities for our learning environments to better reflect those in which our new doctors will be practising in the future.

4. Methodology

The Working Group represented 20 different medical schools across Australia and New Zealand. Terms of Reference (Attachment 1) were developed to be clear on the expected outcomes, and a methodological approach agreed.

To understand what activities medical schools currently use to teach and assess professionalism, a survey was developed and disseminated to all medical schools in Australia and New Zealand. The survey consisted of a mix of quantitative and qualitative questions and Survey Monkey® was used as the survey tool. The survey (Attachment 2) included questions on the school's definitions of professionalism and professional identity, its teaching and assessment, as well as remediation processes used to address lapses in student professionalism. In addition, all medical schools were asked to provide key literature sources relevant to definition, teaching, assessment, and remediation of professionalism which are collated in Attachment 4. Medical schools were given three weeks to complete the survey. The working group acknowledges that there were a range of aspects that were worthwhile considering and that may not have been noted by schools in their responses. The "aspects to consider" which are highlighted in this document do not suggest gaps within medical schools' teaching or assessment, only that some aspects were not included in the in responses provided. These may also be reflective of the breadth of areas included under the umbrella of "professionalism", which is defined differently by different medical schools.

The vast majority of medical schools in Australia and New Zealand completed the survey (22 of 23) and drew on the expertise and resources across their staff to inform their responses, given the breadth of information requested.

Categorical data are presented as totals and percentages (Attachment 3). Qualitative answers were analysed using content analysis, and common themes as well as additional aspects to consider were identified and presented in tables for ease of summarising the analysis.

As the survey addressed four broad areas (definitions, teaching, assessment, and remediation), subgroups were formed to analyse the responses and note areas of shared systemic challenges or for further exploration. This method allowed for identification of common themes, areas of overlap and limitations. The Working Group met regularly to share discuss their interpretations and the issues they had found.

5. Key findings from the survey

The teaching, learning and assessment of 'professionalism' and how it was defined was clearly seen as important and valued content in the curriculum by all schools. A variety of reliable and valid assessment modalities were used, suggesting that medical schools were making efforts to assess with rigour what they recognise as a key component of medical education and training.

A number of challenges were identified through the survey. Although the majority of institutions (86 percent, see Table 1) stated that they have a definition of professionalism, how the definition was used in the medical curriculum varied widely across institutions (Table 2). Definitions of professionalism tended to comprise a number of components – often professional or ethical/moral values, behaviours, attributes, references to codes of conduct, or statements about how to acquire or demonstrate these aspects (Table 1). Which of these components were included in definitions of professionalism, how they were weighted and then used in the curriculum was very varied across the schools. These differences highlight the heterogeneous, multifaceted and complex nature of the term 'professionalism'. This variety is operationalised in the teaching methods, which draw on a range of options (Table 3) but distils into two groups:

(i) self-reflection and personal development, and
(ii) knowledge, attitudes, and skills.

Having a clear definition of professionalism that is common to and threads through the entirety of the medical program and in all learning environments, for both staff and students, was important; from what is expected, to how it is role-modelled, the way it is taught and measured, through to remediation where necessary; with remediation seen as part of the learning journey rather than taking a solely punitive approach. Without this, there is the risk that different values and individual biases can lead to varying and potentially conflicting views of professionalism being taught and assessed; a significant issue considering the many components involved.

The difficulties of not having a clear definition and conceptual framework of professionalism were also highlighted when it comes to either the assessment or measurement of the concept, and in the design of a remediation approach. A variety of tools were used to assess professionalism. Most medical schools identified issues with how professionalism was assessed and monitored in the curriculum as well as how unprofessional behaviours were remediated when there was a lapse. There was less certainty among responses about the effectiveness of the assessment and/or remediation process that were used. Lack of a clear definition and the components that make up the definition may obscure the effectiveness of systematic programs of assessment. Subsequently, this would affect: judgements about what is and is not going well for students; what is and is not working in teaching and learning; and, how to remediate issues with professional behaviour and how to know if this remediation has been effective.

Remediation approaches also tended to focus more on what happens when things go wrong, as opposed to tapping into opportunities to either reinforce professional behaviour or address smaller lapses early. Measuring and remediating issues in professionalism were addressed in varying ways, with seemingly two broad points of view:

(i) professionalism as an assessment (judgement), either as a hurdle or as a summative component of the curriculum; and

(ii) professionalism as an indicated set of behaviours (diagnosis), which initiated the application of formal policies and procedures.

The approach to teaching methods could be further defined by either a positive approach or a more punitive approach to teaching, learning and assessment. While these were not necessarily mutually exclusive the importance of this difference became evident in relation to remediation. For example, some medical schools reported on the results of substandard performance on professionalism assessment tasks (e.g. OSCE stations) as part of their remediation processes, whilst other schools reported on professional behaviour lapses in the campus and clinical practice environment (i.e. 'fitness to practice'). Most medical schools commented on the need for developmental, supportive approaches to lapses in professional behaviour that were tailored to the individuals and contexts, rather than a punitive approach with set pathways. Most medical schools acknowledged that remediation is more than repetition of the same tasks again.

Effective communication systems for reporting and handing over both minor and serious concerns between the different teams and staff involved in medical education are not well established. There was not a clear relationship between the professional lapse, the remediation offered and the outcome of that remediation. This warrants further exploration. Processes and referrals to regulatory bodies (the Medical Board of Australia or Medical Council of New Zealand) also varied between medical schools.

A range of systemic challenges were outlined by the medical schools, and are discussed further in Section 7 of this Report. Often these related to lack of clarity of expectations of staff (whether university employed or not) and students alike, monitoring and management of these expectations, as well as the differences in expectations between universities and health services.

Detailed findings from the survey are set out in Section 7. Analysis in these sections considered both the quantitative and qualitative data provided. Responses to the quantitative questions are found at Attachment 3.

6. Analysis and ideas

The Working Group analysed the findings from the survey and discussed their implications for how professionalism is embedded in the curriculum. This section presents the discussion and ideas that emerged from this analysis, including the systemic challenges and opportunities that were identified.

This is the first time all medical schools in Australia and New Zealand had been surveyed and shared experiences on professionalism. While there is a great deal in the literature describing professionalism in a medical program, there was no report on a national level of how the topic is implemented within a medical curriculum in Australia and New Zealand.

Overall, the volume and breadth of activity dedicated to teaching and assessing professionalism and embedding a culture of professionalism within the school indicates it is valued and seen as important in a medical curriculum, whether implemented as a core 'stand-alone' theme or threaded through the medical curriculum. A consistent theme throughout the analysis was the importance of bringing the definition of professionalism to the centre of learning. A definition was not only important for teaching, assessment, and remediation, but an inadequate definition was seen as the root cause of several systemic challenges.

From an educational perspective, systemic challenges relate to the interpretation of professionalism among individual educators or staff, and the standards expected of students compared to those of staff. Definitions of professionalism are often left to the purview of specific staff or components of medical programs (such as Personal and Professional Development streams) rather than being driven by Faculty level input. Additionally, conflating terms such as 'professionalism', 'professional behaviour' and 'professional identity' seems relatively common practice and has the potential to create confusion for students about what is being taught, or confusion for staff about what is being learnt.

From an organisational perspective, university embedded definitions of professionalism do not necessarily translate across to individual health services where much of the clinical teaching occurs. This fact needs to be explicit in student 'transition' programs to the clinical environment. Individual interpretations of professionalism across academic and clinical settings and the interchangeable use of different terms enables the persistence of a 'hidden curriculum' around the concept of professionalism. There is a risk that a paradox may occur in a program whereby well-developed systems assess a student's professionalism but are less applicable to staff. A concrete example is that most medical schools rely on role modelling as a teaching and learning method for professionalism, but few have the means to act on poor role models whose actions may not align to the framework of professionalism being taught to students. This also applies to academic codes of professional conduct at a university level and an assumption that the same codes will apply equally to all staff across the university and in a clinical setting. This may not always be clear to non-academic clinicians involved in teaching and assessment

Professionalism can be a difficult concept to measure in ways other than identifying when something is 'unprofessional'. We emphasise that professionalism can be developed and learnt. As such, within a program, it is vital that students are allowed to make mistakes by taking risks and trying different approaches but given the opportunity to learn from these. Therefore, not all lapses should be treated punitively.

Assessment of professionalism can be difficult and there is a risk that it will be interpreted as testing for a lack of unprofessionalism and result in only lapses being acted upon. While a variety of assessment tools may be used, it is not always clear which aspect(s) of professionalism they are aimed to assess. As an example, for an observed clinical encounter or peer rating, what aspect of professionalism is being commented on – manners, timeliness, language, dress code? Or for a Mini-CEX or OSCE station it may be unclear whether professionalism is assessed as a global judgment or related to specified aspects of the encounter. When it comes to decision making, it is not always clear how the various aspects of professionalism are synthesised and possibly judged. Consider the scenario below.

Hypothetical scenario

A student is late for class and appears somewhat dishevelled. However, that same student, on the way to class, stopped to help a member of the public who had collapsed in the street. The student also spent the previous evening helping some classmates revise their understanding of how to interpret findings from a clinical trial.

In this scenario, the student showed strengths in helping others, but some might interpret the student behaviours as showing a weakness in reliability and timekeeping. Do we simply 'add up' the strength in helping others with the weakness in reliability to say the student on average is probably satisfactory? Alternatively, do we take a broader view and conclude that overall, the student is directing their energies appropriately and is behaving very professionally?

Decisions about these issues require a synthesis of information, which may not be evident, transparent, or consistent. Unless we define, review, and dissect out the components of professionalism we are at risk of not always making a robust assessment of professionalism. Knowing what these components or pieces might be is a crucial first step.

This scenario also illustrates that there is a responsibility for students to explain their actions, and staff should provide opportunities for students to do this.

A system that captures information so a valid assessment can be made over time, and that captures the development of professionalism, also allows for correct conclusions to be drawn and allows transfer of information. However, often staff across the university and in clinical settings may not always have documentation or handover required, especially in regard to lapses in professionalism as students transition from one stage in training to the next. As such, the right people cannot always access the right information in the right context to support the learner – without breaching issues of privacy. Effective processes to facilitate the synthesis of professional behaviour information across different stages and environments would support tailored remediation programs for individual students that are outcome-focused and not focused on punitive measures.

So, what is professionalism?

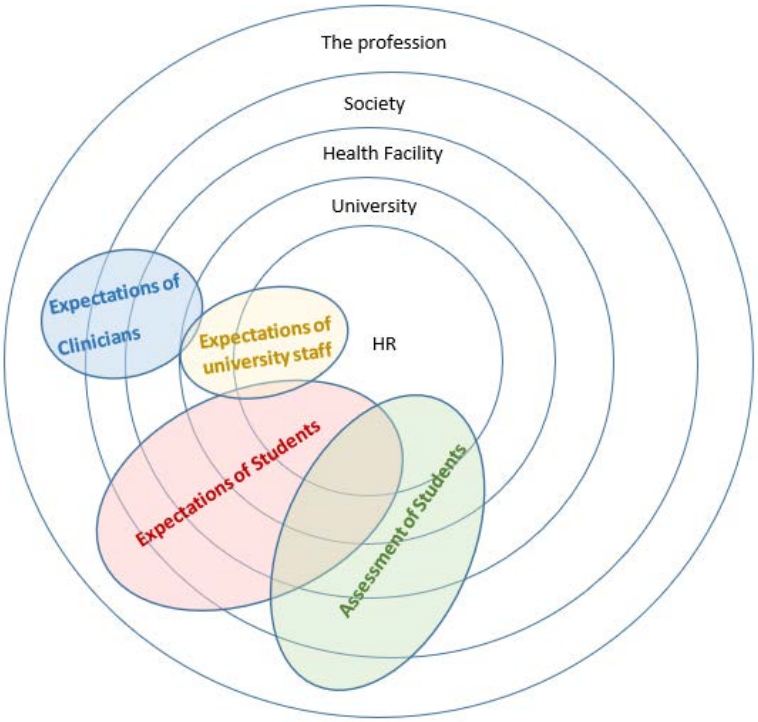
Given the heterogeneous and complex nature of the term 'professionalism', a single ubiquitous definition may not meet all medical schools' needs or capture the richness and multifaceted nature of the term. Instead, medical schools reflect on what they mean by the term 'professionalism' at different stages in the medical program and what components might be included.

In their responses, some medical schools described what professionalism is and some also added how it is acquired. Being explicit about what is being defined and for what purpose, its context and relevancy, and with whom it is shared, are important factors in ensuring students, staff and clinical educators have a common understanding of the term, how it is intended to be used and measured, and how to report positive or negative professional behaviours.

Professionalism could be that which is defined, assessed, in codes of practice; and is also shaped by the expectations of society. Professionalism is expected of:

- students
- staff
- the profession
- the university
- human resources
- role models

A schematic representation could currently look like this:



In this schema, what is expected of students may not be the same as what we expect of staff or clinicians. They may overlap but may not be the same. These expectations may not all align across the different contexts where students interact. For example, broader society's expectations may not align with the expectations of the facility, university or human resources. The medical profession is likely to have additional expectations about what constitutes professionalism. The schema demonstrates the importance of being explicit with students about what professionalism means because expectations may not align across all contexts. In addition, assumptions cannot be made that expectations of one group are correct because they were correct for another group.

Also, what we expect of students may not be what we assess. For example, students may be subject to a high level of scrutiny as part of assessment processes and be sanctioned for behaviours which appear to be accepted among staff or doctors. However, professionalism in clinical practice occurs in a complex context of simultaneous tensions and demands. Behaviours need interpretation and whilst it may appear staff can act inconsistently, the context they are operating in may provide good reason to do so and is not always apparent or appreciated on face value. Because of these complexities, professionalism should not be understood as a linear concept. Students learn to appreciate the balancing of tensions in decision making in these complex and messy situations as their knowledge and experience broadens and deepens.

It is also possible that we assess what is measurable in an effort to be 'objective' rather than including the breadth of what is expected by universities and society. We suggest therefore that there needs to be greater alignment among all these aspects and recognition by students that the context in clinical practice where decisions are made often make it difficult to clearly define what is and what is not professional.

Professional identity

'Professionalism' and 'professional identity'[3] are separate but related concepts. Fostering a positive professional identity was identified as essential to training doctors that are sensitive and responsive to their

[3] For the purposes of this report, 'professional identity' was generally defined by schools who did have a definition as the 'action' or 'doing' nature of the term. That is, it is a process of becoming socialised into professional expectations and

community's needs. However, this was often not explicitly incorporated in the teaching and learning activities medical schools noted in their feedback. Many schools did not define professional identity or note specific methods related to fostering a positive professional identity formation. Those schools that did define it often referred to it as the 'doing' or 'action' aspect of being socialised into the medical profession and taking on the associated expectations. Providing positive experiences and role modelling of what professionalism looks like in practice can help shape a student's professional identity and is the responsibility of all staff contributing to the delivery of the medical program, reinforcing the teaching.

Being explicit about what professional identity is, how it is developed and how it differs from professionalism is important to embed a culture of professionalism. A framework could highlight positive examples of how professionalism is 'lived' and developed over time with experience rather than framed as an abstract concept.

7. Detailed analysis of findings

7.1 Definitions

Essential components identified

The majority of responding medical schools stated they had a definition of professionalism and noted that they included 'professionalism definitions' in their teaching and learning programs. The majority of definitions referenced a range of literature. Some definitions of professionalism appeared to be combined with value statements, codes of conduct, or fitness to practise guidelines, which seem to function as a substitute for a specific definition.

Definitions identified a variety of components. Table 1 below compares the different components identified and the proportion of medical schools that included those components in their definitions. Differing weight afforded to these various components is likely to drive the focus of teaching, learning and assessment strategies, although this is not explicitly stated.

Table 1: Comparison of various components included in the definitions of professionalism and professional identity and the proportion of 22 Australian and New Zealand medical schools who used these components in their definitions

Components	Result^	Key points
Definition of professionalism	86%	Complex construct with many universities drawing on professional organisation definitions, university policy documents or definitions from the literature rather than providing a specific definition for their school
Definition – professional values*	26%	Range of components mentioned: ***respect*** *for self & others;* ***compassion/caring****; continual improvement;* ***accountability****;* ***self-regulation****/self-discipline****; patient interests are paramount****; ethical standards/regulatory frameworks; ambition; responsibility; legal obligations*
Definition – ethics/moral values*	53%	Range of components mentioned: *honesty/truthfulness****; integrity****; role virtues; focus on the benefit of 'other'; worthy of trust****; respect*** *for human dignity; confidentiality/privacy*
Definition – expected attributes*	63%	Range of components mentioned: ***essential for clinical competence****; essentially a 'contract with society'; is affected by context; essential for patient safety, essential for effective practice; special/ expert knowledge & skills; works effectively in a team; reliability/dependability; ability to work independently*

seeing medicine as a vocation and service to others. It is seen as a dynamic process that fosters interdisciplinary practice and is 'career long'.

Definition – codes of conduct	58%	Codes of conduct are mentioned as the reference point for a number of schools' definitions of professionalism, emphasising the focus on behaviour.
Definition - Acquisition	53%	This is a composite of statements about **how professionalism is demonstrated** (*engage in reflective practice & receive feedback; build on a foundation of basic clinical skills, scientific knowledge & moral development; judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values & reflection in daily practice*; *know and demonstrate a commitment to high standards of personal and professional behaviour with patients and their families, colleagues and inter-professional teams)* and **how students might acquire it** (*gained through experience, observation and persistence; habitual use of skills daily; requires reflective practice).*
Definition of Professional Identity (PI) formation	29%	Some schools indicated that professional identity and professionalism are interconnected terms. Professional identity appears to some to be the 'act' of professionalism. It embodies the concept of 'becoming a doctor', is regarded as life long and involves learning how to 'think, act and feel like a physician'
Applying definitions of professionalism and/or PI	82%	The benefit of a definition for providing a benchmark is frequently mentioned, especially in relation to professional behaviour and teaching professional values
Professionalism standards for teaching staff	91%	**All** responding universities indicated they used university-based codes of conduct rather than a specific medical school documents to guide staff on professionalism, even the two universities who responded 'no' to this question

**Commonly used terms are in bold*
^The percentage of schools including the components

Other possible components

It is recognised that professionalism can include a range of different aspects, as demonstrated in Table 1. We did not ask the medical schools to provide us with an explanation about the different aspects included in their definition of professionalism, and therefore cannot comment on the components included in their definitions of professionalism.

The impact of culture on professional norms was mentioned by a small number of universities, however, components such as Indigenous cultural elements, cultural safety, and leadership did not seem to be explicitly included in definitions of professionalism. It is worthwhile considering the diversity of voices that have input when developing a definition of professionalism. Inclusion of different cultural voices will shape how professionalism is defined and subsequently, how it is taught and assessed. It also influences the culture created in the medical school, which provides the environment required to nurture the values, attributes and behaviours included in the definition.

General findings from the analysis of professionalism definition responses included the following:

- Generic statements linking the profession's relationship to society appeared to be used in some instances as a substitute for a specific definition. This may explain the limited mention of 'professional value' terms compared to other components of the definition.
- Synonyms or alternative terms appeared to be used as a substitute for a specific definition.
- When codes of conduct were linked to definitions of professionalism, then these often mentioned explicit behavioural expectations.
- Some schools listed specific behavioural attributes as learning outcomes that are embedded in their teaching programs rather than providing definitions of professionalism.

Schools with a specific definition of professional identity emphasised the 'action' or 'doing' nature of the term. That is, it is a process of becoming socialised into professional expectations and seeing medicine as a vocation and service to others. It is seen as a dynamic process that fosters interdisciplinary practice and is 'career-long'. Professionalism definitions appear to be used for a range of purposes, including:

- To underscore policies and procedures within specific schools
- To inform professionalism teaching or behavioural expectations across teaching and learning platforms
- To guide remediation or to be used in conjunction with codes of conduct.

Aspects to consider

- Addressing both the ethos and the expression of professionalism within a single definition seems challenging. Emphasis varied across Australian and NZ medical schools, which may result in medical graduates having a variety of understandings of the term.
- Very few schools commented on the developmental nature of professionalism requiring time to develop. Some included life-long learning as part of professional identity.
- A large number of schools did not provide a specific definition of professional identity, perhaps seeing it as a component part of professionalism.
- The majority of medical schools did not identify specific professionalism standards for their clinical teaching staff, although a number identified professional behaviour policies at a central university level.
- While many clinicians are governed by the policies at several health services employing them, ensuring they are also aware of Faculty level expectations is important for aligning student –staff behaviour.

Differing schools may be covering their professionalism teaching in a range of domains/threads/themes of their program. Ensuring transparency about where in the program this is being taught could foster a common understanding of professionalism in Australian and NZ medical graduates.

Definitions: reflective questions to test how the different components of a professionalism definition are embedded and aligned throughout the medical program

- Is the desired outcome and purpose for the definition clear? How does it consider the context and variables that influence professional behaviour and the ethical choices that underpin professional decision-making?
- Has the development of a statement articulating the core components of professionalism been considered - what it is, how it is acquired and how it is demonstrated?
- Has a strong understanding of cultural sensitivity and cultural safety been incorporated in the description of professionalism?
- Is the relationship between the separate definitions of professional identity and professionalism clear?
- How is the Faculty's definition of professionalism promoted and embedded across all layers of the program?
- Are all staff involved in teaching programs aware of, have an understanding of and using the definition to help reduce the impact of individual interpretation or fostering a 'hidden' curriculum?
- Is the process for weighting the components of the professionalism definition within the teaching, learning and assessment programs clearly articulated?
- Does the definition emphasise the dynamic nature of professionalism with clearly identified stage appropriate acquisitions, is a product of its time and requires regular revision to ensure relevancy?

Recommendations

- Ensure a definition of professionalism that applies to both staff and students. It should be: explicit about its components; applicable to different stages of the medical program; and relate to the teaching, learning, assessment activities and remediation processes. It needs to incorporate a strong understanding of cultural sensitivity and cultural safety.

- Ensure expectations of professional behaviour for both students and staff are clearly expressed and consistently monitored.
- Advocate for the definition to be endorsed, or if possible adopted, in the health service setting.
- Make explicit the alignment between the components that make up the definition of professionalism, and the associated teaching, learning and assessment activities and remediation processes.
- Have a glossary of terms to help reduce confusion about the use of terms such as professional competence, professional behaviour, and professional identity.

7.2 Teaching and learning

The approach to implementation of this curriculum component varied across institutions, likely as a result of variation in the definition of professionalism. Key differences could stem from:

- an approach based on self-reflection and personal development in contrast to one based on the development of knowledge, attitudes, and skills through more explicit teaching; and/or
- a positive, skill acquisition and attitude development approach in contrast to a more punitive approach focused on addressing breaches in professional behaviour or inappropriate conduct.

All institutions sought to instil strong ethical and professional principles in their students. While explicit teaching and learning existed for professionalism, the goal could be seen as the development of a positive professional culture among both students and staff. Explicit teaching of theoretical knowledge (ethics and law, professional codes, professional behaviours, and expectations) most often occurred in the early stages of programs, while later, clinical stages relied largely on immersive learning that included role-modelling.

While there was variation in the inclusion of some components in the curriculum (e.g. First Nations' health, communication), all institutions included some components common across responses. These, and the teaching and learning approaches commonly used to address them are summarised in the table below. The level of control refers to the degree to which medical schools controlled or shaped students' learning in each of the contexts.

Table 2: Common teaching and learning core components of professionalism

Content	Medium or method	Level of control
Knowledge of ethics and associated clinical reasoning and decision-making	Lectures and workshops in early stages of programs	High
Legal considerations and awareness of professional codes of practice	Lectures and workshops in early stages of programs, or pre-internship programs with presentations from regulatory and professional bodies	High
Development of professional attitudes and behaviours including respect, patient-centred care, critical reflection, leadership, lifelong learning, cultural awareness and dealing with prejudice	Principles shared early and often reinforced through modelling including written reflective tasks, the expectation of professional behaviours in clinical contact and OSCEs, and behavioural modelling in clinical placement	Moderate
Teamwork and communication including speaking up	Principles shared early through lectures, later opportunities for experiential learning through workshops and behavioural modelling in clinical placement	Moderate
Self-care and mindfulness	Seminars, modelling and student support	Moderate
Behavioural and academic expectations including attendance, punctuality, and academic integrity	Lectures, written codes, online and self-directed modules. Also modelled through assignment marking, expectation of citation in academic writing etc	Moderate

Aspects to consider

Explicit professionalism learning objectives

In many cases, learning in clinical settings is implicit and opportunistic. In the absence of explicit professionalism learning objectives within sessions such as Problem Based Learning or explicit debrief, discussion, learning is likely to be tutor-dependent with a risk of missed opportunities for reflection about what they may have learned whilst in a clinical setting. Even when there are explicit learning objectives, the manner in which they are delivered is very dependent on tutor confidence in the subject area.

Role modelling, whether it is by a clinician, academic or professional staff, may have a significant impact on embedding an understanding of and commitment to professionalism by immersing the students in a culture of professionalism. Role modelling and debriefs about why that role modelling was positive also demonstrates what professionalism is, rather than assuming that professionalism is a lack of unprofessionalism.

Similarly, without structured discussion of positive and negative role-models and examples of professional and unprofessional behaviour, there is a risk of unreflective imitation[4] and the development of negative professional behaviours or attitudes. Some institutions routinely include debriefing and discussion of both positive and negative role-modelling which ensures that learning opportunities are realised.

Professional identity

Professionalism and professional identity seem related but are distinct concepts. Behaving in a professional manner is not always the same as feeling like a professional. However, both are developmental and require nurturing longitudinally. Few teaching and learning activities relate explicitly to professional identity. It seems that professional identity is assumed to develop naturally as a result of immersion in medical education, but there may be scope for more direct teaching to foster a positive professional identity.

Without clarity about what professional identity is and how it is developed, confusion may result where the concept of 'objective assessment' may be misapplied to a notion of professionalism as phronesis or 'being'. Dissecting out these issues, in parallel with being clearer about definitions on professionalism and professional identity, is likely to be helpful to many schools.

Recommendations

- Ensure a range of learning opportunities on professionalism are embedded in the curriculum and are made explicit, particularly in the transition into clinical settings as this represents an opportunity for specific teaching regarding expectations.
- Work with health service providers to ensure the medical school's professionalism definitions are enacted in their placement teaching programs.
- Provide learning opportunities related explicitly to professional identity formation, to foster an understanding of the direct connection between the two
- Build a positive culture around professionalism, empowering students to act professionally and embrace and learn about professionalism rather than having the focus on penalising bad behaviour (e.g. empower students to inform of absences rather than marking a roll and penalising non-attendance). This may be through creation of a safe space to enable students to explore and make mistakes and learn from them.
- Ensure expectations of role models for students are consistent with the expectations of students.

[4] Unreflective imitation refers to instances where students engage in imitation without critical reflection or assessment of the attributes and behaviours of role models and which of those attributes the students should choose to adopt. Benbassat J. (2014). Role modeling in medical education: the importance of a reflective imitation. Academic medicine: journal of the Association of American Medical Colleges, 89(4), 550–554. https://doi.org/10.1097/ACM.0000000000000189

- Explore opportunities to share teaching and learning resources, including further consultation with the Medical Board of Australia about the development of professionalism modules for students.

7.3 Assessment

All schools had a system of integrating assessment of professionalism across a program. They also showed a commitment to identifying single episodes of unprofessional behaviour and using these to help determine if there is a pattern of recurring lapses. Some used portfolios for this purpose. The variety of assessment modalities used suggests that medical schools are making efforts to assess, with high degrees of reliability and validity, what they recognise as a key component of medical education and training

Table 3 shows the types of tools used. Note that the survey relied on free text answers to open ended questions, so there are likely to be schools using assessment methods or tools that are not included in the table.

Table 3: Multiple choice responses to question 8 – assessment tools used in assessing the professional behaviour of students

Assessment tools	Number of schools	Percentage
Assessment of an observed clinical encounter (e.g. mini-CEX, mini-evaluation exercise, standard direct observation assessment tool)	21	95%
Collated views of co-workers (e.g. multisource feedback, student peer review)	14	64%
Record of incidents of unprofessionalism (e.g. incident reporting form)	21	95%
Critical incident report (e.g. Critical incident report)	13	59%
Simulation (e.g. OSCE, ethical dilemmas in high-fidelity patient simulations)	17	77%
Paper-based test (e.g. objective structured video exams, multiple choice test)	14	64%
Patient opinion (e.g. FACE cards, patient assessment questionnaire, simulated patient rating scales, humanism scale)	8	36%
Global view of supervisor (e.g. Global rating scale, University of Michigan Department of Surgery Professionalism Assessment Instrument, Evaluation of professional behaviour in general practice (EPROGP))	15	68%
Self-administered rating scale (e.g. Time Management Inquiry Form, Cultural competence self-assessment questionnaire, Groningen Reflection Ability Scale)	7	32%
Critical reflection tools (e.g. portfolio)	19	86%
Other (e.g. use of tools such as cultural competence self-assessment questionnaire, Interpersonal Reactivity Index)	5	23%

The tools most commonly used are observed clinical encounters and exercises involving reflection. Related to the problems with definitions, mentioned above, it is not always clear which aspects of professionalism a student or rater is asked to reflect or comment on and therefore whether the reflection all comes from a restricted range of activities. Most also have records of unprofessionalism which are presumably related to and/or overlapping with any Fitness to Practise procedures.

Feedback from the schools indicated that there might be less assessment in the later years of a program. Alternatively, it could be that the assessment is more integrated as they are likely to be in clinicals placements: this is desirable, but requires clarity and visibility of the components. There may be different aspects of professionalism that are assessed as students develop in experience and over time, building on previous years.

Aspects to consider

Feedforward

- This refers to sharing information about a student's past performance with people who have yet to see the student, such as the staff involved in the student's next clinical placement. The argument against this is that subsequent judgements might be prejudicial. The counter argument is that professionalism is developmental and needs nurturing over time.
- There was variation in the approach to sharing information so that students can be helped as they progress through the program. Such 'mapping and tracking' could apply across years, not just within years and would include any systems for longitudinal monitoring.
- A second area of 'feedforwarding' relates to passing on information to the health service once a student has graduated, or to the regulator. The same benefits of learning, and risks of being prejudicial, apply as discussed above in sharing information with staff involved in the student's next clinical placement.
- Ideas on best practice here are worthy of sharing and the transfer of this information is an area the Medical Deans' Student Health Committee is exploring.

Professionalism is more than lack of unprofessionalism

- Many schools provided examples of how they acted on unprofessionalism and the sanctions that could be applied to students; fewer schools described how they showed that students had met the requirements of professionalism.
- Even if unintentional, the subliminal message to learners may be provided to learners is 'provided I don't do anything bad I must be OK'. This is a blurring of professionalism and a lack of misconduct.

Recommendations

- Further explore the value of methods to longitudinally track students' behaviours within and across years. Any such system needs to recognise that professionalism is developmental and ensure that students are supported as they progress through the program and develop their professional identity. Positive re-enforcement is as important as correcting unwanted behaviour.

- Assess professionalism as part of a general assessment of a student, being explicit about what attributes or components of professionalism are being assessed and sharing any rating forms.

7.4 Remediation

Consistent with the definitions, teaching and assessment of professionalism, there was considerable variability between schools in their approach to remediation. Some medical schools reported on the results of substandard performance on professionalism assessment tasks (e.g. OSCE stations), whilst other schools reported on professional behaviour lapses in the campus and clinical practice environment (i.e. 'fitness to practise'). Remediating these each requires different approaches.

There was recognition of the need for individualised approaches and targeted support for students demonstrating a lapse in professional behaviour. Most schools described an initial attempt to provide support and to identify factors associated with the possible lapse in professional behaviour rather than adopting a punitive approach. This was generally done at a local level and involved a senior Faculty member or academic co-ordinator. Several schools described a sequential escalation according to the nature of the behaviour and the student's response, to a lapse that was considered minor, more significant or major or, to a pattern of repeated lapses. It was recognised that the majority of students can be successfully remediated with awareness raising and behaviour modification, sometimes involving formal psychological support. Several schools mentioned the need for shared responsibility, student engagement, and a clear action plan with clear measurable expectations, to ensure success of these measures.

Generally,

- More serious or repeated issues were escalated to a higher level (e.g. Associate Dean, Program Director) and many schools have a formal disciplinary (or Fitness to Practise) committee, often at the Faculty level.
- Factors identified as effective in these cases included adherence to school and university policies, clear communication with students, gaining trust and maintaining confidentiality and good documentation.
- Almost all schools had processes in place for when remediation is unsuccessful or where there were serious breaches that could not be addressed by remediation.

Most schools would refer a student to a regulatory body (such as either the Australian Health Practitioners Regulatory Authority, Medical Board of Australia, or Medical Council of New Zealand). Most had a mechanism to suspend or remove a student from the program when remediation of a student's lapse in professionalism is not successful or there are significant breaches that cannot be addressed through remediation.

All the medical schools surveyed had a process for identifying professionalism issues, had at least one person dedicated to managing the process, and all applied remediation plans tailored to the severity of a 'lapse' in professionalism and individualised to specific students' problems or needs. Many schools also highlighted the importance of sound documentation and having an appointed person or people to oversee the actual remediation. When student lapses in professionalism became a long-term issue, despite attempts at remediation, all schools had a process for escalating the situation for closer review which may result in barriers to progression or even eventual exclusion.

It is not always clear how good the fit was between the aspect of professionalism in question and the remediation plan. In other words, what were the 'symptoms' of a lapse in professional behaviour, what was the actual 'diagnosis', based on which set of 'investigations', and therefore what was the specific 'treatment'? Reflection and mentoring seemed to be common 'treatments' regardless of the 'diagnosis'.

Aspects to consider

Documentation and information synthesis

Appropriate documentation (confidentiality, storage of information) was identified as a possible gap as some schools do not have a formal process for synthesising information about students, or if systems exist it is not certain that all relevant information is recorded.

Effectiveness of remediation processes

- It was common for most of the medical schools surveyed to have in place systems for monitoring professionalism lapses, which in turn often triggered a tailored remediation program for an individual student. However, there was uncertainty regarding the effectiveness of particular interventions and there was a lack of longitudinal follow up.
- From a quality assurance point of view, what was missing was a sense of the effectiveness of different approaches to remediation, what aspects of behaviour were more remediable than others and what kinds of interventions resulted in better outcomes than others.
- To use the analogy of treating a patient, there was a distinct lack of evidence-based practice in understanding which lapses in professional behaviour were most amenable to remediation; and which strategies of remediation resulted in a tangible improvement in outcome for the student.

Recommendations

- Focus on the desired outcome from remediation considering what works well or less well with students and for which professional behaviours, ensuring student perspectives inform this. This could be an area for further research.

- Make clear to students, role models[5] and health services (i.e. all parties involved), the processes for identifying and remedying lapses in professional behaviour. Processes and discussions should be documented and 'handed over', to improve the ongoing support of the learner who experiences a lapse in professional behaviour.

- Communicate channels of reporting and notification of both minor and serious concerns between the different teams and staff involved in medical program delivery and students. For example, do clinical supervisors know with whom to speak if they notice an incident that may be considered minor but possibly worth further discussion?

7.5 Literature and resources

In addition to providing responses to survey questions, schools were invited to share relevant literature or resources that contribute to their teaching, assessment of professionalism, or remediation of lapses in professionalism.

A curated list of recommended literature that was gathered by the working group and participating medical schools is found at Attachment 4. It is divided into five areas of relevance: definitions, teaching and learning, assessment, remediation, and professional identity. A range of additional materials was provided and included:

- Examples of Codes of Conduct or Charters for students and Codes of Conduct or professional behaviours expected of staff.
- Documented behavioural expectations such as policies or statements.
- Guidelines, procedures, or documentation for managing misconduct or lapses in professionalism.
- Examples of learning outcomes, assessments or program outlines related to professionalism teaching.
- Presentations or explanatory frameworks for how teaching and assessment is conceived in their curriculum.

8. Limitations

There were limitations of the survey methodology, including a short time frame for response to the survey. Medical schools were given three weeks to respond, which may have limited the breadth of consultation within schools. In addition, each section of the survey was analysed by a subgroup of the working committee, prior to review by the entire group. This may have introduced bias due to different interpretations of how professionalism was defined, taught, and assessed at different medical schools.

Given the static nature of the survey, and that data were provided individually by schools without any examples or semi-structured interview follow-up, some schools may have not provided the full range of information about how they teach and assess professionalism. Consequently, insights that were drawn from the survey cannot be considered definitive. The majority of questions used in the survey were open-ended questions. This was useful as it allowed for free text answers but also made it difficult to quantify areas or activities.

9. Areas for further research

The areas below were identified for further exploration and research.

- Professionalism may be assessed as part of a general assessment of a student; for example their interaction with a patient. Sharing which attributes of professionalism are mentioned on rating forms could be of mutual interest.
- Multi-centre collaboration and research to document the use of remediation programs and measuring their long and short term outcomes would facilitate sharing best practice.

[5] The term 'role models' in this context applies to university academics, clinicians, supervisors or other staff that are involved in the delivery of the medical program.

- Facilitating networking of relevant personnel from each school to share experiences and examples of good practice in the remediation of professional behaviour. It is possible that each person who is responsible for arranging remediation may feel somewhat isolated and unsupported.
- In focusing on outcomes, an assessment of the students' perspectives regarding remediation could be a focus of further research. Why, for example, do students engage or not engage with a particular remediation process, or why did they engage in unprofessional behaviour in the first instance?
- Given the importance of a definition, the development of guidance defining professionalism in medical schools may be worthwhile exploring.

10. Sharing good practice

As part of this process, the Working Group seek to gather and share a range of good examples from different medical schools about how they define, teach and assess professionalism and the remediation processes they use. This is intended to be used to share good practice among schools and enable schools to connect to others who may have solutions to specific problems that schools might be facing.

11. References

Benbassat J. (2014). Role modeling in medical education: the importance of a reflective imitation. Academic medicine : journal of the Association of American Medical Colleges, 89(4), 550–554. https://doi.org/10.1097/ACM.0000000000000189

Working party of the Royal College of Physicians; Doctors in society medical professionalism in a changing world. Technical supplement to a report of a working party of the Royal College of Physicians of London. London: RCP, 2005 [http://www.rcplondon.ac.uk/pubs/books/docinsoc/]

Medical Deans Professionalism Working Group
Terms of Reference

Role and responsibilities

The Medical Deans' **Professionalism Working Group** is a group established by and reporting to the Medical Education Collaborative Committee (MECC). The group is tasked with developing a report that provides practical advice on embedding a culture of professionalism among students as part of forming their professional identity as a medical practitioner. This includes guiding and encouraging students to reflect on the impact of their own values, assumptions and beliefs and those of their peers, teachers and patients, when engaging with them. The group will consider and recommend appropriate approaches in the teaching, development and assessment of professionalism in medical programs. This work will also consider cases of lapses in professional behaviour and appropriate techniques for remediation or approaches to reinforce positive behaviours.

The role of the Professional Working Group is to:

- Develop appropriate and practical definition(s) of professionalism, professional behaviours, professional identity and any other relevant terms often used in relation to medical education
- Briefly review and share literature relevant to teaching and assessing professionalism in medical programs
- Identify and share the current activities of medical schools to guide students to develop professionalism, professional behaviours and professional identity through training, coaching, mentoring, role modelling and assessment
- Identify and share practical initiatives, both nationally and internationally
- Identify gaps and recommend future initiatives that may address known gaps
- Consider the systemic challenges that negatively impact the effectiveness of training, coaching, mentoring, role modelling professionalism
- Identify shared issues across medical schools and techniques for remediation or consequences for lapses in professionalism
- Provide a report based on the findings from these tasks to be circulated within medical schools in Australia and New Zealand for their consideration.

Members of the group may choose to develop or contribute to a publication based on the activities or findings of this working group. This work would be a separate activity outside the remit of this working group.

Membership

Membership will comprise MECC members or other nominated employees of medical member schools. The Chair of the working group is to be a member of MECC and should be reviewed and approved by the MECC Chair.

Operations

The Professionalism Working Group will meet as necessary and agreed by the group, via video/teleconference (using Zoom). Communication and the sharing of information and relevant documents will be via the Professionalism Working Group area on the Medical Deans Basecamp portal.

Medical Deans will provide the Professionalism Working Group with secretariat support, as well as policy, research, communications and project support when required.

The Professionalism Working Group will be disbanded once the group or MECC confirms the completion of the task asked of them.

Authority

The Professionalism Working Group will report as requested to MECC on their progress.

Other than the support described above, any use of Medical Deans' resources or expenditure requires prior approval of both MECC and the Medical Deans' Executive Committee.

The Professionalism Working Group members do not have authority to speak on behalf of Medical Deans or authorise Medical Deans' endorsement of any materials (whether developed within Medical Deans, a member school or university, or by an external stakeholder) without prior approval by MECC and the Executive Committee.

16 June 2020

Attachment 1 Professionalism Working Group Baseline survey

Introduction

In order to establish a snapshot baseline for the work of the working group, please provide the information requested below as best you can. Questions asked are specifically about student professionalism unless otherwise specified. If you do have any supporting resources or documents you would like to share with the working group, you may upload them to the resources folder on Basecamp, available here.

Definitions

1. Does your school/medical program have a definition for the term "Professionalism"?

If so, please provide the definition. *(Free text)*
If no, please place N/A below.

2. Does your school/medical program have a definition for the term "Professional identity"?

If so, please provide the definition. *(Free text)*
If no, please place N/A below.

3. If you do have a definition for either terms, how do you use them in your program (i.e teaching and learning, a professionalism course, code of conduct, used in assessments, benchmark for remediation or more significant breaches, etc)? *(Free text)*

4. Does your school have professionalism standards for teaching staff? *(yes/no)*

Please upload any supporting resources or documents you would like to share with the working group to the resources folder on Basecamp, available here.

Teaching, learning and assessment

5. Please select which of the following tools you use in teaching and learning in relation to professionalism. *(Tick box – select all that apply)*
    - Lectures
    - Case studies
    - Small group sessions
    - Role modelling
    - Acting on poor role models (e.g. use of poor role model behaviour as a teaching point, stopping the poor behaviour of the role model or using role players modelling unprofessional behaviour)
    - Coaching
    - Mentoring
    - Interprofessional learning
    - Tutorial, group or self-directed tasks
    - Assessment tools for learning
    - Other, please specify *(Free text)*

6. Please provide any further information about the professionalism teaching and learning methods in your program. *(Free text)*

7. At which stage of the course (i.e. year, pre-clinical or clinical) do you use each of these teaching and learning methods? Please list the tool/method and stage of the program when these are used (ie. Which year and part of the year such as in-course or end of year) *(Free text)*

8. Please select which of the following tools you use in assessing the professional behaviour of students. *(Tick box – select all that apply)*
    - Assessment of an observed clinical encounter (e.g. mini-CEX, mini-evaluation exercise, standard direct observation assessment tool)
    - Collated views of co-workers (e.g. multisource feedback, student peer review)
    - Record of incidents of unprofessionalism (e.g. incident reporting form)
    - Critical incident report (e.g. Critical incident report)
    - Simulation (e.g. OSCE, ethical dilemmas in high-fidelity patient simulations)
    - Paper-based test (e.g. objective structured video exams, multiple choice test)
    - Patient opinion (e.g. FACE cards, patient assessment questionnaire, simulated patient rating scales, humanism scale)
    - Global view of supervisor (e.g. Global rating scale, University of Michigan Department of Surgery Professionalism Assessment Instrument, Evaluation of professional behaviour in general practice (EPROGP))
    - Self-administered rating scale (e.g. Time Management Inquiry Form, Cultural competence self-assessment questionnaire, Groningen Reflection Ability Scale)
    - Critical reflection tools (e.g. portfolio)
    - Other (e.g. use of tools such as cultural competence self-assessment questionnaire, Interpersonal Reactivity Index), please specify *(Free text)*

9. Please provide any further information about the professionalism assessment tools used in your program. *(Free text)*

10. At which stage of the course do you use each of these assessment tools to assess students' professional behaviour? Please list the tool and stage of the program when these are used (ie. Which year and part of the year such as in-course or end of year) *(Free text)*

11. Please share with us what you find has worked well in relation to teaching, learning or assessment of professionalism at your medical school *(Free text)*

12. Please share with us areas where you have identified gaps or would like to improve on, or where ideas from other medical schools could help you? For example, do you have any ideas for new teaching, learning or assessment tools you would like to implement? *(Free text)*

Please upload any supporting resources or documents you would like to share with the working group to the resources folder on Basecamp, available here.

Remediation

13. What processes do you have in place for remediation of student lapses in professionalism? *(Free text)*

14. What works well in relation to the remediation processes in your medical school and how do you know it works? *(Free text)*

15. Do you have any processes for when remediation of a student's lapse in professionalism is not successful or there are significant breaches that cannot be addressed through remediation? *(Yes/No)*

16. If so, what are those processes? Below are some examples to select from. *(Tick box – select all that apply)*

- N/A (if answered no to Q11)
- Suspending the student
- Removing the student from the program
- Referral to regulatory body
- Other (Please provide information about any other processes you may have) *(free text)*

17. If you selected, "Referral to a regulatory body", please specify which regulatory body. If not, please type N/A *(free text).*

18. What do you find has worked well in relation to these processes? *(Free text)*

19. What is your process to synthesise information about students? *(Free text)*

Please upload any supporting resources or documents you would like to share with the working group to the resources folder on Basecamp, available here.

References

20. Please provide a list of seminal references you are using to guide the development of your program or you find useful. *(Free text)*

Please upload any supporting resources or documents you would like to share with the working group to the resources folder on Basecamp, available here.

21. Please provide your name or university, and the type and duration of degree. *(Free text)*

Attachment 2 Quantitative response tables

Professionalism Working Group

Section 1: Definitions

Table 1: Medical Schools in Australia and New Zealand have a definition for the term "Professionalism"?

Response	Number of schools	Percentage
Yes	18	82%
No	4	18%
Total	22	100%

Table 2: Medical Schools in Australia and New Zealand that have professionalism standards for teaching staff? *(yes/no)*

Response	Number of schools	Percentage
Yes	20	91%
No	2	9%
Total	22	100%

Section 2: Teaching, learning and assessment

Table 3: Medical Schools in Australia and New Zealand's tools used in teaching and learning in relation to professionalism.

Teaching and learning tools	Number of schools	Percentage
Lectures	22	100%
Case studies	20	91%
Small group sessions	19	86%
Role modelling	22	50%
Acting on poor role models (e.g. use of poor role model behaviour as a teaching point, stopping the poor behaviour of the role model or using role players modelling unprofessional behaviour)	15	68%
Coaching	7	32%
Mentoring	19	86%
Interprofessional learning	17	77%
Tutorial, group or self-directed tasks	20	91%
Assessment tools for learning	21	95%
Other, please specify *(Free text)*	11	50%

Table 4: Medical Schools in Australia and New Zealand's tools used in assessing the professional behaviour of students

Assessment tools	Number of schools	Percentage
Assessment of an observed clinical encounter (e.g. mini-CEX, mini-evaluation exercise, standard direct observation assessment tool)	21	95%
Collated views of co-workers (e.g. multisource feedback, student peer review)	14	64%
Record of incidents of unprofessionalism (e.g. incident reporting form)	21	95%
Critical incident report (e.g. Critical incident report)	13	59%
Simulation (e.g. OSCE, ethical dilemmas in high-fidelity patient simulations)	17	77%
Paper-based test (e.g. objective structured video exams, multiple choice test)	14	64%
Patient opinion (e.g. FACE cards, patient assessment questionnaire, simulated patient rating scales, humanism scale)	8	36%
Global view of supervisor (e.g. Global rating scale, University of Michigan Department of Surgery Professionalism Assessment Instrument, Evaluation of professional behaviour in general practice (EPROGP))	15	68%
Self-administered rating scale (e.g. Time Management Inquiry Form, Cultural competence self-assessment questionnaire, Groningen Reflection Ability Scale)	7	32%
Critical reflection tools (e.g. portfolio)	19	86%
Other (e.g. use of tools such as cultural competence self-assessment questionnaire, Interpersonal Reactivity Index), please specify *(Free text)*	5	23%

Table 5: Medical Schools in Australia and New Zealand that have processes for when remediation of a student's lapse in professionalism is not successful or there are significant breaches that cannot be addressed through remediation

Answer	Number of schools	Percentage
Yes	20	91%
No	2	9%
Total	22	100%

Table 6: Medical Schools in Australia and New Zealand's processes used when remediation of a student's lapse in professionalism is not successful or there are significant breaches that cannot be addressed through remediation

Process	Number of schools	Percentage
N/A (if answered no to Q11)	0	0%
Suspending the student	14	70%
Removing the student from the program	15	75%

Referral to regulatory body	18	90%
Other (Please provide information about any other processes you may have)	16	80%
Total	20	N/A as multiple selections enabled

Table 7: Medical Schools in Australia and New Zealand's referral to regulatory body of students lapsing in professionalism

Regulatory body	Number of schools	Percentage
APHRA or MBA	17	85%
MCNZ	2	10%
University committee	3	15%
Total	20	N/A as multiple selections enabled

Attachment 4 Professionalism and professional identity literature

Professionalism Working Group

Area of relevance: Definitions

1. Birden H, Glass N, Wilson I, Harrison M, Usherwood T, Nass D. Defining professionalism in medical education: a systematic review. Medical Teacher. 2014;36(1):47-61.
2. Working Party of the Royal College of P. Doctors in society. Medical professionalism in a changing world. Clin Med (Lond). 2005;5(6 Suppl 1):S5-40.
3. Jha V, McLean M, Gibbs TJ, Sandars J. Medical professionalism across cultures: a challenge for medicine and medical education. Medical teacher. 2015;37(1):74-80.
4. van der Horst F, Lemmens P. Medical education and professionalism across different cultures. Medical Education. 2012;46(3):238-9.
5. Irby DM, Hamstra SJ. Parting the Clouds: Three Professionalism Frameworks in Medical Education. Acad Med. 2016;91(12):1606-11.
6. Sattar K, Roff S, Meo SA. Your professionalism is not my professionalism: congruence and variance in the views of medical students and faculty about professionalism. BMC medical education. 2016;16(1):285.
7. Aguilar AE, Stupans L, Scutter S. Assessing students' professionalism: considering professionalism's diverging definitions. Education for Health. 2011;24(3):599.
8. Barnhoorn PC, Youngson C. Refining a definition of medical professionalism. Academic Medicine. 2014;89(12):1579.
9. McCammon S BH. How virtue ethics informs medical professionalism. HEC Forum. 2012;24:25-7
10. Ali A, Anakin M, Tweed MJ, Wilkinson TJ. Towards a Definition of Distinction in Professionalism. Teaching and Learning in Medicine. 2020; 32(2): 126-38.
11. Epstein, RM, Hundert, EM (2002) Defining and Assessing Professional Competence. JAMA 287, 226-235
12. Cruess S.R. and Cruess R.L. (2012). Teaching professionalism – Why, What and How. Facts Views Vis, Obgyn., 4(4): 259–265.
13. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002 Feb 5;136(3):243-6. doi: 10.7326/0003-4819-136-3-200202050-00012. PMID: 11827500.
14. Hilton, Sean & Southgate, Lesley. (2007). Professionalism in medical education. Teaching and Teacher Education. 23. 265-279. 10.1016/j.tate.2006.12.024.
15. General Medical Council (2016) Professional behaviour and fitness to practise: guidance for medical schools and their students.
16. Medical Council of New Zealand (2016) Good Medical Practice.
17. Australian Council of Professions (2016) What is a profession? [Website] Available at: http://www.professions.com.au/about-us/what-is-a-professional
18. Breen et al, (2010) Good Medical Practice: Professionalism, Ethics and Law, Australian Medical Council
19. Swick HM. (2000) Towards a normative definition of medical professionalism. Acad Med 75: 612-16
20. Cruess, Richard & Cruess, Sylvia & Boudreau, J & Snell, Linda & Steinert, Yvonne. (2014). Reframing Medical Education to Support Professional Identity Formation. Academic medicine : journal of the Association of American Medical Colleges. 89. 10.1097/ACM.0000000000000427.
21. Monrouxe, L. (2010). Identity, identification and medical education: why should we care? Medical Education, Vol.22:1. https://doi.org/10.1111/j.1365-2923.2009.03440.

Area of relevance: Teaching and learning

22. Weaver R, Wilson I. Australian medical students' perceptions of professionalism and ethics in medical television programs. BMC medical education. 2011;11:50.
23. Stern DT, Papadakis M. The developing physician--becoming a professional. N Engl J Med. 2006;355(17):1794-9.
24. Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. Acad Med. 2004;79(3):244-9.
25. Papadakis MA, Arnold GK, Blank LL, Holmboe ES, Lipner RS. Performance during internal medicine residency training and subsequent disciplinary action by state licensing boards. Ann Intern Med. 2008;148(11):869-76.
26. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. A schematic representation of the professional identity formation and socialization of medical students and residents: a guide for medical educators. Academic medicine : journal of the Association of American Medical Colleges. 2015;90(6):718-25.
27. Brody H, Doukas D. Professionalism: a framework to guide medical education. Medical education. 2014;48(10):980-7.
28. Parker M, Luke H, Zhang J, Wilkinson D, Peterson R, Ozolins I. The "pyramid of professionalism": seven years of experience with an integrated program of teaching, developing, and assessing professionalism among medical students. Academic medicine : journal of the Association of American Medical Colleges. 2008;83(8):733-41.
29. Bryden P, Ginsburg S, Kurabi B, Ahmed N. Professing professionalism: are we our own worst enemy? Faculty members' experiences of teaching and evaluating professionalism in medical education at one school. Academic Medicine. 2010;85(6):1025-34.
30. Bandini J, Mitchell C, Epstein-Peterson ZD, Amobi A, Cahill J, Peteet J, et al. Student and Faculty Reflections of the Hidden Curriculum. The American journal of hospice & palliative care. 2017;34(1):57-63.
31. General Medical Council and Medical Schools Council (2016) Achieving good medical practice: guidance for medical students. Available at: https://www.gmc-uk.org/-/media/documents/Achieving_good_medical_practice_0816.pdf_66086678.pdf
32. Worthington , R, Hays, R, 2013, Practical Professionalism in Medicine: A Global Case-Based Workbook, Radcliffe Publishing, London & New York
33. Hilton, S. & Slotnick, H. 2005. “Proto-professionalism: how professionalism occurs across the continuum of medical education,” Med Education, vol.39, pp. 58–65.
34. Irby, D.M., Hamstra, S.J. December 2016, Parting the Clouds: Three Professionalism Frameworks in Medical Education Academic Medicine, vol. 91, no. 12, p 1606-1611
35. Cruess, R. L., Cruess, S. R., & Steinert, Y. (2016). Teaching medical professionalism: supporting the development of a professional identity (Second ed.). New York;Cambridge, United Kingdom;: Cambridge University Press.
36. van de Ridder, J. M. M., McGaghie, W. C., Stokking, K. M., & ten Cate, O. T. J. (2015). Variables that affect the process and outcome of feedback, relevant for medical training: A meta-review. Medical Education, 49(7), 658-673. doi:10.1111/medu.12744
37. Paterson, Ron (2012). The Good Doctor: what patients want. Auckland University Press.
38. Breen, Cordner and Thomson (2016). Good Medical Practice: Professionalism, Ethics and Law. Australian Medical Council Ltd.
39. Cruess et al. Teaching Medical Professionalism Cambridge University Press 2016
40. Wilson, H. & Cunningham, W. (2013) Being a doctor: understanding medical practice, Otago University Press
41. General Medical Council, Medical Professionalism Matters (2016) Available at: https://www.gmc-uk.org/-/media/documents/mpm-report_pdf-68646225.pdf

42. General Medical Council, The reflective practitioner. Available at: https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice
43. https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx
44. Bryant JH. Educating tomorrow's doctors. World Health Forum. 1993;14(3):217-230.
45. Anderson MB. In progress: reports of new approaches in medical education. Academic Medicine. 1999;74(5):561-618.
46. Kropiunigg U, Pucher I, Weckenmann M. Learning in groups: Teamshaping in the teaching of medical psychology. Med Educ. 2002;36(4):334-336.
47. General Medical Council. Outcomes for graduates 2018. https://www.gmc-uk.org/-/media/documents/outcomes-for-graduates-a4_pdf-77470228.pdf. Published 2018. Accessed March 22, 2019.
48. Kemmis S, & McTaggart R. The Action Research Planner. 3rd edn Published 1988. Geelong: Deakin University Press.
49. Van Luijk SJ, Project Team Concilium Abeundi. Professional Behaviour, Teaching, assessing and coaching students. Maastricht: Universitaire Pers Maastricht
50. https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx Good Medical practice: Professionalism, Ethics and Law
51. Breen, K. J., Cordner, S. M., Thomson, C. J H. & Plueckhahn, V. D. (2010). Good Medical practice: Professionalism, Ethics and Law. Sydney: Cambridge University Press.
52. Richard L. Cruess, Sylvia R. Cruess, J. Donald Boudreau, Linda Snell, and Yvonne Steinert. Reframing Medical Education to Support Professional Identity Formation. Academic Medicine. 2014. November 2014 - Volume 89 - Issue 11 - p 1446-1451
53. Paul Macneill, Roy Joseph, Tamra Lysaght, Dujeepa D. Samarasekera & Shing Chuan Hooi (2020) A professionalism program in medical education and training – From broad values to specific applications: YLL School of Medicine, Singapore, Medical Teacher, 42:5, 561-571, DOI: 10.1080/0142159X.2020.1714021
54. Torda, A., Mangos, J.G. Medical ethics education in Australian and New Zealand (ANZ) medical schools: a mixed methods study to review how medical ethics is taught in ANZ medical programs. International Journal of Ethics Education (2020). https://doi.org/10.1007/s40889-020-00097-w
55. Hudson Birden, Nel Glass, Ian Wilson, Michelle Harrison, Tim Usherwood & Duncan Nass (2013) Teaching professionalism in medical education: A Best Evidence Medical Education (BEME) systematic review. BEME Guide No. 25, Medical Teacher, 35:7, e1252-e1266, DOI: 10.3109/0142159X.2013.789132
56. Benbassat J. (2014). Role modeling in medical education: the importance of a reflective imitation. Academic medicine : journal of the Association of American Medical Colleges, 89(4), 550–554. https://doi.org/10.1097/ACM.0000000000000189

Area of relevance: Assessment

57. Wilkinson TJ, Wade WB, Knock LD. A blueprint to assess professionalism: results of a systematic review. Acad Med. 2009;84(5):551-8.
58. Jha V, Bekker HL, Duffy SR, Roberts TE. A systematic review of studies assessing and facilitating attitudes towards professionalism in medicine. Medical education. 2007;41(8):822-9.
59. Lynch DC, Surdyk PM, Eiser AR. Assessing professionalism: a review of the literature. Medical teacher. 2004;26(4):366-73.
60. Rees CE, Knight LV. The trouble with assessing students' professionalism: theoretical insights from sociocognitive psychology. Academic Medicine. 2007;82(1):46-50.
61. Gordon M, Farnan J, Grafton-Clarke C, et al. Non-technical skills assessments in undergraduate medical education: a focused BEME systematic review: BEME Guide no. 54. Med Teach. 2019; Feb 8. Epub ahead of print. doi: 10.1080/0142159X.2018.1562166

62. Australian Medical Council. Standards for Assessment and accreditation of primary medical programs by the Australian Medical Council 2012. https://www.amc.org.au/wp-content/uploads/accreditation_recognition/primary-medical-education/Standards-for-Assessment-and-Accreditation-of-Primary-Medical-Programs-by-the-Australian-Medical-Council-2012.pdf. Published 2012. Accessed May 6, 2019.
63. Van Luijk SJ, Project Team Concilium Abeundi. Professional Behaviour, Teaching, assessing and coaching students. Maastricht: Universitaire Pers Maastricht
64. Wilkinson TJ, Tweed M, Egan T, Ali A, McKenzie J, Moore M, et al. Joining the dots: Conditional pass and programmatic assessment enhances recognition of problems with professionalism and factors hampering student progress. BMC Medical Education. 2011; 11(1): 29
65. Meeks M, Wilkinson TJ. Learning and assessing professionalism using simulation. In: Forrest K, McKimm J, editors. Healthcare simulation at a glance. United Kingdom: John Wiley & Sons Ltd; 2019. p. 60-1.
66. Wilkinson, T. J. (2019). Failure to fail & conditional passes: Part 1. Med Ed Source. Retrieved from: https://player.whooshkaa.com/episode/463948. [Podcast].
67. Wilkinson, T. J. (2019). Failure to fail & conditional passes: Part 2. Med Ed Source. Retrieved from: https://player.whooshkaa.com/episode/463953 [Podcast].
68. Yielder, J. & Moir, F. Assessing the Development of Medical Students' Personal and Professional Skills by Portfolio, Journal of Medical Education and Curriculum Development. 2016:3
69. Aguilar AE, Stupans L, Scutter S. Assessing students' professionalism: considering professionalism's diverging definitions. Education for Health. 2011;24(3):599.
70. Hodges BD, Ginsburg S, Cruess R, Cruess S, Delport R, Hafferty F, et al. Assessment of professionalism: Recommendations from the Ottawa 2010 Conference. Medical Teacher. 2011; 33(5): 354-63.
71. Roberts C, Wilkinson TJ, Norcini J, Patterson F, Hodges BD. The reframin of assessment, selection and professionalism in the service of patient care. Medical Teacher. 2019; 41(3): 243-8
72. Richard L. Cruess, Sylvia R. Cruess, J. Donald Boudreau, Linda Snell, and Yvonne Steinert. Reframing Medical Education to Support Professional Identity Formation. Academic Medicine. 2014. November 2014 - Volume 89 - Issue 11 - p 1446-1451
73. Ali A, Anakin M, Tweed MJ, Wilkinson TJ. Towards a Definition of Distinction in Professionalism. Teaching and Learning in Medicine. 2020; 32(2): 126-38.
74. Swick, H. M. (2000). Toward a normative definition of medical professionalism. *Academic medicine, 75*(6), 612-616.
75. Mak-van der Vossen, M., Teherani, A., van Mook, W., Croiset, G., & Kusurkar, R. A. (2020). How to identify, address and report students' unprofessional behaviour in medical school. Med Teach, 42(4), 372-379.
76. Birden, H., Glass, N., Wilson, I., Harrison, M., Usherwood, T. & Nass, D. (2014). Defining professionalism in medical education: a systematic review. Medical Teacher, 36 (1), 47-61.

Area of relevance: Remediation

77. Srinivasan M, Litzelman D, Seshadri R, Lane K, Zhou W, Bogdewic S, et al. Developing an OSTE to address lapses in learners' professional behavior and an instrument to code educators' responses. Academic medicine : journal of the Association of American Medical Colleges. 2004;79(9):888-96.
78. Tucker CR, Choby BA, Moore A, Parker RS, Zambetti BR, Naids S, et al. Speaking up: using OSTEs to understand how medical students address professionalism lapses. Medical education online. 2016;21:32610.
79. Adam J, Bore M, Childs R, Dunn J, McKendree J, Munro D, et al. Predictors of professional behaviour and academic outcomes in a UK medical school: A longitudinal cohort study. Medical teacher. 2015;37(9):868-80.

80. Arnold EL, Blank LL, Race KE, Cipparrone N. Can professionalism be measured? The development of a scale for use in the medical environment. Academic Medicine. 1998;73(10):1119-21.
81. Arnold L, Shue CK, Kalishman S, Prislin M, Pohl C, Pohl H, et al. Can there be a single system for peer assessment of professionalism among medical students? A multi-institutional study. Academic Medicine. 2007;82(6):578-86.
82. Goldie J. Assessment of professionalism: a consolidation of current thinking. Medical Teacher. 2013;35(2):e952-6.
83. Mak-van der Vossen M, van Mook W, van der Burgt S, Kors J, Ket JCF, Croiset G, et al. descriptors for unprofessional behaviours of medical students: a systematic review and categorisation. BMC medical education. 2017;17(164).
84. Greenburg DL, Durning SJ, Cohen DL, Cruess D, Jackson JL. Identifying medical students likely to exhibit poor professionalism and knowledge during internship. Journal of general internal medicine. 2007;22(12):1711-7.
85. Bennion, L. D., Durning, S. J., Larochelle, J., Yoon, M., Schreiber-Gregory, D., Reamy, B. V., & Torre, D. (2018). Untying the Gordian knot: Remediation problems in medical schools that need remediation. BMC Medical Education, 18(1), 120-110. doi:10.1186/s12909-018-1219-x
86. Lacasse, M., Audétat, M.-C., Boileau, É., Caire Fon, N., Dufour, M.-H., Laferrière, M.-C., . . . Théorêt, J. (2019). Interventions for undergraduate and postgraduate medical learners with academic difficulties: A BEME systematic review: BEME guide no. 56. Medical teacher, 1-21. Retrieved from https://doi.org/10.1080/0142159X.2019.1596239. doi:10.1080/0142159X.2019.1596239
87. Mak-van der Vossen, M. C., Croix, A. d. l., Teherani, A., Mook, W. N. K. A. v., Croiset, G., & Kusurkar, R. A. (2018). A Roadmap for Attending to Medical Students' Professionalism Lapses. Academic Medicine, 1. doi:10.1097/ACM.0000000000002537
88. Mak-van der Vossen, M., Teherani, A., Mook, W. N. K. A., Croiset, G., & Kusurkar, R. A. (2018). Investigating US medical students' motivation to respond to lapses in professionalism. Medical Education, 52(8), 838-850. doi:10.1111/medu.13617 Shaw,
89. M. K., Rees, C. E., Andersen, N. B., Black, L. F., & Monrouxe, L. V. (2018). Professionalism lapses and hierarchies: A qualitative analysis of medical students' narrated acts of resistance. Social Science & Medicine, 219, 45-53. doi:10.1016/j.socscimed.2018.10.009
90. Steinert, Y. (2013). The "problem" learner: Whose problem is it? AMEE Guide No. 76. Medical teacher, 35(4), e1035-e1045. doi:10.3109/0142159X.2013.774082
91. Ziring, D., Danoff, D., Grosseman, S., Langer, D., Esposito, A., Jan, M. K., . . . Novack, D. (2015). How Do Medical Schools Identify and Remediate Professionalism Lapses in Medical Students? A Study of U.S. and Canadian Medical Schools. Academic Medicine, 90(7), 913-920. doi:10.1097/ACM.0000000000000737
92. The Vanderbilt Program of Professionalism is very useful see https://www.vumc.org/cppa/45627 based on G.B. Hickson, et al. A Complementary Approach to Promoting Professionalism: Identifying, Measuring, and Addressing Unprofessional Behaviors, Academic Medicine, Vol. 82, No. 11 / November 2007.
93. Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board. Academic Medicine. 2004;79(3):244-249.
94. Papadakis M, Osborn E, Cooke M, Healy K. A Strategy for the Detection and Evaluation of Unprofessional Behavior in Medical Students. Academic Medicine 1999;74(9):980-90. .
95. Papadakis MA, Teherani A, Banach MA, Knettler TR, Rattner SL, Stern DT, et al. Disciplinary Action by Medical Boards and Prior Behavior in Medical School. New England Journal of Medicine 2005;353:2673-82.

Area of relevance: Professional identity

96. Monrouxe LV. Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries. Current Narrative 2009;1:41-59.
97. Richard L. Cruess, Sylvia R. Cruess, J. Donald Boudreau, Linda Snell, and Yvonne Steinert. Reframing Medical Education to Support Professional Identity Formation. Academic Medicine. 2014. November 2014 - Volume 89 - Issue 11 - p 1446-1451
98. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. A schematic representation of the professional identity formation and socialization of medical students and residents: a guide for medical educators. Academic medicine : journal of the Association of American Medical Colleges. 2015;90(6):718-25.
99. Cruess, R. L., Cruess, S. R., & Steinert, Y. (2016). Teaching medical professionalism: supporting the development of a professional identity (Second ed.). New York;Cambridge, United Kingdom;: Cambridge University Press.
100. Holden, Mark & Buck, Era & Luk, John & Ambriz, Frank & Boisaubin, Eugene & Clark, Mark & Mihalic, Angela & Sadler, John & Sapire, Kenneth & Spike, Jeffrey & Vince, Alan & Dalrymple, John. (2015). Professional Identity Formation: Creating a Longitudinal Framework Through TIME (Transformation in Medical Education). Academic medicine : journal of the Association of American Medical Colleges. 90. 10.1097/ACM.0000000000000719.
101. Cruess RL, Cruess SR, Steinert Y. Amending Miller's Pyramid to Include Professional Identity Formation. Acad Med. 2016;91(2):180-185. doi:10.1097/ACM.0000000000000913
102. Cruess, Richard & Cruess, Sylvia & Boudreau, J & Snell, Linda & Steinert, Yvonne. (2014). Reframing Medical Education to Support Professional Identity Formation. Academic medicine : journal of the Association of American Medical Colleges. 89. 10.1097/ACM.0000000000000427.
103. Monrouxe, L. (2010). Identity, identification and medical education: why should we care? Medical Education, Vol.22:1. https://doi.org/10.1111/j.1365-2923.2009.03440.

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