

PROFESSIONALISM IN MEDICINE IN SOUTH AFRICA – A FOCUS ON MEDICAL STUDENTS AND THEIR EDUCATORS

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Lorna Olckers

OLCLOR001

Division of Public Health Medicine

School of Public Health and Family Medicine

Faculty of Health Sciences

University of Cape Town

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Supervisors

Doctor Catherine Draper

Division of Exercise Science and Sports Medicine

Sports Science Institute of South Africa

University of Cape Town

Professor Steve Reid

Primary Health Care Directorate

Faculty of Health Sciences

University of Cape Town

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Signed by candidate

Lorna

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ABSTRACT

The notion of 'professionalism in medicine' has become increasingly topical globally. It is a complex and 'slippery' concept that is variously understood – from ideas of values or virtues that reflect aspects of 'being', to those that are more closely associated with behaviour and aspects of 'doing'. More recently, issues of 'identity formation' have added a third dimension to these two broad areas of understanding. The lack of a shared and coherent understanding of what actually constitutes professionalism has resulted in challenges with the teaching, learning and assessment of professionalism in medicine. This has been widely reflected, including within the medical curriculum at the University of Cape Town (UCT) in Cape Town, South Africa, which provides the context for this research.

The aim of this study was to explore how medical students and their educators understand and experience professionalism in medicine in the South African (SA) context. The specific objectives in relation to professionalism in medicine were to explore how aspects of being or character are understood and experienced; how aspects of doing or practice are understood and experienced; how global and profession-specific changes have influenced its understandings and experiences; how the SA context is understood and experienced in relation to professionalism in medicine; and how it is understood and experienced within the Health Sciences Faculty at UCT.

The research was framed within an interpretive theoretical paradigm in order to illuminate issues of context, difference and power. Qualitative methods, specifically focus groups and individual interviews, were used with participants including medical students studying at UCT, interns who had graduated from UCT, and educators from within the university.

Results from the study revealed themes that were considered against physician and philosopher Dr Edmund Pellegrino's virtue-based understanding of professionalism in medicine that shaped the conceptual framework for the study. Four key issues formed the focus of discussion – the understanding of professionalism; its development alongside emerging identity; its relationship to power and hierarchy; and the implications of context. Unlike the discrete vision of professionalism as embedded within virtues or values as expressed by Pellegrino, the understandings and experiences of study participants reflected a multi-faceted view of professionalism in medicine as a combination of values, knowledge and skills, behaviour, and responsibilities, linked to a core relationship founded on trust between doctors and patients. This understanding was informed by issues of emerging identity, influenced particularly by the 'hidden curriculum' and role models, as well as experiences of power and hierarchy within the university and practice settings. Contextual realities included the

commercialisation of medicine, and the increasing impact of the internet and social media. The South African context, reflected by the healthcare system and patient population, further informed this multi-faceted understanding of professionalism in medicine. What became clear was that professionalism in medicine was understood and experienced by participants as complex in both theory and practice, and that curriculum design processes and medical practice must therefore be cognisant of the interdependence of the key issues.

ABBREVIATIONS

ABMS	American Board of Medical Specialities
ANC	African National Congress
APS	Admissions Points Score
BHP	Becoming a Health Professional
BP	Becoming a Professional
CPD	Continuing Professional Development
CPHC	Comprehensive Primary Health Care
CS	Community Service
DHS	District Health System
FHS	Faculty of Health Sciences
FPS	Faculty Points Score
GMC	General Medical Council
GMER	Global Minimum Educational Requirements
HPCSA	Health Professions Council of South Africa
IHP	Integrated Health Professional
IP	Intervention Programme
MChB	Bachelor of Medicine and Bachelor of Surgery
NHI	National Health Insurance
NSFAS	National Student Financial Aid Scheme
PHC	Primary Health Care
PSC	Professional Standards Committee
SA	South Africa/African

SADAC	Southern African Development Community
SAMA	South African Medical Association
UCT	University of Cape Town
WMA	World Medical Association
WW2	World War 2

GLOSSARY OF TERMS

Becoming a Professional (BP)	First semester multi-professional course that forms part of the core curriculum for all FHS students at UCT.
Becoming a Health Professional (BHP)	Second semester multi-professional course that forms part of the core curriculum for all FHS students at UCT.
Becoming a Doctor (BaDr)	Course specifically designed for medical students. Taken after BP and BHP in FHS at UCT.
Doctor/Physician	Individual who has successfully completed, passed the required studies and graduated as a medical doctor.
Faculty of Health Sciences (FHS)	One of five faculties at the University of Cape Town. Includes undergraduate degree programmes in Audiology, Medicine, Occupational Therapy, Physiotherapy, and Speech Language Pathology. A wide range of post-graduate degree programmes are also offered.
Integrated Health Professional (IHP)	The framework used to guide student learning related to professionalism that draws on the three key domains of knowledge, interpersonal skills and reflective practice in BP/BHP (Olckers, Gibbs & Duncan, 2007).
Intervention Programme (IP)	The yearlong development programme that first year health science students enter if they have not successfully completed semester 1 and are unable to progress to semester 2. On successful completion of IP, students return to mainstream and continue with semester 2.

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CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

Professionalism in medicine has become an area of significant interest in medical education and medicine globally, resulting in what is referred to as “medicine’s modern day professionalism movement” (Hafferty, 2018, p. 1). Despite this increased attention, it is a ‘slippery’ concept that some would argue is so poorly understood that it has virtually lost its meaning (Swick, 2000). It includes complex “issues regarding professionalism, acting like professionals and actually becoming professionals” (Albardiaz, 2012, p. 440).

It has been stated that professionalism in medicine is decreasing, with patients being dissatisfied with their quality of care and choosing to seek alternative or complementary healthcare interventions (Hilton & Southgate, 2007; Katz, Kessler, O’Connel & Levine, 2007). Increases in medico-legal malpractice disputes have emerged, with clear links between the malpractice issues and lapses in professionalism while in medical school (Papadakis, Hodgson, Teherani & Kohatsu, 2004). Doctors too are reportedly feeling concerned about what is perceived to be the erosion of values and ideals of professionalism (Cohen, 2006; Hafferty, 2006; Kling, 2017; Sivalingam & Mal, 2004; Smith, 2005). These issues point to the importance of prioritising professionalism within medical education and medical practice.

A key area of challenge in medical education has been the lack of a shared understanding of professionalism. This has been a focus of attention for medical education since the mid-1980s and early 1990s (Arnold & Stern, 2006; Hafferty, 2009). Definitions and understandings of professionalism in medicine have typically been associated with the two broad areas of ‘being’ and ‘doing’; with ‘being’ aligned with intrapersonal virtues or values and ‘doing’ with aspects of behaviour. Recently however a third area of identity formation has been added to these two broad areas of understanding (Irby & Hamstra, 2016). Understandings and experiences of professionalism have typically been Western and Eurocentric in origin (Hafferty, 2018), with very little being written from a developing world, and more specifically a South African, perspective.

There have been numerous appeals for a return to understanding medicine as a moral practice with virtuous practitioners and caring for patients at its core (Bain, 2018; Gardiner, 2003; Kotzee, Ignatowicz & Thomas, 2017; Leffel et al., 2018), a position that is reflective of the virtue-based

understanding of professionalism posited by physician and educator, Edmund Pellegrino (2002, 2012). Attention has however also begun to shift to concern for the context in which practice takes place (Hafferty, 2018), and this has had implications for debates around medical curricula and what should be taught, learnt and assessed.

Experiences within the Faculty of Health Sciences at the University of Cape Town reflect these issues and concerns. Two first year health science courses, 'Becoming a Professional' (BP) and 'Becoming a Health Professional' (BHP), were introduced as core aspects of the 'new' medical curriculum that was introduced in 2002. These are multiprofessional courses that bring together students from audiology, speech therapy, occupational therapy, physiotherapy and medicine, in order to explore a range of issues pertinent to healthcare under the broad umbrella of professionalism (Duncan, Alperstein, Mayers, Olckers & Gibbs, 2006; Olckers, Gibbs & Duncan, 2007). BP and BHP make use of a framework for an 'Integrated Health Professional' (IHP) in which knowledge, interpersonal skills and reflective practice provide the hooks for explaining aspects of professionalism (Olckers et al., 2007). These issues are further explored in the 'Becoming a Doctor' (BaDr) course that follows BP and BHP and focuses specifically on medical students. Notwithstanding the usefulness of these courses and the IHP framework, the core question has remained – what is professionalism? What is evident is that professionalism in medicine is not only slippery, it is complex, and in need of further exploration, particularly within the South African (SA) context (Seggie, 2010).

1.2 STUDY AIM AND OBJECTIVES

Given the above issues, the aim of this study was to explore how medical students and their educators understand and experience professionalism in medicine in the context of South Africa.

The specified objectives were to explore:

1. how aspects of being or character are understood and experienced in relation to professionalism in medicine
2. how aspects of doing or practice are understood and experienced in relation to professionalism in medicine
3. how global and profession-specific changes have influenced understandings and experiences of professionalism in medicine
4. how the SA context is understood and experienced in relation to professionalism in medicine
5. how professionalism in medicine is understood and experienced within the Health Sciences Faculty at the University of Cape Town

1.3 THESIS STRUCTURE

The current chapter has introduced and framed the issues around professionalism in medicine and provided context and motivation for the study, and its aim and objectives.

Chapter 2 includes a review of the literature associated with professionalism in medicine. The concepts 'profession' and 'professional' are explored before moving onto a detailed discussion of the profession of medicine. This leads to the central question of what is meant by professionalism, and issues associated with the teaching, learning and assessment of professionalism. Attention is then turned to exploring the wider contextual factors that are reported to have an impact on professionalism in all its complexity.

Chapter 3 is the methodology chapter. It begins with the broad theoretical paradigm and then details the conceptual framework that provides the backdrop for this study. The setting, methods, sampling, procedure, research instruments and method of analysis are described, ending with discussion of ethical considerations and my own potential biases as the researcher.

Chapter 4 is the results chapter, where the views of student, intern and educator participants are explored. The four main themes that emerged in this study – understandings of professionalism, professionalism and emerging identity, the teaching, learning and assessment of professionalism, and professionalism – in context are described in detail.

Chapter 5 is the discussion chapter. The results detailed in Chapter 4 are discussed against the aim, objectives and conceptual framework of virtue-based ethics as presented by Edmund Pellegrino, and wider literature. Four key areas are highlighted and explored in detail, including understanding professionalism; professionalism and emerging identity; professionalism, power and hierarchy; and the implications of context for professionalism.

Finally, the thesis ends with Chapter 6 and the recommendations and conclusion. Recommendations for how to take the study forward are suggested, and ideas for further research are shared.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

The terms 'profession', 'professional' and 'professionalism' are used extensively when referring to and describing the practice of medicine. Despite their extensive use, these terms are notoriously poorly understood, particularly that of 'professionalism'. This lack of clarity has had implications for the practice of medicine, and the education and training of doctors.

This chapter covers the literature most closely associated with the overriding theme of this thesis – professionalism in medicine. It begins with an overview of the search strategies used to gather this information, and then presents an overview of the literature. The concepts 'profession' and 'professional' are explored more generally before moving onto the profession of medicine itself. This leads to the central question of what is meant by professionalism, followed by an overview of issues associated with the teaching, learning and assessment of professionalism before exploring the contextual factors that are reported to have had an impact on professionalism. This brings the chapter to the point of asking why professionalism in medicine should be of concern and worthy of our attention.

2.2 SEARCH STRATEGIES

A combination of search strategies was used to source the most relevant information. Peer-reviewed journal articles and books were sourced through the EBSCOHost research data base. Keyword searches using a combination of terms were used, including profession, professional, professionalism, professionalism in medicine, medicine in South Africa. Articles referenced in related publications were also consulted. Periodic checks for new literature were done using Google and Google Scholar. Researchers who are known to have contributed to the field were also used as a source of relevant literature. Finally, literature collected over many years of teaching and assessing Health Science students was consulted. This process of searching for relevant literature was carried out throughout the duration of the study and proposal phases of the thesis process.

2.3 PROFESSIONS AND PROFESSIONALS

The terms 'profession' and 'professional' are central to understanding 'professionalism' and are explored in this section before moving onto the core concept of 'professionalism' in section 2.4. 'Profession' and 'professional' come from the Latin 'professio', which is a public declaration or promise that members of a profession will behave in a certain way, and that the group as a whole will take responsibility for controlling its members, the professionals (Kling, 2017). A profession is typically characterized by specialized knowledge and expertise gained through lengthy training, being autonomous and self-policing, having a monopoly over practice, but also importantly being altruistic in nature (Nettleton, 2006). The basis of the relationship between professions and the public is a social contract that asserts "high standards of competence and moral responsibility" on the part of professionals in exchange for occupational autonomy (Sullivan, 2000, p. 673).

From a sociological perspective, professions have been linked to class, status, power and competition for rewards (Freidson, 1988; MacDonald, 1995). An alternative view aims to reflect higher ideals of moral character regarding what professionals should and should not do (Flores, 1988). Social critics and the public generally have however criticised this view, and shared experiences of behaviour that are perceived to be self-serving and focused on wealth, power and status on the part of professionals (Benatar, 1997).

2.3.1 The profession of medicine

Historically, lawyers, doctors and the clergy were the first to be distinguished as members of the learned professions, with medicine often seen as the quintessential profession (Freidson, 1988), because it contains not only the altruism expected of professions generally but also the suppression of self-interest, therefore inviting trust in the service of others (Pellegrino, 2002). The profession of medicine is based on a public-professional social contract, which is a shared set of unspoken or tacit as well as explicit understandings of what patients, doctors and society at large should be able to expect from one-another (Cruess, 2006; Wynia, 2008). A code of ethics and conduct is what makes altruism, in other words serving the best interests of the patient and society, and the suppression of self-interest, explicit (Blane, Brunner & Wilkinson, 2002).

The term profession in relation to medicine is historically linked to English Physicians Drs John Gregory and Thomas Percival. In 1803 Thomas Percival published his book 'Medical Ethics' in which he attempted to persuade physicians to agree to a shared set of standards or a code of ethics for practice. His efforts were however rejected at the time as the pervading sentiment was that "proper

gentlemen didn't need written ethical standards, because they already knew how to behave" (Wynia, 2008, p. 567)! The 1858 Medical Registration Act finally legitimated medicine as an autonomous profession in Britain, but for men only. A separate London School of Medicine for Women followed 16 years later (Nettleton, 2006).

Edmund Pellegrino, who was a prolific contributor to understandings and debates around the profession of medicine, described medicine as a 'moral community' with its members, the medical professionals being "bound together by a common moral purpose ... some fundamental rules, principles, or character traits that define a moral life consistent with the ends, goals, and purpose of medicine" (Pellegrino & Thomasma, 1993, p. 3). He framed this view in terms of the inequality inherent in the doctor-patient relationship, the fiduciary basis of the relationship, the moral nature of the sorts of decisions doctors have to make, the character of medical knowledge, and the doctor's moral complicity in what happens to his/her patients (Pellegrino & Thomasma, 1993). This brings into focus the power differential between doctor and patient, an issue of broad concern to professions referred to earlier (Freidson, 1988, 2001; Kling, 2017). Pellegrino's work on professionalism and the profession of medicine forms the conceptual framework for this thesis and will be discussed in more detail in Chapter 3.

In South Africa, the profession of medicine is inextricably linked with that of the political and social history of the country. Khoikhoi and San tribes lived in Southern Africa for thousands of years and practised their own traditional forms of medicine long before the arrival, in 1652, of Jan van Riebeeck. Van Riebeeck was a Dutch barber surgeon who had been tasked by the Dutch East India Company with setting up the first European settlement, including the building of a hospital and a place for recuperation for sick sailors in the Cape (Louw, 1969). Centuries of colonial dominance and rule followed, establishing the roots of racial discrimination that have defined South Africa, particularly during the years of colonialism and apartheid. This history of racial discrimination resulted in extreme disparities in health and healthcare. At the height of apartheid, sections of land within South Africa were allocated as 'Bantustans' or homelands for black African people. The implication for healthcare was that fourteen different health departments were responsible for health services across South Africa, resulting in extensive duplication and fragmentation of services, and huge differentials in expenditure on health services based on race (Price, 1986). Significant differences in disease prevalence and mortality rates were clearly evident, as were disparities in the provision of healthcare between urban and rural facilities, private and public health services, and between the high-tech and primary health care priorities (De Beer, 1986; Deacon, Phillips & Van Heyningen, 2004).

The new democratic South Africa of 1994, under the leadership of the African National Congress (ANC), based its health plan on the primary health care (PHC) approach, with the 1997 White Paper on the Transformation of the Health Care System in South Africa (Department of Health, 1997) and the National Health Act (Act No 61 of 2003) (2004) proposing the establishment of a unified health system based on the principles of Comprehensive Primary Health Care (CPHC), and a District Health System (DHS). Despite areas of progress since the first democratic elections, including the establishment of the DHS, South Africa remains a country in transition, with evidence of extreme socioeconomic inequalities as a result of colonialism and apartheid, and health outcomes have remained poor and significantly unequal (Naledi, Schneider & Barron, 2011). The ability to take forward the new policy vision has been constrained by concurrent epidemics that are particular to the Southern African Development Community (SADAC) region. These include poverty-related illnesses including infectious diseases, maternal death and malnutrition, non-communicable diseases, HIV/AIDS, and violence-related injuries. Added to these challenges are insufficient human resource capacity and planning, poor leadership and management, and increased pressure on the public health system (Ataguba & Akazili, 2010; Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). A need for social justice through improved access to healthcare is paramount, and has led to the push for a universal health system in the form of National Health Insurance (NHI) that is tasked with responding to the wider public discourse about poverty, health and the 'Right to Access Healthcare', as mandated in the South African Constitution and the Bill of Rights (Benatar, 1997, 2013, 2014; McIntyre, 2010).

2.3.1.1 A code of conduct

The profession of medicine is underpinned by a code of ethics and conduct, referred to earlier, that guides its members. Rothstein (2010) refers to this as the 'Hippocratic bargain', the code that delineates the parameters of practice. Internationally, the first set of modern-day ethical and practice standards was created in America in 1847, with the establishment of the American Medical Association (AMA) Code of Medical Ethics. It was presented as a three-part contract with reciprocal obligations between physicians and patients, physicians and other physicians, and physicians and other communities. The goal of this code was to inculcate public trust through the assurance of the quality of its members. The result was that codes of professional practice were gradually accepted universally, and the social status of physicians increased enormously (Wynia, 2008).

In South Africa, the code of conduct and professional regulation of doctors goes back to as early as 1807, paralleling much of what was going on in the United Kingdom and the United States, as doctors sought to define themselves as a profession separate from other forms of healing. The

Colonial Medical Committee, for example, was established in 1830, with its main responsibility being the maintenance of standards in the profession, including the much contested difference between surgeons and physicians, and the requirements for registration to practice (Deacon et al., 2004). Today, the legal body that oversees the medical profession in South Africa is the Medical and Dental Professions Board, which is under the umbrella of the Health Professions Council of South Africa (HPCSA). The role of the HPCSA “is that of a coordinating, advisory and communicatory body in relation to the activities of the affiliated professional boards ... Its motto is ‘protect the public and guide the professions’” (van Rensburg, 2004, p. 325). All doctors are required to be registered with the HPCSA in order to practice as doctors in South Africa. Doctors are also represented by a professional association, the South African Medical Association (SAMA), but unlike the HPCSA, it is not a statutory body and its membership is voluntary. SAMA is a member of the World Medical Association (WMA), an international organization representing physicians across the world, by setting standards for medical ethics and professional competence. The aim of the WMA is “to serve humanity by endeavouring to achieve the highest international standards in Medical Education, Medical Science, Medical Art and Medical Ethics, and Health Care for all people in the world” (Global Health Workforce Alliance [GHWA], n.d., para. 2).

2.3.1.2 The Oath

The Oath or public declaration that is taken on entry into the profession of medicine, and that is so central to the profession, has its roots in ancient Greece and the ethical obligations expressed in the Hippocratic Oath (Miles, 2009; Pellegrino, 2012). The Oath was shaped by the culture of its time, including acceptance of slavery, and subordination of women, but has been modified in response to changes over the years to include various adaptations that recognise different religions, beliefs and practices (Miles, 2004). The present-day dedication was realized after the atrocities of World War 2 (WW2) and the complicit role of some doctors was revealed. Doctors who were supporters of the Nazi regime were discovered to have participated in designing and running horrific experiments on concentration camp inmates to further the goals of racial cleansing. After the end of WW2, the Nuremberg Code was created to address these abuses committed by medical professionals, and the principle of informed consent and required standards for research were initiated (U.S Holocaust Memorial Museum, 2018). 1948 saw the adoption of the Declaration of Geneva, the Physician’s Pledge, by the WMA. The Pledge, or a version of it, typically forms the modern-day Oath taken by medical graduates as they enter the ‘moral medical community’ of practice (Pellegrino, 2002). It has gone through various iterations, most recently in October 2017, and reads as follows:

“The Physician’s Pledge

AS A MEMBER OF THE MEDICAL PROFESSION: I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour” (World Medical Association [WMA], n.d.).

This latest iteration focused on the need to be explicit about patient autonomy and so added this to the earlier version of the Declaration. Other changes included the addition of the wording “and in accordance with good medical practice” and “I will give to my teachers, colleagues, and students the respect and gratitude that is their due”, as well as “I will attend to my own health, well-being, and abilities in order to provide care of the highest standard”, reflecting increasing understanding of the importance of self-care as part of patient care. These updates and changes are indicative of the desire of the WMA to keep the Physician’s Pledge relevant within an ever-changing medical and societal context. Other iterations have been adopted by different medical schools and some, like UCT, have created their own Oath. Despite changes over time, what has remained unique about the Oath in all its forms is that it is written in the first person, so that the ethics of practice that it represents are “pledged and lived rather than merely codified and taught” (Miles, 2004, p. 176).

In South Africa, the HPCSA describes the practice of medicine as a moral enterprise and emphasises that “to be a Health Care Practitioner requires a life-long commitment to good professional and ethical practices and an overriding dedication to the good of one’s fellow humans and society” (Health Professions Council of South Africa [HPCSA], 2016, p. i). Medical graduates across South Africa all take a pledge that is typically a modified version of the Hippocratic Oath and the WMA Physician’s Pledge as their rite of passage into the profession of medicine. As mentioned earlier, UCT medical students, together with students from the Health and Rehabilitation professions of audiology, occupational therapy, physiotherapy and speech language pathology, recite an Oath that was specifically written for UCT and was adopted at a faculty assembly held on 9 May 2002. A Faculty Charter and the new Oath brought attention to the need for tolerance, respect and human rights in the practice of healthcare. The Oath reads as follows:

“At the time of being admitted as a member of the Health Profession:

I SOLEMNLY PLEDGE to serve humanity

MY MOST IMPORTANT CONSIDERATIONS will be

The health of patients and the health of their communities

I WILL NOT PERMIT considerations of age, gender, race, religion, ethnic origin, sexual orientation, disease, disability or any other factor to adversely affect the care I give to patients

I WILL UPHOLD human rights and civil liberties to advance health, even under threat

I WILL ENGAGE patients and colleagues as partners in healthcare

I WILL PRACTISE my profession with conscience and dignity

I WILL RESPECT the confidentiality of patients, present or past, living or deceased

I WILL VALUE research and will be guided in its conduct by the highest ethical standards

I COMMIT myself to lifelong learning

I MAKE THESE PROMISES solemnly, freely and upon my honour”. (University of Cape Town [UCT], 2018a, p. 296)

While the WMA Physician’s Pledge has gone through numerous iterations, this has not happened with the UCT pledge, which remains as it was written in 2002.

Professionalism and how it is understood is linked to the Code of Conduct and the Oath as these are aspects that are central to how professionalism is understood. They explicitly frame professionalism by detailing the practice and ethical underpinnings of practice. In 2.4, professionalism is explored in detail through three current understandings, namely being, doing, and identity.

2.4 PROFESSIONALISM IN MEDICINE

Professionalism is probably the most challenging and ‘slippery’ of the terms associated with the profession of medicine, as it is so poorly understood that it has virtually lost its meaning (Swick, 2000). Hafferty (2018, p. 4) noted that despite the amount of literature being generated, “professionalism continues to occupy an enigmatic presence in the medical community”. It is a term that is being used increasingly beyond the traditional domains of professions – in everything from advertising and marketing to company mission statements, managerial literature, and political and policy arguments (Evetts, 2006).

Some would say that professionalism in medicine can be traced to as far back as the Code of Hammurabi (2000 BCE), and the Hippocratic Oath (5th century BCE) (Kling, 2017), and to Aristotle, who identified moral excellence and phronesis – practical wisdom or reflective judgement for good clinical judgement – as what a physician should embody (Pellegrino, 2002). Others date it to the 1800s when the roles and responsibilities of doctors and medical curricula started to become clearer (Wynia, 2008). Whatever its origins, until recently debates and literature related specifically to professionalism in medicine were not clearly evident, and only really came to the fore in the mid-1980s and 1990s (Arnold & Stern, 2006; Hafferty, 2009), through a discourse of “nostalgic professionalism” and a call for medical doctors to recommit themselves to an ethic of professionalism grounded in altruism (Hafferty, 2009, p. 14). Its rise has resulted in deep engagement with questions of how doctors are expected to behave and how they should be trained (Gabbard, 2018; Wear & Kuczewski, 2004).

The qualities and attributes that we associate with professionalism in medicine are not new, but have existed for decades as something tacit and implicit, more assumed rather than anything else, but also somewhat paternalistic in nature (Erkut, 2000; Hilton, 2008). Definitions and understandings of professionalism in medicine have been typically associated with two main frameworks including that of ‘being’ on the one hand, and ‘doing’ on the other. ‘Being’ is closely associated with virtue-based ethics and ‘doing’ with behaviour (Irby & Hamstra, 2016). It is useful to think of these two main understandings or frameworks as existing on a continuum with ‘being’ on the one end and ‘doing’ on the other, and with definitions and understandings that draw on both as in-between.

2.4.1 Professionalism as 'being'

Understanding professionalism as linked to 'being' or the morals and values or virtues of the individual has been extensively explored and closely linked to virtue-based ethics (Pellegrino, 2002). Virtue-based ethics is the oldest form of ethics, and focuses on moral being rather than on behaviour. Plato and Aristotle associated virtue with both intellectual and moral excellence describing a "virtuous person (as) someone we can trust to act habitually in a good way – courageously, honestly, justly, wisely, and temperately. He or she is committed to being a good person and to the pursuit of perfection in private, professional, and communal life. The person is someone who will act well even when there is no one to applaud, simply because to act otherwise is a violation of what it is to be a good human being" (Pellegrino & Thomasma, 1988, p. 116). The focus is therefore on the kind of person the physician is, with the belief that a physician of virtue is the 'ultimate guarantee' that the good of patients will always be respected (Pellegrino, 2012; Pellegrino & Thomasma, 1988). This perspective will be discussed in greater detail in the following chapter, as we explore the work of Edmund Pellegrino that forms the conceptual framework for the current thesis.

Although different virtues are emphasised, phronesis is a core aspect of virtue-based ethics. It is described as the "hallmark of professionalism" and the quality that "justifies the trust in the doctor to make the best decision in the interests of the patient" (Hilton, 2008, p. 357). Phronesis is what Aristotle referred to as 'practical wisdom' and is very closely linked to the kind of person one is, the phronimos (Dunne, 1997). It is where moral and intellectual virtues are united, resulting in doctors being able to make "right choices in complex clinical circumstances" (Pellegrino, 2002, p. 382). Other personal or intrinsic attributes that have been described as central to professionalism and 'being' include respect for patients, ethical practice, reflection and self-awareness, compassion, empathy and trustworthiness (Hilton, 2004; Hilton & Slotnick, 2005; Hilton & Southgate, 2007; Pellegrino, 2002).

Essentially, this 'being' or virtue-based focus of professionalism in medicine is centred on the inner or intrapersonal being of an individual doctor rather than the skills that are typically associated with professionalism (Chin-Yee, 2017). Richard and Sylvia Cruess, who have also been prolific in their contributions to the understanding of professionalism in medicine, pick up on the social contract aspects of professionalism (illustrated below) as the bridge between physicians and society. Their understanding of professionalism is that it is dependent on respect for this shared 'social contract', and that when the expectations of society or medicine are not met, or valued, tensions may arise

resulting in professionalism being compromised (Cruess & Cruess, 2006; Cruess, Cruess & Johnston, 2000).

Figure 1: Social Contract between Medicine and Society (Cruess, 2006, p. 171)

Society's expectations of Medicine	Medicine's Expectations of Society
<ul style="list-style-type: none"> • Services of the healer • Assured competence • Altruistic service • Morality and integrity • Accountability • Transparency • Source of objective advice • Promotion of the public good 	<ul style="list-style-type: none"> • Trust • Autonomy • Self-regulation • Health-care system <ul style="list-style-type: none"> – value driven – adequately funded • Participation in public policy • Shared (patients and society) responsibility for health • Monopoly • Status and rewards <ul style="list-style-type: none"> • non-financial • respect • status <ul style="list-style-type: none"> – financial

Cruess and Cruess describe morality, integrity and honesty of physicians as central to the building of trust (Cruess, 2006; Cruess & Cruess, 2008). Sullivan (2000, p. 673) described trust as “the moral understanding among professionals that gives concrete reality to this social contract”. Jordan Cohen, President of the Association of American Medical Colleges, also focused on trust, and defined professionalism more comprehensively as “central to sustaining the public’s trust in the medical profession; it is the essence of the doctor-patient relationship” (Cohen, 2006, p. 607). As with Pellegrino, Cruess and Cruess, and others, the virtue-based doctor and the trusting doctor-patient relationship are seen as central to professionalism (Cruess, 2006).

The image of the doctor who epitomises professionalism as aligned with trust has been increasingly challenged with increases in medico-legal negligence and malpractice issues (Evetts, 2006). As described in 2.3.1.1, the HPCSA is the legal body that oversees the medical profession in South Africa. It is responsible for dealing with issues of medico-legal negligence and malpractice, and deciding on appropriate penalties. Penalties typically take the form of fines or suspension from practice for a period of time (Health Professions Council of South Africa [HPCSA], 2018). Criminal cases are also reportedly on the increase with two of the most notorious criminal cases being those of British family practitioner Dr Harold Shipman and South African cardiologist Dr Wouter Basson, both famously nicknamed ‘Dr Death’. Dr Harold Shipman is reportedly Britain’s most prolific serial killer and was found guilty of killing 15 of his patients, all of whom were women, and none of whom

were reportedly terminally ill. It is however estimated that he may have murdered in the region of 218 patients under his care during the period 1975 to 1998, with the use of lethal injections. He was sentenced to life imprisonment on 31 January 2000, and hanged himself in his prison cell. At the time of his trial, it was revealed that Dr Shipman had a previous conviction for fraud for forging prescriptions in order to support his own drug addiction. The General Medical Council (GMC) (2013) took no action at the time, and Dr Shipman simply moved cities and started practising medicine once again. He was able to do so because his patients trusted him. Ultimately he betrayed that trust, and the trust and professionalism of all doctors (Sommerland, 2018). South African cardiologist, Dr Wouter Basson, is viewed as the South African version of 'Dr Death'. He has a controversial history as the former head of chemical and biological warfare under apartheid. Dr Basson was found to have committed acts which included "the production of deadly drugs and other substances to be used against 'enemies' of the apartheid state, providing substances to tranquilise victims of cross-border kidnapping, and providing cyanide-filled suicide capsules for members of special units" ("Basson wins challenge", 2018). He was acquitted in 2002 of 67 charges brought against him. The HPCSA however found him guilty of four counts of unprofessional conduct. Sentencing was started in 2014, but was interrupted by Basson's application to have two council members recused from the case. The process is still on-going.

A being or virtue-based perspective is linked strongly with a more moral understanding of professionalism. One of the challenges with this has been that of how to measure virtue or aspects of being. This was one of the strong motivations for a move towards a more 'doing' perspective. Another challenge has been that of the divide between professionalism and ethics. Vogelstein (2016) and Salloch (2016), for example, argued that doctors do not have the moral reasoning and ethical theory to adequately engage with existentially ethical questions such as termination of pregnancy and assisted suicide.

2.4.2 Professionalism as 'doing'

As with 'being', understandings of professionalism related to 'doing' are extensive, with a wide range of theorists focusing on what doctors do or should do in their profession as defining professionalism. For Swick (2000), "the concept of medical professionalism must account for the nature of the medical profession and must be grounded in what physicians actually do and how they act, individually and collectively" (p. 614). Central to this is the need to demonstrate that the physician is in fact worthy of the trust placed in him/her. He describes nine specific behaviours including that:

1. Physicians subordinate their own interest to the interests of others
2. Physicians adhere to high ethical and moral standards
3. Physicians respond to societal needs, and their behaviours reflect a social contract with the communities served
4. Physicians evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others, and trustworthiness
5. Physicians exercise accountability for themselves and for their colleagues
6. Physicians demonstrate a continuing commitment to excellence
7. Physicians exhibit a commitment to scholarship and to advancing their field
8. Physicians deal with high levels of complexity and uncertainty
9. Physicians reflect upon their actions and decisions (Swick, 2000, pp. 614-615).

This perspective, although often linked with aspects of 'being', focuses very much on what the doctor does, and reflects professionalism as skills-based. Stern, for example, describes professionalism as "demonstrated through a foundation of clinical competence, communication skills, and ethical and legal understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability and altruism" (Stern, 2006, p. 19), therefore seeing the 'doing' as the basis of professionalism, with the 'being' arising from this doing. Other theorists also make this link between being and doing with, for example, co-operative attributes of professionals such as commitment to excellence and life-long learning, teamwork and social responsibility as central to the doing aspects of professionalism (Hilton, 2004; Hilton & Slotnick, 2005; Hilton & Southgate, 2007). For Lesser and colleagues, professionalism in medicine is described as "not simply a set of text-based ideals for practice, rather it is an approach to the practice of medicine that is expressed in observable behaviours ... a lived approach" (Lesser et al., 2010, p. 2733).

A number of collaborative efforts have also resulted in detailed descriptions of professionalism. One of the most comprehensive collaborative works on professionalism is that of The European Federation of Internal Medicine, the American College of Physicians, American Society of Internal Medicine (ACP-ASIM) and American Board of Internal Medicine (ABIM) (2002), who combined and launched the Medical Professionalism Project in 1999 that resulted in The Charter on Medical Professionalism, also known as the Physician's Charter. The Charter describes professionalism in medicine as the basis of medicine's contract with society, and focuses attention on the three principles of patient welfare, patient autonomy and social justice, with professional responsibilities identified and contained in a list of commitments including professional competence, honesty with

patients, patient confidentiality, appropriate relations with patients, improving quality of care and access to care, the just distribution of finite resources, scientific knowledge, maintaining trust by managing conflicts of interest and commitment to professional responsibilities (American Board of Internal Medicine [ABIM], 2002). There has been extensive support for the Charter but it has also had its critics. Hafferty (2006), for example, described the Charter as the most complete statement of professional principles available, but not in itself a definition of professionalism. In South Africa, a qualitative study done by van Rooyen and Treadwell (2007) reported that students did not find the Charter on Medical Professionalism entirely relevant in the South African context because of the country's diversity of language, culture, social class and religion.

In parallel, but independently of the Charter, other professional bodies have also explored professionalism. These include the Working Party of the Royal College of Physicians who, after a process of interviews and consultations with an expert panel, defined medical professionalism as "a set of values, behaviours, and relationships that underpin the trust the public has in doctors" (2005, p. 8). Six characteristics were identified: integrity, compassion, altruism, continuous improvement, excellence, working in partnership with the wider healthcare team. Another professional body was that of The Royal College of Physicians and Surgeons of Canada (2005) who developed the CanMeds framework described and illustrated in the form of seven separate but overlapping competencies, including that of communicator, collaborator, manager, health advocate, scholar and professional, with medical expert at the centre of the diagram. The description of the professional focuses on the "commitment to health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour" (Royal College of Physicians and Surgeons of Canada, 2005, p. 23).

In 2012, the American Board of Medical Specialties (ABMS) began work on an operational definition of professionalism, drawing attention to the limitations of existing definitions that were seen as essentially lists of desired behaviours. The ABMS definition that was unanimously adopted reads: "Medical professionalism is a belief system about how best to organise and deliver health care, which calls on group members to jointly declare ("profess") what the public and individual patients can expect regarding shared competency standards and ethical values and to implement trustworthy means to ensure that all medical professionals live up to their promises" (Wynia, Papadakis, Sullivan & Hafferty, 2014, p. 713). Central to this definition is a focus on professionalism as a normative belief system based, again, on trust (Wynia et al., 2014).

The challenge with a more 'doing' perspective is that it tends to be somewhat reductionist, and assumes that behaviours accurately reflect aspects of inner being (Irby & Hamstra, 2016). Chandratilake, McAleer, Gibson and Roff (2010) reported that "the general public recognises doctors as professionals by their good behaviour, high values and positive attitudes ... They expect doctors to be confident, reliable, dependable, composed, accountable, and dedicated across all settings. Personal appearance, physical features or social standing may play little or no role in a doctor being considered 'professional'" (p. 368).

Evident from the discussion above are differences in understandings of professionalism and what constitutes professionalism. These can be presented along a continuum with aspects of behaviour, competence and conduct or doing at the one end, and focus on aspects of individual qualities and moral character, intrinsic attributes or being at the other end, with many falling somewhere in between. Trust is a concept that is clearly aligned with both being and doing, and brings attention to the relational aspect of professionalism.

2.4.3 Professionalism as 'identity'

More recently, there has been a move towards the addition of a third framework of understanding – that of identity formation through an adaptive journey from student to professional, also referred to as professionalization (Irby & Hamstra, 2016). A process of socialising learners is understood to take place through student integration and participation in medicine's community of practice, the observation of positive role models, and through the formal curriculum including, for example, courses in ethics (Irby, Cooke & O'Brien, 2010; Cruess, Cruess, Boudreau, Snell & Steinert, 2014). The focus is therefore on the process of being and becoming, by bringing together the two previous understandings of being and doing professionalism (Cruess et al., 2014; Irby & Hamstra, 2016), and on the process of students increasingly identifying with what it means to be a doctor (Monrouxe, 2016), by redeveloping their "sense of self" as medical professionals (Shaw, Rees, Andersen, Black & Moroux, 2018, p. 46). As Gee (1990) explains, everyone is born into a primary discourse that includes the language, behaviour and values of that community, but go on to become part of many other discourses in their lives. Studying medicine means going through a process of secondary socialization (Monrouxe, 2016), in order to become part of the profession or community of practice by learning and internalizing what is perceived to be right and normal for that particular context (Wenger, 1998). Different discourses are not always compatible, and conflicts can arise as individuals grapple with their own multiple identities which are historically, socially and politically situated (Gee, 1990). Identities are also not static, and continue to evolve throughout the life of each individual, meaning that the student who is admitted to study medicine may be quite different as a graduate

and different again as a practising doctor (Cruess et al., 2014). This process is described as proto-professionalism (Hilton & Slotnick, 2005) and involves personal transformation of the self through a series of stages throughout medical training and the early years of practice (Smith, 2005). It is a process that happens not only at the level of the individual, but also through collective socialisation (Jarvis-Selinger, Pratt & Regehr, 2012).

Interestingly, Richard and Sylvia Cruess, who contributed extensively to understanding professionalism from a more being perspective, have been prominent in promoting the value of understanding professionalism in terms of identity formation, and in proposing that it be a primary objective of medical education. They propose that the identity of a physician “is a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician” (Cruess et al., 2014, p. 1447).

Despite the fact that these three broad frameworks of being, doing and identity are presented as discreet from one another, the reality is that the divisions are not always clear, and many understandings of professionalism in medicine include a combination of two or all three frameworks.

2.5 TEACHING, LEARNING AND ASSESSMENT OF PROFESSIONALISM

The teaching, learning and assessment of professionalism is complex. Given its complexity, professionalism is considered to be one of the most challenging content areas in medical education (Wagner, Hendrich, Moseley & Hudson, 2007). Increasingly, pleas for the inclusion of more attention to the teaching, learning and assessment of professionalism have become evident (Rimal, 2018). Understanding professionalism in terms of the different aspects of being, or doing, or linked to identity formation require different educational approaches (Hafferty, 2009). One of the biggest challenges with the teaching and learning of professionalism is that it typically takes a long time to acquire (Wenger, 1998), with the new naïve medical student growing into the graduate who epitomises moral maturity (Monrouxe, 2016; Pellegrino & Thomasma, 1993). The domains of teaching and learning can be divided into three main areas of the formal or official curriculum, the informal curriculum which includes events and instances of learning that happen around the formal curriculum, and the hidden curriculum which “can be broadly defined as the attitudes and values conveyed most often in an implicit and tacit fashion, sometimes unintentionally, via the educational structures, practices, and culture of an educational institution” (Hafferty, Gaufberg & O’Donnell, 2015, p. 131).

The teaching and learning process is usually dynamic, takes place in numerous settings, and involves all domains of curricula and learning (Hafferty & Levinson, 2008). Sociological approaches typically focus on societal issues and the resultant dynamics that influence the practice of medicine, while bioethical approaches are more inclined to focus on the attributes and values associated with the doctor-patient relationship (Cruess & Cruess, 2008). Given the complexity of professionalism and the recognition that it is more than the acquiring of skills, informal and hidden curricula are recognized in much of the literature on the subject as critically important, more so than formal teaching experiences (Goldie, 2012). This does not however negate the importance of formal curricula and outcomes reflective of professionalism.

Detailed descriptions of curricula are limited and, where they are described, the approaches to teaching differ widely from more 'aspirational' (Goldstein, 2016) to more explicit integration of professionalism content into the formal curricula through a range of methodologies associated with behaviour that can more easily be measured (Cruess et al., 2014). These have included, amongst others, problem-based learning (PBL) (Maudsley & Taylor, 2009), situated learning, experiential learning, and reflection.

Informal and hidden curricula reflective of professionalism are most strongly linked to that of role models in the formation of student identity. Aristotle said "we learn by practice and that the best practice is to follow a model of the virtuous person" (Pellegrino, 2002, p. 383). As said by van der Merwe and colleagues (2016), "the quality and values of these graduates – irrespective of where they come from – are influenced by the training curriculum, quality of teaching and role models they are exposed to once they are enrolled in medical school" (p. 79). In order for learning to be effective, the professionals who teach need to be positive role models who are able to demonstrate the virtues and values associated with professionalism, and that competence and character are inseparable (Pellegrino & Thomasma, 1993). In a study conducted by Mclean at the South African Nelson R Mandela School of Medicine, students identified role models as important. Faculty members were chosen increasingly through students' years of studies, but many identified their own parents as having traits worth emulating such as "hard-working, for persevering through crises or disadvantage, or for providing for and educating a family (often single-handedly) under difficult circumstances" (Mclean, 2004, p. 137).

It is important to note that negative role models also have their role in shaping the young doctor (Pellegrino, 2002), as medical school can be a "breeding ground for aggressiveness, pride, poor communication with patients, and other character traits" (Pellegrino & Thomasma, 1993, p. 177) that go against the values and virtues required of a doctor. Dominance and subordination, or power

and privilege are therefore important relational positions to acknowledge and be aware of when exploring the education, experience and context of professionalism in medicine (Apple, 2012). A further challenge has been the decrease in opportunities for authentic context-based learning and role-modelling because of ever-changing personnel, patients staying in hospital for shorter periods, and shortened clerkships (Seggie, 2011).

The teaching, learning and assessment of professionalism in medicine is clearly complex. Focusing on more measurable aspects of doing have therefore become more attractive, but even that is challenging. Van de Camp for example identified 90 elements that constitute professionalism and that potentially require assessment (van de Camp, Vernooij-Dassen, Grol & Bottema, 2004). Other areas of focus associated with professionalism have also emerged as potentially important in teaching and learning such as reflective ability and emotional intelligence (Hafferty, 2017). Criteria for assessment of professionalism are wide-ranging, as educators search for and focus on that which is measurable (Hodges et al., 2011; Stern, 2006). Assessment methods vary from observed clinical encounters, multisource feedback including patient surveys, views of co-workers, and records of lapses in professionalism, to simulations and written assignments (Goldie, 2013; Wilkinson, Wade & Knock, 2009). Miller's Pyramid (1990) has proved to be a useful tool for understanding and designing the various levels of assessment associated with clinical competence starting with 'knows', and moving to 'knows how', 'shows how', and finally 'does'.

Motivations for the longitudinal integration and assessment of professionalism at the individual, interpersonal and institutional/societal levels, from prior to admission right through to internship and beyond, are increasingly being heard (Rimal, 2018). What is important is that the assessment method, as with all educational practice, is aligned with what is being taught and that it is on-going (Jha, Bekker, Duffy & Roberts, 2013). The process, therefore, needs to start with a clear, shared understanding of what constitutes professionalism in order that it can be assessed (Arnold & Stern, 2006; Cruess, 2006). This must then be reflected in the pedagogical practices (Hafferty, 2009). Antiel, Kinghorn, Reed and Hafferty (2013), for example, believe that professionalism is associated with virtues, and that therefore medical education should be promoting virtue as a life-long goal.

Turning to South Africa, the teaching, learning and assessment of professionalism in medicine needs to be explored within the context of medical curricula needing to produce a graduate "fit-for-service in post-apartheid South Africa" (Seggie, 2010, p. 8). The HPCSA draws on Pellegrino's work by viewing the practice of medicine as a moral enterprise, emphasising the need for life-long commitment to good professional and ethical practices. All medical schools in South Africa are required to adhere to the guidelines of the HPCSA. At UCT, professionalism is embodied within the

Graduate Profile (2006) and the pledge that all Health Science students commit to at graduation. The Graduate Profile (Appendix 1) has been adapted from the Global Minimum Essential Requirements (GMER) of the International Institute of Medical Education (IIME) list of seven competencies (Core Committee, Institute for International Medical Education, 2002). As introduced in section 1.1, professionalism within the FHS at UCT is explicitly integrated into the outcomes and activities of two multi-professional first year courses BP and BHP (Appendix 2) through use of the IHP framework (Olckers et al., 2007), and picked up through the six year degree programme in BaDr and other courses, particularly those that form part of the Family Medicine curriculum (Appendix 3). A shared understanding of what should be taught and learnt related to professionalism however remains unclear as no one shared understanding has been agreed upon and integrated across the six years of the MBChB curriculum. Teaching methods also vary significantly from bed-side teaching and practicals, to lecture-based and small group experiential learning, and problem based learning methods. The assessment of professionalism also varies with some courses integrating professionalism into written assessments, practical assessments, and self-assessments as in the case of the 6th year Family Medicine course (Appendix 3). Some courses do not however include professionalism in their assessments at all.

Given the need to further establish the best and most appropriate means of teaching, learning and assessing professionalism in medicine, Seggie's (2010) plea for ensuring professionalism as the next goal for medical education and training in South Africa seems appropriate, and provides clear motivation for the current study.

2.6 A COMPLEXITY SCIENCE APPROACH TO PROFESSIONALISM

A complexity science approach that shifts the focus of professionalism from issues of its definition, teaching, learning and assessment to understanding that it exists within a dynamic interplay of broad contextual influences is useful (Hafferty & Levinson, 2008). The relevance of context for professionalism generally, and the South African context specifically, has been picked up extensively (Birden et al., 2014; van Rooyen & Treadwell, 2007; Verkerk, de Bree & Mouritz, 2007). A wide range of contextual shifts that influence professionalism in medicine have been identified, and include the commercialization of medicine, the influence of the internet and social media, generational differences, and changes within the practice of medicine itself. Bryan (2011) refers to these issues as creating a perfect storm – what he sees as “a rare combination of circumstances that drastically affects a situation for the worse” (p. 465).

2.6.1 Commercialisation of medicine

A shift towards career, self-interest, money, status and power within a broader context of a capitalist market ideology, and away from the more historical 'calling', is seen as having serious implication for professionalism and resulting in distrust of doctors and the medical profession globally, as well as within the South African context more specifically (Benatar, 1997; Lundberg, 1990; Macintyre, 1981). Sullivan (2000) sees the present global context as working against the trust that is essential to professionalism, with a need to return to the moral core of professionalism and the maxim that: "Medicine must always be treated as a public good, never as a commodity" if it is to have a future (p. 675).

The profession of medicine has moved from being profession-orientated and internally regulated to market-orientated (Cruess, 2006) with regulation through management (Hilton, 2008). Doctors seldom manage their own practices, but operate within a larger bureaucratic system managed by business in the pursuit of profits, or government in pursuit of compliance, which has resulted, some would say, in the undermining of the physicians' ability to care for patients (Ludmerer, 1999). Doctors have been stripped of their ability to govern themselves as a result of the corporatisation and bureaucratisation of medicine within capitalist society (McKinlay & Marceau, 2002) and the appropriation of medical practice by state and corporate sectors (Cruess, Cruess & Johnston, 2000). This commercialism with financial profit as its goal is perceived to be "antithetical to the spirit of professionalism" (Hafferty & Castellani, 2010, p. 291). Benatar (1997) has gone as far as to express concern that medicine is losing its soul through becoming most concerned with wealth, power and status. Pellegrino too saw the act of profession, the very promise of dedication to the sick, as under threat because of this "obsession with the bottom line, professional competition, profit, honours, and prestige" (Pellegrino, 2012, p. 22). He framed this against the increasingly industrialised and commercialised models of care, and the "prevailing moral scepticism, relativism, and self-interest..." that dominate society today (Pellegrino, 2012, p. 22). This commodification and commercialization has had the consequence of causing confusion about patients' and physicians' roles, conflict of interests, and decreased trust in physician's judgement, moral responsibility and accountability (Bryan, 2011).

2.6.2 The Internet and social media

On a global scale, the development of the Internet means that knowledge is being produced and shared at a rate that was unimaginable in the past. Its power, as Snyder (2011) points out, is 'daunting', and has resulted in the need for students and graduates to commit to continuing

professional development (CPD). At the same time, patients have more access to health-related information than ever before, although a significant drawback is that much of this information has been found to be inaccurate (Gabbard, 2018). It has however impacted positively on the relationship between doctor and patient, which has become more of a partnership rather than a situation of the doctor holding all the knowledge, as was typical of the more paternalistic doctor-patient relationship of past decades (Royal College of Physicians, 2005).

Associated with the increase in on-line information, has been a surge in the use of social media. Facebook is reportedly most popular with over one billion users world-wide (George, Rovniak & Kraschnewski, 2013). According to Patricios and Goldstuck (2018), 9.4 million South Africans were reported to be making use of Facebook in 2018 which accounts for 29% of the South African population, making it a rival to TV and radio, but with its advantage of being about two-way communication. The rapid increase in usage of social media has also been reflected within medicine, with reported increases from 41% in 2010 to 90% usage by doctors in 2011, and as many as 60% to 80% of doctors using text messaging for clinical communication in the USA (Gabbard, 2018). Social media is now seen by many as “part of the landscape of modern medicine” (George et al., 2013, p. 1). Brown, Ryan and Harris (2014) reported that despite social media being part of the personal lives of doctors, few changes had been made by doctors to integrate social media into their professional practices. Mostaghimi and Crotty (2011) however pointed out that separating personal and professional identities in social media is nearly impossible.

A divide between ‘digital natives’ (students born after 1980 and into the digital age) and ‘digital immigrants’ (educators and practitioners who graduated before 1980) is reported to exist (Gholami-Kordkheili, Wild & Strech, 2013). This reflects generational differences and possibly something of a paradigm shift in communication and what is acceptable for medical professionalism (Chou, Hunt, Beckjord, Moser & Hesse, 2009; Chretien, Farnan, Greysen & Kind, 2011). This shift in communication, as Snyder (2011) points out, is potentially challenging for the establishment and maintenance of public trust in medical professionals. Doctors need to be particularly vigilant about privacy, confidentiality, and respect for their patients (Fisher & Appelbaum, 2017), but also understand that while they are bound by a code of ethics, their patients are not, and this may potentially leave doctors exposed. Social media essentially facilitates the gathering of information about the professional and personal lives of doctors (Gabbard, 2018).

It is worth noting that, until recently, articles exploring the use of social media and its implications for professionalism in medicine tended to focus on negative repercussions (George et al., 2013; George & Green, 2012; Greysen, Kind & Chretien, 2010; Lateef, 2013). Issues of privacy and

confidentiality, and the blurring of lines between friendship and professional relationships have been of particular concern (Brown, Ryan & Harris, 2014; Chretien et al, 2011; Jain, 2009, Mansfield et al., 2011). This has been an issue reported by doctors and faculty members who have had to grapple with requests to 'friend' patients or students (Chretien et al., 2011). It seems that many social media users experience a sense of disinhibition when using social media because of a feeling of anonymity. For doctors this may mean that that they do not apply the usual principles of professionalism that they would otherwise apply in a face-to-face context. The problem is then further exacerbated because of the "digital footprint" left by users and the wide reach of social media (Greysen et al., 2010, p. 1227). An extensively reported example was that of healthcare professionals who were working as aid workers in Haiti and posted clearly inappropriate content on Facebook, including doctors holding guns and bottles of alcohol, as well as photographs of doctors standing next to unconscious patients (Greysen et al., 2010). A moment of "rashness (by doctors or medical students) could have unintended and irreversible consequences in the future such as suspension from medical school, loss of employment ..., and loss of trust in the medical profession" (Gholami- Kordkheili et al., 2013, p. 2).

George et al. (2013), Lateef, (2013) and Gholami-Kordkheili et al. (2013) see medicine and its associated values of privacy, confidentiality and more formal conduct as something of a polar opposite to the values associated with social media such as sharing, openness and informality. These contrasting 'cultures' are seen to result in particular challenges for professionalism in medicine, where conduct typically associated with professionalism may be seriously tested, particularly with regards to privacy and confidentiality.

Despite these challenges, there is an increase in the numbers of articles motivating for the positive use of social media, because of the potential power of social networks to share information and offer support (George et al., 2013; Gholami-Kordkheili et al., 2013). Suggestions are made for how to manage challenging issues that may impact on professionalism, including taking responsibility for checking and updating privacy settings and creating user groups such as Google+ 'circles', where users can sort their contacts into appropriate groupings making sure that friends and patients are kept separate. Medical associations such as the American Medical Association (AMA) have begun to publish guidelines on social media such as the AMA CEJA 'Report on Professionalism and Social Media' (Shore, Halsey, Shah, Crigger & Douglas, 2011), and medical curricula are starting to include courses on managing social media (Gholami-Kordkheili et al., 2013; Chretien et al., 2011; Shore et al., 2011). Recommendations include prioritising patient privacy and confidentiality, using privacy settings when making use of social media, maintaining clear boundaries between doctors and

patients, and taking responsibility for acting on any unprofessional content shared by other colleagues (Snyder, 2011). It is clear that the internet and social media are very much part of 21st century lives, but care needs to be taken to manage them in positive, informed and responsible ways, so as to further professionalism and the trust relationship between doctors and society.

2.6.3 Generational priorities

As indicated in the previous section, generational differences are evident between those born into the world of the internet and social media, what Gholami-Kordkheili et al. (2013) called 'digital natives' and those born beforehand, 'digital immigrants'. Within the profession of medicine, criticism is frequently levelled by the older 'Baby Boomer' generation at their younger 'Generation X' colleagues for lacking what it takes to be a physician. The perception is that medical students nowadays value balanced lives over and above total commitment to their profession. Women are in the majority and, with wanting to create a balance between work and family lives, reportedly want to work fewer hours with greater opportunities for flexibility (Seggie, 2011; Smith, 2005). This feminisation of the profession is not unique to South Africa, and reflects a global trend of women students now outnumbering men studying medicine. Within South Africa a further change has taken place as a result of the end of apartheid, with black African students studying medicine now outnumbering white students (Breier & Wildschut, 2006; FHS Undergraduate office, personal communication, April 2015).

Despite generational differences there is also the recognition that there are more similarities than differences, and that the "learning environment should accept generational differences, forgive students struggling at the start of the transformation to physician and nurture the process. Educators need to talk more about the wonder, privilege and honour of being someone's doctor, creating a positive, professional 'hidden curriculum'" (Smith, 2005, p. 441) for students coming into the profession of medicine.

2.6.4 Biomedicine to holistic care

Since the late eighteenth century, when scientific medicine first showed positive results in the battle against diseases such as typhoid, diphtheria, gastritis and tuberculosis, many came to see medicine as superior to other forms of healing, with doctors as something akin to heroes. This resulted in a generally more mechanistic, biomedical approach to medicine and the human body, as well as a paternalistic attitude towards patients. Assumptions were that the body could be repaired like a machine (Nettleton, 2006). Understandings of medicine and health have changed over time, with the purely biomedical approach being questioned extensively. Improvements in health, a decline in

mortality and increased life expectancy have been found to have more to do with social causes (e.g. nutrition and hygiene) than medicine itself. There has therefore been a shift within medicine to a more holistic view and a need to locate the body within the wider socio-environmental context, taking account of issues such as the impact of social inequalities.

Within South Africa, the ramifications of the HIV/AIDS pandemic cannot be underestimated. According to STATS SA, 12.9% of the population (7.52 million) are reported to be living with HIV, and the average life expectancy of men at birth is just 61.1 years and women 67.3 years (STATS SA, 2018). It is estimated that there are 36.7 million people worldwide infected with HIV, but that the HIV pandemic is most severe in South Africa (Africa Check, 2016). HIV/AIDS has clearly had serious implications for healthcare in South Africa, but has also contributed to many medical graduates opting to emigrate to countries such as the United Kingdom, United States, Canada and Australia, where HIV is less prevalent, and career opportunities are perceived to be more promising (Mills et al., 2011).

With these shifts and changes in the practice of medicine has come a transformation in the doctor-patient relationship, from knowledgeable expert informing ignorant lay person on the one hand to a 'meeting between experts' on the other (Tuckett, Boulton, Olson & Williams, 1985). As a result of the move from a doctor-centred to a patient-centred approach (Mead & Bower, 2000), patients are encouraged to "act as discriminating consumers" (Nettleton, 2006, p. 138). This shift has been described by Walsh and Abelson (2008) as moving from an 'age of heroes', when the majority of practitioners were white, male, family doctors who worked long hours of up to seven days and many nights. The doctor's role was to offer support at the bedside. Practice was patient focused and involved physical examinations and history taking. Doctors were seen to hold high moral standards, but with no balance in their own lives. Moving to present day 2000s, Walsh and Abelson (2008) describe how some doctors choose the business over the practice of previous generations, largely in response to a drive for more balance in their lives. Medical information is publicly available, but with different degrees of accuracy, and resulting in doctors fearing repercussions of not doing enough (Walsh & Abelson, 2008). Given that it has been found that patients are generally dissatisfied with their quality of care (Katz et al., 2007), many patients are also seeking alternative or complementary healthcare interventions (Le Frau in Hilton & Southgate, 2007). Patients want to be able to trust their doctors (Lupton, 2002), and want "physicians who are accessible, knowledgeable, meticulous, and patient. They want clear explanations for their health problems and constructive suggestions on how to manage these problems" (Katz et al., 2007, p. 138).

2.7 CONCLUSION

This chapter has covered and presented much of the literature, current debates and challenges associated with professionalism in medicine. Concepts, including those of profession and professional, were explored generally and then in the specific context of medicine. The central role of the Oath and Code of Conduct were discussed regarding their relevance for professionalism, and then different understandings of professionalism were presented drawing attention to the lack of one shared understanding and the complexities related to this. Contextual factors on a global as well as within the South African context were then discussed, highlighting the challenges for professionalism in medicine associated with modern-day commercialisation of medicine, the internet and social media, different generational priorities, and the shift from biomedicine to more holistic care. The following chapter presents the methodology, followed by the results chapter, and then the detailed discussion of issues reflected in the results and their relation to the literature presented above.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

Following on from the literature review described in Chapter 2, Chapter 3 details the research methodology used in the current study. Descriptions of the broad theoretical paradigm and the more specific conceptual framework are provided, giving attention to the framing of the study. This is followed by practical details of setting, methods, sampling, and procedure, as well as the research instruments and method of analysis that were used. Finally, the chapter ends with discussion of ethical considerations and the researcher's own potential biases within the study.

3.2 THEORETICAL PARADIGM

A theoretical paradigm is also referred to as a worldview, and is a set of beliefs that underpin actions, and therefore ultimately the choice of method/s used in research (Creswell, 2014). According to Guba and Lincoln (1994), what defines a particular theoretical paradigm can be summarised by the responses given to three fundamental philosophical questions:

1. The ontological question: What is the form and nature of being and reality?
2. The epistemological question: What is the basic belief about knowledge, how it is created, acquired and communicated?
3. The methodological question: How can the researcher go about finding out whatever s/he believes can be known?

Two opposing paradigms of objectivism and relativism have been put forward in response to these fundamental philosophical questions (Bernstein, 1983). Objectivism, as the name implies, is the belief that there is a permanent a-historical reality. It is also referred to as the scientific or positivist paradigm, and has as its ontological position that of realism, meaning that reality and objects are understood to exist independently of the researcher. It sees knowledge as objective and existing independently with no relation to context or values, and the methodology is typically about explaining relationships of cause and effect while remaining value neutral (Scotland, 2012). Relativism, on the other hand, is the belief that whatever one takes to be most fundamental is relative to all else. It has as its ontological position that of historical realism which assumes that reality is socially constructed, and influenced by social, political, economic and other beliefs, as well as more subjective elements (Bernstein, 1983; Scotland, 2012).

In an effort to move beyond these two opposing views, with the goal of elucidating aspects such as context, difference, and power, is the interpretive or hermeneutical theoretical paradigm (Bernstein, 1983; Gadamer, 2013; Rabinow & Sullivan, 1987; Scotland, 2012). The interpretive paradigm sees reality as ‘intrasubjectively’ and ‘intersubjectively’ constructed (Angen, 2000), with the aim of explaining and understanding phenomena within individuals themselves, and between individuals, groups and societal contexts. The phenomenon of hermeneutics, or the hermeneutic circle, helps to explain the iterative process of creating new meanings, by focusing on both the parts and the whole in a movement of understanding, interpretation and meaning (Gadamer, 2013). Understanding is therefore seen as always evolving as people go through and are exposed to new and different experiences in the context of their own biases, pre-judgements or prejudices, in other words what the researcher brings with him or herself to the research (Gadamer, 2013). Despite the fact that these three paradigms of objectivism, relativism and interpretivism are presented as separate, they often coexist and this means that researchers may, at times, draw on more than one paradigm (Terre Blanche & Durrheim, 1999).

The aim of this study was to gain an understanding of how medical students and their educators understand and experience professionalism in medicine in the South African context. With the focus on understanding and experience, it was therefore appropriate to frame the research within an interpretive, or hermeneutical, theoretical paradigm that draws attention to how participants, in this case students, interns and educators, make sense of professionalism in medicine within their own circumstances (Babbie & Mouton, 2009; Bernstein, 1983; Gadamer, 2013; Kaplan & Maxwell, 1994; Rabinow & Sullivan, 1987; Thorne, 2000). Making use of the interpretive paradigm meant that qualitative methods, including focus groups and individual interviews, were most appropriate for this study, so that questions requiring depth and understanding could be explored (Babbie & Mouton, 2001; Denzin & Lincoln, 2000). As Roche (1991) points out, qualitative research methods are most appropriate in studies concerned with experiences, insights and behaviour – exactly what was being explored in this study.

3.3 CONCEPTUAL FRAMEWORK

The previous chapter included an overview of the literature related to professionalism in medicine. The broad areas of ‘being’ and ‘doing’ were identified and described as representing two opposing ends of a continuum in understanding professionalism in medicine, with the more recent addition of ‘identity formation’ (Irby & Hamstra, 2016). The work of Edmund Pellegrino falls squarely within the ‘being’ understanding of professionalism in medicine, and forms the conceptual framework for this thesis.

3.3.1 Who was Edmund Pellegrino?

Edmund Daniel Pellegrino was an American physician, philosopher and educator. Born on 22 June 1920 into a working class family, Pellegrino graduated summa cum laude from St. John's University, a Catholic University in Queen's New York. Being Catholic and of Italian descent, Pellegrino faced enormous prejudice from numerous Ivy League universities when he tried to pursue his dream of studying medicine. Persistence however prevailed, and Pellegrino was finally admitted to and graduated from the New York University College of Medicine in 1944. This was the same year he married Clementine Coakley, to whom he was married for 68 years, and with whom he had seven children. Dr Pellegrino died on 13 June 2013 just short of his ninety-third birthday (Geraghty, 2001).

Dr Pellegrino was a prolific contributor to the exploration and understanding of professionalism in medicine and healthcare more generally. His CV included an impressive list of accolades, honours and awards. He was the author or co-author of more than 600 publications on medicine, philosophy and ethics, including 23 books, and was the founding editor of the *'Journal of Medicine and Philosophy'*. He and long-time friend and colleague David Thomasma co-authored *'A Philosophical basis of medical practice – toward a philosophy and ethic of the healing professions'* in 1981. This book formed the basis of much of what was written about professionalism in medicine by Pellegrino and Thomasma together, and independently. It was followed by numerous other books including *'For the patient's good – The restoration of beneficence in health care'* in 1988, and *'The virtues in medical practice'* in 1993.

Amongst Pellegrino's many achievements were that he was named to the International Bioethics Committee of UNESCO in 2004, and in 2005 he became the chairman of the President's Council on Bioethics (Georgetown University Kennedy Institute of Ethics, n.d.). Dr Pellegrino was Professor Emeritus of Medicine and Medical Ethics at the Kennedy Institute of Ethics and the founding director of the Centre for Clinical Bioethics, which was renamed the Edmund D. Pellegrino Centre for Clinical Bioethics in his honour in 2013.

3.3.2 Pellegrino and professionalism in medicine

3.3.2.1 The practice of medicine

As a doctor, philosopher and educator, Pellegrino was deeply concerned about the profession of medicine and the doctor-patient relationship. He described medicine as a “learned profession” like law, teaching and the ministry because of its “dedication to something other than self-interest ... a certain degree of altruism, or suppression of self-interest when the welfare of those they serve requires it” (Pellegrino, 2002, p. 378). To Pellegrino medicine was more than a mere occupation, but rather a commitment “to help, to care, to ease suffering, and to cure where possible” (Pellegrino, 2012, pp. 22–23).

To Pellegrino, every doctor-patient interaction involved the ‘act of profession’, demonstrated through the doctor’s taking of the Oath upon entering the medical community, but also in each patient encounter through an unspoken promise, commitment and dedication to patient care when a doctor asks the patient what s/he can do for the patient, and then acts for the good of the patient by helping and, where possible, healing the patient (Pellegrino, 2006, 2010). He described how, when a patient seeks the assistance of a Doctor, the Doctor must focus his/her clinical judgement around three key questions: “What can be wrong? What can be done? What should be done for this patient?” (Pellegrino & Thomasma, 1981, p. 125). The answers to these questions and the ultimate goal of medicine was understood by Pellegrino to be framed by the ‘good’ of the patient. He described four specific aspects to this ‘good’ of the patient including:

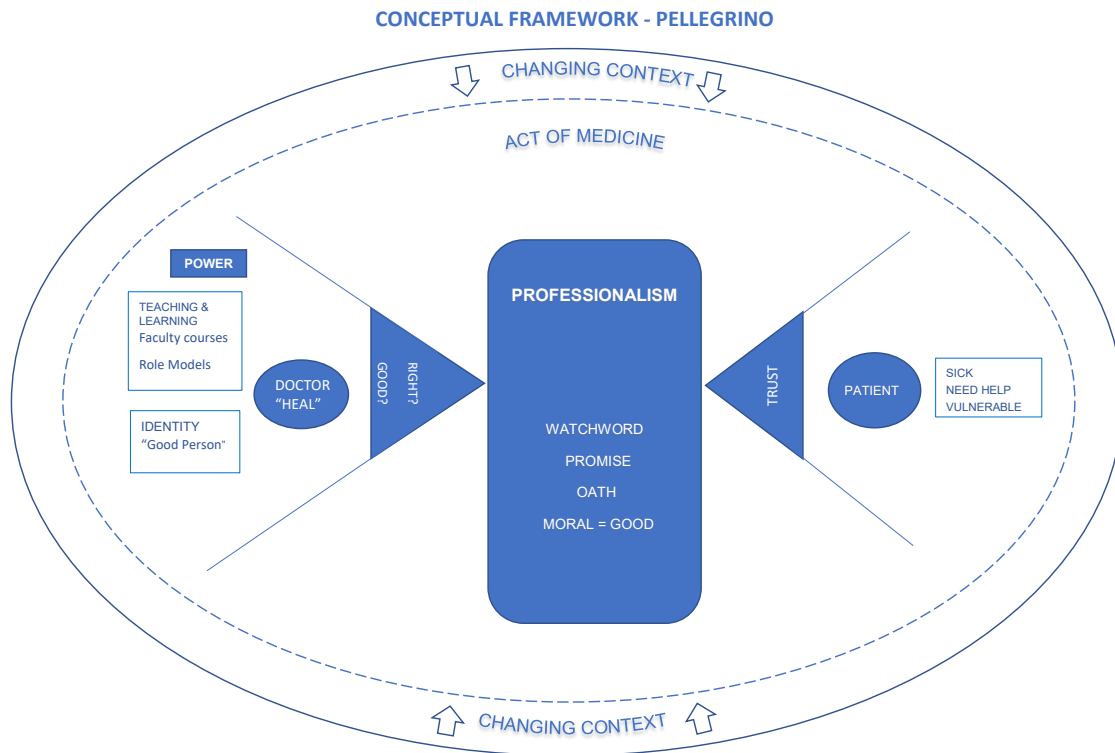
1. The clinical or bio-medical good of body and mind
2. The patient’s own unique perception of good including for example individual preferences, choices and values, and the kind of life s/he want to live
3. The good of the patient as a human being generally including respect for dignity and other broad principles of medical ethics
4. The ultimate good or spiritual good, referring to the patient’s spiritual being, whether religious or not (Pellegrino, 1983, 1985, 2001; Pellegrino & Thomasma, 1988).

Pellegrino therefore understood the practice of medicine to be clinical but also inherently moral, because of what he referred to as the triad of illness that makes a patient dependent and vulnerable and having to trust their doctor; the non-proprietary nature of medical knowledge that is acquired through medical education for the good of the sick; and the professional oath that symbolizes the doctor's entry into the profession (Geraghty, 2001; Pellegrino, 2006; Pellegrino & Thomasma, 1993). Given this moral focus, Pellegrino believed that a doctor must be a virtuous person before s/he is anything else. He defined virtue as being about excellence, both intellectual and moral (MacIntyre, 1981; Pellegrino, 1985, 2002; Pellegrino & Thomasma, 1988). His belief was that the virtuous doctor will act well and with attention to good even when others are not watching (Pellegrino, 1999; Pellegrino & Thomasma, 1988).

3.3.2.2 Professionalism in medicine

Pellegrino described professionalism as the “watchword for those qualities and modes of conduct proper to professions” (Pellegrino, 2002, p. 378), and explored professionalism in medicine through the lens of virtue-based ethics, by drawing attention to the virtues, values and morals of the individual practitioner (Pellegrino, 1981, 2002). He justified this most strongly by focusing on the kind of person one is, and believing that the virtues of the doctor best guarantee that the patient's good will be respected (Pellegrino, 2012; Pellegrino & Thomasma, 1988). Pellegrino's understanding of professionalism can therefore be understood as framed within the ‘being’ end of the continuum that was described in Chapter Two. Figure 2 below provides an overview of the key elements of Pellegrino's view of professionalism in medicine.

Figure 2: Conceptual framework – Pellegrino



The concept of virtue is situated within the classical-medieval writings of philosophers Plato, Aristotle and Thomas Aquinas. Their understanding of virtue as including fortitude, temperance, justice, wisdom and self-restraint has framed the ethics of health professions and formed the basis of the Hippocratic Oath (Pellegrino, 1995). Pellegrino believed that doctors need to be moral and virtuous because of the inequality inherent in the doctor-patient relationship, the fiduciary basis of the relationship, the moral nature of the sorts of decisions doctors have to make, the character of medical knowledge, and the doctor’s moral complicity in what happens to his/her patients (Pellegrino & Thomasma, 1993).

For him, “the virtuous person is someone we can trust to act habitually in a good way – courageously, honestly, justly, wisely, and temperately. He or she is committed to being a good person and to the pursuit of perfection in private, professional, and communal life” (Pellegrino & Thomasma, 1988, p. 116). He did however point out that creating a list of virtues is notoriously difficult (Pellegrino, 1995). It is interesting to note that over the years his list changed, but compassion, fidelity to trust and phronesis were evident throughout (Pellegrino, 1995, 2012).

Pellegrino described compassion as a combination of objectivity and empathy – including both moral and intellectual components (Pellegrino, 2012; Pellegrino & Thomasma, 1993). “Its components are many – psychological, sociological, cultural, ethnic, and intellectual. But compassion is also a moral virtue in the classical sense ... a habitual disposition, to act in a certain way, a way that facilitates and enriches the *telos* or purpose of whatever human acts we perform ... Compassion is the character trait that shapes the cognitive aspect of healing to fit the unique predicament of *this* patient” (Pellegrino & Thomasma, 1993, p. 79). It therefore involves making informed clinical decisions in the context of the individual patient (Pellegrino, 2002). Pellegrino distinguished compassion from empathy, which he saw as something broader. To him, compassion was about focusing specifically on suffering rather than the broader human experience (Pellegrino & Thomasma, 1993).

Fidelity to trust drew attention to the need for patients to trust their doctors not to exploit or harm them, but to use their skills and knowledge for the good of the patient (Pellegrino & Thomasma, 1993). Pellegrino described fidelity to trust as ‘an indispensable virtue’ (Pellegrino & Thomasma, 1993).

Phronesis is what Aristotle referred to as ‘practical wisdom’. Pellegrino clearly described phronesis as where moral and intellectual virtues are united, and doctors are able to make “right choices in complex clinical circumstances” (Pellegrino, 2002, p. 382).

3.3.2.3 Can virtues of professionalism be taught?

Pellegrino grappled with the question of whether virtues can be taught, a question that has been explored since the time of Plato. Socrates concluded that men learn virtue by divine inspiration, while Anytus and Aristotle took the view that virtue is learnt through observation and following the example modelled by a virtuous person (Pellegrino, 1995, 2002). Pellegrino followed this view and was therefore of the opinion that the professionals who teach medical doctors are responsible for being role models for students, and ultimately reflect the values of the faculty, whether positive or negative (Pellegrino & Thomasma, 1993). Pellegrino was therefore concerned that “medical school training is sometimes a breeding ground for aggressiveness, pride, poor communication with patients, and other character traits that directly contravene the virtues” required of a doctor (Pellegrino & Thomasma, 1993, p. 177).

While he viewed educators as the primary role models for emerging professionalism, Pellegrino was also of the opinion that certain additional educational efforts can help to shape the young doctor, such as courses in medical ethics and humanities, as a means of sensitizing students to be more critically reflective of what they are taught and what they see modelled (Pellegrino, 2002). He was also of the opinion that moral maturity and professionalism take time, refinement and critical self-reflection (Pellegrino & Thomasma, 1993).

3.3.2.4 Threats to professionalism

Pellegrino saw professionalism and what he called the act of profession, a dedication to the sick, as under threat because of an “obsession with the bottom line, professional competition, profit, honors, and prestige” (Pellegrino, 2012, p. 22). It was his belief that the violation of the trusting relationship had resulted in the decline of the current credibility of the medical profession (Pellegrino & Thomasma, 1988). Pellegrino believed that virtues in medicine had diminished over time, as a result of broad societal upheaval and a decline in moral values, the weakening of religious consensus, and a general distrust of authority (Pellegrino, 1993, 1995, 2000), and he was concerned that these shifts had resulted in the deprofessionalisation of medicine (Pellegrino, 2000). He framed this threat to medicine against increasingly industrialized and commercialised models of care, and the “prevailing moral skepticism, relativism, and self-interest ...” that he perceived as dominating society today (Pellegrino, 2012, p. 22). This shift to self-interest was, in his view, incompatible with the virtues of fidelity to trust and beneficence (Pellegrino & Thomasma, 1993).

Within this changing context, and criticism of virtue-based ethics as ‘morally indefensible’ (Veatch, 2001), principle-based medical ethics emerged during the mid-1960s, with nonmaleficence, beneficence, respect for autonomy, and justice as its four key principles in search of more practical action guidelines (Beauchamp & Childress, 2009). Pellegrino however pointed to the fact that cycles of moral confusion were not new, but had been evident throughout the history of medicine as far back as the Hippocratic physicians themselves, who had broken away from their contemporaries and identified themselves with specific moral principles and teachings (Pellegrino, 2000). Pellegrino’s argument remained that practical issues that principle-based ethics was trying to address remained moral problems at their core (Pellegrino, 2012), and that doctors must ultimately choose between doing good and pursuing, for example, profit (Geraghty, 2001). He did however express concern that the term ‘professionalism’ itself may be problematic as it may not carry the ‘moral force’ of responsibility required of doctors (Pellegrino, 2010), and could become an “ideology, or a symbol of a guild; it can generate a union mentality focussed on defending the group’s own interests” (Pellegrino, 2002, p. 379).

3.3.3 Summary

Pellegrino situated professionalism in medicine in the domain of virtue-based ethics, believing that doctors must be moral and virtuous as individuals and as members of what he perceived to be the moral community of medicine, because of the unique relationship between doctors and their patients. He believed that doctors have the responsibility to choose to be moral beings. This moral and virtue-based focus positioned his understanding of professionalism within the 'being' end of the continuum of understandings of professionalism, and forms the conceptual framework against which the current study is explored. The interview questions (see Appendix 4) were specifically designed to provide opportunity for in-depth exploration of this 'being' conceptualisation of professionalism; and analysis of the results was framed against the work of Pellegrino thereby facilitating discussion of similarities and differences between Pellegrino and the study findings (see 3.8 Research Instrument). While numerous contributions have been made to the study of professionalism in medicine, Pellegrino's voice continues to hold a significant position making further interrogation of his perspective valuable.

3.4 SETTING OF STUDY

The setting of this study was the Faculty of Health Sciences, UCT, in Cape Town, South Africa. South Africa has a population of 57.7 million (Stats SA, 2018), and is widely reported to be one of the most unequal societies in the world, with the richest 1% of the population owning 42% of the total wealth (Oxfam, 2017); and the total net wealth of just three billionaires in South Africa being equivalent to that of the bottom 50% of the country's population ("The wealth of these", 2017). This inequality is born out of the country's history of colonialism and apartheid. Despite becoming a democracy in 1994, with a constitution that enshrines equal rights, the inequality is evidenced in all aspects of society including unequal access to higher education. Only 18% of school leavers are accepted into university in South Africa (Nkosi, 2015) in comparison with global figures of 32% ("Excellence versus equity", 2015). The demographic profile of students selected into medicine at South African universities is reportedly moving closer to the population distribution of the country, but black African students are still underrepresented (van der Merwe et al., 2016).

UCT is the oldest university in South Africa, with over 29 000 students, and is one of only eight universities in South Africa that offer Medicine as a degree programme (University of Cape Town, 2018). UCT's Medical School traces its history back to 1912 as the oldest Medical School in South Africa. The first medical students graduated from UCT in 1922, but it was only in 1945 that UCT graduated its first three black doctors. Until then training of black (African, Coloured and Indian)

doctors was only possible overseas, usually with funding from the church or through family support (Mayosi, 2015). It was however not until decades later, in 1985, that the first black African student was admitted into medicine at UCT (“Truth and Reconciliation”, 2002). In an effort to redress past inequalities, attention focused on transforming the Faculty, including its renaming to the Faculty of Health Sciences in 1999, and the adoption of a Faculty Charter on 9 May 2002. The 10-point Faculty Charter had as its goal the creation of a “culture of human rights based on dignity and non-discrimination” (Appendix 2). At the same time the new Oath outlined in Chapter 2 was also adopted.

Students are able to apply to study and enter the MBChB programme straight from High School. As indicated in Table 1, records for 2013 and 2014, the years of data collection for the current study, competition for places to study medicine at UCT was intense. Only 3% to 4% of applications were successful in each of these years (University of Cape Town, 2014).

Table 1: FHS, UCT application and registration numbers for MBChB during years of data collection – 2013 & 2014

Year	Applications received	Numbers registered	Percentage registered
2013	5375	218	4.05 %
2014	5747	224	3.89 %

In line with international trends, both academic and non-academic indicators are used in the selection of students into medicine (van der Merwe et al., 2016). Given the need for transformation of the institution as a whole as well as within the FHS, UCT developed a complex system for the selection of students based on Admissions Points Score (APS); Faculty Points Score (FPS) including National Benchmark Tests that test academic literacy, quantitative literacy and mathematics; and Weighted Points Score (WPS). The aim of this complex system was to redress the South African history of disadvantage and inequality at UCT, and to make the university and its faculties reflective of wider South African society (The University of Cape Town, 2018). As a result of this process of transformation in admissions, the demographics of those students who are accepted into the FHS has changed significantly since 1922. The number of women students studying medicine now outnumbers the number of men studying medicine (Breier & Wildschut, 2006). Most significant however is the change in the racial profile of students. By 2013 and 2014, the years when data for this study were collected, black African students made up the largest number of successful applicants (see Table 2 – figures supplied by FHS Undergraduate office, personal communication, April 2015).

Table 2: FHS Student Admissions during years of data collection – 2013 & 2014

Racial classification according to that assigned to the parent	Registered for first year MBChB 2013	Percentage of total registered 2013	Registered for first year MBChB 2014	Percentage of total registered 2014
African	99	45.41	87	38.83
Coloured	45	20.64	44	19.64
Chinese	1	0.45	3	1.33
Indian	21	9.63	26	11.60
White	43	19.72	53	23.66
Unknown	9	4.12	11	4.91
Non-SA	0	0	0	0
TOTAL	218	100%	224	100%

The study of medicine at UCT involves a six-year degree of Bachelor of Medicine and Bachelor of Surgery (MBChB). Although patient contact takes place earlier in the curriculum, the curriculum is largely divided into preclinical study in the first three years of study and is more clinical in focus in the second half. The formal degree programme is followed by two years of Internship, and one year of compulsory Community Service (CS). CS for health professionals was implemented in 1998, and requires that doctors and other health professionals work in assigned public institutions for one year once they have completed their formal training (Reid, 2002). Transformation has not only been in terms of demographics, but also in teaching and learning methodologies. In line with international trends, the FHS has moved from traditional large subject-specific lecture-based teaching to an integrated curriculum using a combination of lectures, problem based learning (PBL), and other small group learning methodologies. The clinical teaching platform has moved to more primary-level and community-based exposure, in line with the Primary Health Care (PHC) approach that was made central to healthcare delivery in the new democratic South Africa of 1994. An Intervention Programme (IP), for first year students struggling to meet the academic demands of the ‘new’ MBChB programme, was introduced in 2002 as a means of academic support towards the successful completion of the MBChB degree programme (Hartman et al., 2012).

Transformation was the goal behind the changes within the faculty and university, but the pace was slow, and frustrations led to the ‘fallist’ movements that are identified by their hashtag insignia and use of social media. The first of these was #RhodesMustFall, which sought to draw attention to issues of personal and institutional racism, highlighting the eurocentrism of the institution. This was

followed by #FeesMustFall, which called for free higher education, a decolonised curriculum, and an end to the outsourcing of workers (Mangcu, 2017). Within the FHS, another movement was being formed – #OccupyFHS. This student movement compiled a list of demands to which they wanted responses, resulting in a number of working groups being established to attend to the demands. The student movements had implications for teaching and learning within the faculty and wider university, and resulted in the early closure of the faculty in 2016. Alternative teaching and learning methods were explored including online teaching, and debates raged across the university over the realities of student access and the value of these proposed methods (Hodes, 2017). Courses were carried over into 2017 with the inclusion of a mini semester to complete work not covered in 2016. In 2017, then-President Jacob Zuma announced fee free higher education for poor and working class families. What had been loans from the National Student Financial Aid Scheme (NSFAS), were translated to bursaries (Africa Check, 2016). Although the ‘fallist’ movements came in 2015 and 2016, subsequent to the period when data for this thesis was collected, they help to provide context for what was emerging within the faculty, university and country at large at that time.

More recently, the issue of hierarchy has been highlighted, with students in FHS compiling a report on their experiences within the faculty. The 261 responses highlighted issues within the ‘hidden curriculum’ (Hafferty, Gaufberg & O’Donnell, 2015) that pointed to preferential treatment of medical students over their health and rehabilitation colleagues (Jones on behalf of HSSC, personal communication, October 16, 2018). Further issues of power and hierarchy were highlighted by intern and UCT medical graduate, Yumna Moosa (2016), who shared her experiences of bullying and sexual harassment as an intern on YouTube in 2016. Her experiences and those of others who viewed and shared responses tell a story of wide-spread challenges reflective of power and hierarchy within medicine.

3.5 METHOD

Data collection for this study of professionalism in medicine took place between May 2012 and April 2014. The process began with student focus groups that were run as one complete year of study at a time during the period of data collection. Focus groups, educator and intern interviews were conducted concurrently based on the availability of study participants. The aim was to reflect the views and experiences of two main groupings – educators and learners, with learners including both students in the process of studying towards their MBChB degrees and interns doing their internship training. The qualitative methods of focus groups and interviews were therefore selected as most appropriate (Basch, 1987; Flick, 2014). Focus groups were planned for the student and intern participants, while interviews were deemed most suitable for the educators. Ultimately the idea of

focus groups with the interns had to be abandoned and replaced with interviews. This reflects an important aspect of qualitative research, which is the reality that data collection is not a linear process but rather requires flexibility on the part of the researcher (Flick, 2014).

Focus groups have the advantage of generating discussion and revealing how participants derive and negotiate meaning associated with a particular topic, and potentially provoke diversity and difference of opinion within and between groups (Flick, 2014). A further benefit is that individuals are studied in their own social context, which allows for the co-construction of meaning by participants (Wilkinson, 1998). The researcher is able to observe interactions between participants, and power shifts away from the researcher as priority is given to issues identified and focused on by the group (Morgan & Spanish, 1984; Wilkinson, 1998). Conversation flows as thoughts are 'sparked' and participants ask questions of clarity of one-another. Focus groups have also been found to be particularly effective in examining professional practices (Barbour, 2008) which was the focus of this study. Added to these advantages is that participants are reported to enjoy the process (Wilkinson, 1998).

Criticism of focus groups includes that participants may be enticed to intellectualize and not share emotions, and this can lead to incomplete or skewed information. Participants may also be tempted to make up answers rather than say they 'don't know', resulting in information that may be inaccurate. Care must therefore be taken to encourage open, honest participation, and to balance input from dominant with more silent participants (Krueger & Casey, 2009).

Interviews are interpersonal conversations between two parties about a topic of shared interest (Kvale, 1996). The main benefit of interviews is that they potentially allow interviewees to express their opinions more openly than in focus groups (Flick, 2014). The researcher sacrifices the opportunity to observe participant interactions that are so much a part of focus groups, for more detailed information, deeper personal insights, ideas, thoughts and feelings (Morgan & Spanish, 1984). Interviews allowed the researcher to gain detailed information and check the researcher's impressions and assumptions for accuracy, but as Kvale (2006) points out, it is important to recognize that a research interview is not a conversation between equal partners, because the interviewer is essentially in control of the process and is therefore potentially in a position of dominance. Despite this, the research interview is ultimately an interactive process that results in a shared production of the interviewer and interviewee (Kvale, 1996).

3.6 SAMPLING

3.6.1 Focus groups with medical students

Student participants were purposively sampled to ensure that they would have something to say on the topic (Krueger & Casey, 2009) of professionalism in medicine. The aim was not to have a representative sample of a population, but rather to generate dialogue within a specific group who had expressed interest in the topic, and perceived themselves to have valuable contributions to share (Seale, Gobo, Gubrium & Silverman, 2007).

Students were recruited and grouped according to their year of study so that the focus groups would be as homogenous as possible in terms of participant levels of expertise and experience, and so that power dynamics between participants could be minimised, resulting in participants feeling comfortable to speak more openly (Krueger & Casey, 2009; Morgan, 1988). The aim was to have three focus groups per year of students so that a full range of ideas could be shared (Krueger & Casey, 2009). Each focus group was planned to ideally consist of five to eight participants in order to facilitate open and constructive participation (Babbie & Mouton, 2009).

Students from years 1, 3, 4 and 6 of the medical curriculum were specifically selected to give representative breadth of age, maturity, experience, knowledge and skill of students to the data. Selection based on race, ethnicity, gender and demographic factors beyond year of study was not prioritised as students were invited to self-select to be part of the study based on their own motivations to share their understandings and experiences of professionalism in medicine. Years 1 and 6 were selected so that student input at the start and end of their formal educational experience could be explored. Year 3 is traditionally seen as the end of the 'pre-clinical years' and is the point at which students have completed the courses 'Becoming a Professional', 'Becoming a Health Professional' and 'Becoming a Doctor' – all of which focus on the 'softer' skills most closely linked to emerging professionalism in the formal curriculum. Year 4 is traditionally seen to be the start of the 'clinical years', a turning point, when students move into more clinical and practical, discipline-specific blocks of study.

Recruitment of student participants followed a similar pattern for each year of students. The process began with the researcher emailing the MBChB course convenors, explaining the study and asking for a time to address students during class. Dates and times to address the students were negotiated on the basis of convenor and student availability. On the pre-arranged date, the researcher explained the project to the class, and students were invited to add their names and contact details to a list if they were interested in participating in a focus group. It was stressed that participation

was optional and voluntary, and that choosing to participate, or not, carried no benefits or consequences. Sign up lists were left with the convenors who collected them and returned them to the researcher. This was done to minimise any pressure students might have felt to participate in the study.

Those students who volunteered to participate in the study, by adding their name to the list circulated in class, were each sent a text message detailing the date, time and venue of their focus group. Dates and times were carefully chosen, based on the review of student timetables and their potential availability. Friday lunch-times, for example, were avoided in order to respect the need for Muslim students to attend mosque. Each focus group was arranged for 1 to 1.5 hours in length, and venues on campus were chosen to minimise problems with potential time constraints. Students were asked to confirm, via text message, their willingness to participate in the study and their attendance at the focus group. Where possible, new focus group times were negotiated for those students who indicated their willingness to participate in the study, but who could not attend one of the pre-arranged focus group times. Where the majority of one focus group, for example, was made up of students doing their clinical placement off campus, arrangements were made to have the focus group in a venue at their placement hospital. Recruitment was extensive and included more participants than required, in order to allow for participants who did not arrive for the focus group or changed their minds and decided not to participate in the study (Barbour, 2008; Babbie & Mouton, 2009). Although there is no absolute prescription as to how many focus groups should be conducted, three or four are generally seen as appropriate (Krueger & Casey, 2009), as the purpose of qualitative research is not to generalize but to gain a depth of understanding (Then, Rankin & Ali, 2014). Literature on focus group size varies with recommendations fluctuating between four and fourteen (Then et al., 2014).

3.6.2 Interviews

3.6.2.1 Intern interviews

Sampling for individual interviews with interns was also purposive. The purpose was to gain information from recent graduates who could reflect on their years of study and experiences as students, and share insights from their experiences as interns. The course convenor from the Division of Family Medicine who was responsible for intern support was approached for assistance in contacting potentially suitable interviewees. The aim and objectives of the study were explained to the course convenor in order to clarify the need for interns to be approached to be participants in the study. A list of 15 graduates from UCT who were in their first or second year of internship was

drawn up, and each was approached about being involved in the study. The list included interns working in both urban and rural settings across South Africa. Initial contact was through email and text messages. As indicated previously, the plan was to gather data from interns through focus groups. This proved to be logistically challenging as interns were placed at a wide range of healthcare facilities across the country. Individual interviews were therefore organised. There were pros and cons to this shift from focus groups to interviews. The potential for interaction and sharing of different opinions that may have facilitated shared or opposing ideas within a focus group was lost, but the interview process allowed for deeper individual exploration of ideas and emotions.

3.6.2.2 Educator interviews

The researcher identified educators who she knew to be interested, experienced and involved in the design and implementation of the medical curriculum, and who had expressed interest and concern about professionalism in medicine during formal meetings and informal conversations. Each potential educator participant was approached individually via email. Sampling for these individual interviews with educators was therefore also purposive. The time and place for each interview was negotiated according to the availability of each educator participant.

3.7 PROCEDURE

In order to create a safe atmosphere, in which rapport between interviewer and focus group and individual interview participants could best be established to encourage sharing of thoughts, feelings and experiences, the researcher attempted to create a nonthreatening and supportive physical environment by organizing comfortable and intimate interview environments (Kvale, 1996; Northouse & Northouse, 1998). These were either tutorial or seminar rooms or offices that were booked for the duration of the focus group or interview. A notice was placed outside the venue saying 'please do not interrupt – meeting in progress' to minimize potential interruptions. Where landlines were in the interview rooms, these were redirected to administrative assistants. As with accepted practice, payment was not offered for participation in the study, but refreshments were set up in the venues before the arrival of the interviewees; and on their arrival, interviewees were welcomed and invited to help themselves (Then et al., 2014).

For the focus groups, chairs were arranged around a cluster of tables positioned in the shape of a rectangle to facilitate open and equal communication. An audio-recorder was placed in the middle of the group or between the researcher and interviewee to clearly record the focus group and interview interactions. When participants were comfortably settled, they were each given a copy of the consent form explaining issues of consent and confidentiality (Appendix 3). The form clarified

that participation was voluntary, and that although the interviews and focus groups were being audio recorded, all information would be presented as anonymous with the identities of participants being kept confidential. Questions of clarity were invited and when participants had signed the consent forms and indicated that they were ready to proceed, they were asked to please switch off their cell phones.

The researcher deliberately began each interview and focus group with a broad, non-threatening question, and then moved from this more social level to a deeper more specific focus on the topic and questions requiring in-depth exploration (Yeo, Legard, Keegan & Ward, 2003). In order to facilitate open communication, questions were asked in an open, unbiased, sensitive way specifically intended to present a nonjudgmental attitude – both verbally and nonverbally (Basch, 1987; Krueger and Casey, 2009). Use was made of techniques linked to group therapy and interviewing techniques (Strebel, 1995). These included open-ended questions, and techniques such as clarification, restatement, reflection, paraphrasing, interpretation and summarizing (Northouse & Northouse, 1998; Then et al., 2014). Probing, to draw out more details and to gain clarity by using phrases such as ‘would you explain further?’ or ‘tell us more’, was used extensively (Krueger & Casey, 2009). Non-verbal techniques were used and included expressing interest through eye contact, nodding, and smiling, with careful consideration of tone of voice and body language (Yeo et al., 2003). The pace of the interview and focus group was monitored, and the process of moving through the beginning, contracting, working and termination phases of any group process was carefully followed (Northouse & Northouse, 1998; Ross & Deverell, 2004). The focus groups and interviews were drawn to a close by asking participants to add anything they felt had not been covered. They were then thanked for their time, and after the recorder had been switched off, participants were invited to share reflections as to how they had experienced the interview or focus group. Each focus group and interview lasted between 50 and 80 minutes.

A transcriber was contracted to transcribe verbatim the audio recordings into a written format (Kvale, 1996), and the researcher wrote reflective summaries of each interview/focus group immediately afterwards. The transcriptions and summaries were then used as the data for analysis.

3.8 RESEARCH INSTRUMENT

Each interview and focus group was centred around specific guide questions that were designed by the researcher to focus attention on the aim and objectives of the study (see Appendix 4). These guide questions were semi-structured rather than pre-structured, so that questions could be adapted throughout the interview and focus group process and be guided by answers given by the

participants. Questions were carefully planned to elicit appropriate information and, in the case of the focus groups, to facilitate discussion rather than individual explanations (Barbour, 2008). Different types of questions were used to open up the topic areas, and for more in-depth and specifically focused deeper exploration of answers (Yeo, Legard, Keegan & Ward, 2003). The questions were adjusted and finalised after a piloting procedure conducted with a group of educators who volunteered to be part of this process.

As described earlier, the interviews and focus group process needed to begin with creating rapport, so the initial questions included items such as why participants had chosen to study medicine, or why they were willing to be part of the study. Questions then became more specifically linked to the topic of professionalism in medicine, beginning with how participants understood professionalism in medicine. A brief overview was given of how literature on professionalism is typically linked to aspects of being and doing. This was done to facilitate in-depth exploration of student, intern and educator understandings and to gain insight into whether they perceived professionalism as more about being or doing. Further probing related to these contrasting areas then followed. The next question focused on issues of trust, helping to bring attention to this central concept within literature on professionalism. From there, the questioning moved to exploring the notion that professionalism in medicine may be decreasing. Although Pellegrino's name was not specifically shared or introduced as the conceptual framework, his key aspects of being and trust were key areas of exploration within the study and provided threads for exploration of understandings and experiences of professionalism. As each broad question was presented, new areas of discussion were opened, and more focused direct questions linked to specific details followed. The broad questions directed the interviews and focus groups, but ultimately each interview and focus group brought out different areas of interest and focus.

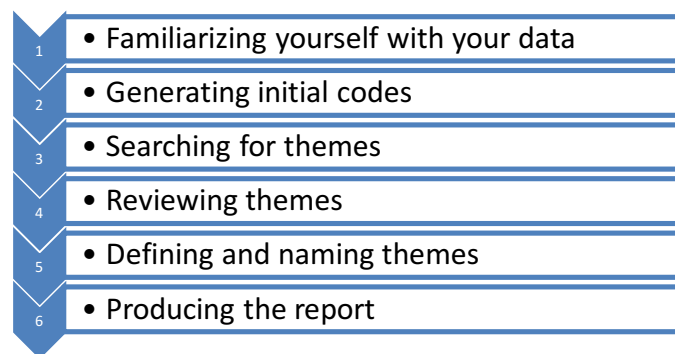
3.9 ANALYSIS

Data analysis is reportedly the most challenging phase of qualitative research (Thorne, 2000), largely because there are numerous approaches but no absolute rules for analysing qualitative data (Ritchie & Lewis, 2003; Spencer, Ritchie, Lewis & Dillon, 2003). It is a longitudinal, continuous, complex and time-consuming activity that is about exploring the data deeply (Then et al., 2014).

As described earlier in this chapter, this study was situated within an interpretive theoretical paradigm. It was therefore appropriate to analyse the data through the use of thematic, or conceptual, analysis in a recursive or iterative process that involved moving between the various data items to identify themes of interest and prevalence, and in order to compare and to establish meaning (Babbie & Mouton, 2009; Braun & Clarke, 2006; Flick, 2014; Saldaña, 2011). The transcribed

audio recordings, notes taken during the interviews and focus groups, and reflective summaries compiled by the researcher after each interview and focus group were included in the data analysis process. The interview and focus group guide questions remained the same throughout the study so that all major areas of interest would be covered. In-depth exploration of various topics however changed according to areas of greatest interest to individual and group participants. The analysis took place at the end of the data collection process and was both deductive and inductive, in that codes and themes were linked to the initial question theme areas, but also developed from the data using the steps detailed by Braun and Clarke (2006) and summarised in the diagram below (Figure 3). Coding was done exclusively by the researcher.

Figure 3: The phases or steps in Thematic Analysis (Braun & Clarke, 2006)



The first step of analysis involved becoming familiar with all aspects of the data. Although the interview and focus group audio-recordings were transcribed by a third party, significant time was spent by the researcher checking the transcriptions against the recordings, making corrections and then re-reading the verbatim transcriptions repeatedly, allowing for detailed checking and immersion in the data. This step also allowed for in-depth reflection on the data (Braun & Clarke, 2006). The second step involved generating initial lists of codes inductively from the data, meaning that the codes emerged from the data itself. Codes are labels assigned to words, phrases or sentences and their associated meaning (Miles & Huberman, 1994). This process was assisted by the use of Atlas TI. The third step of searching for broad themes was facilitated through the interpretive grouping of codes from the initial extensive list into themes and sub-themes. This process was done through the use of practical visualisation involving the drawing, arranging and rearranging of the initial codes into themes or table top categories (Saldaña, 2013). Hand drawn diagrams assisted this process (Luker, 2008). Patterns began to emerge and were grouped according to themes. The fourth step involved an iterative process of reviewing and refining themes and sub-themes from step three to create more coherent patterns across the data, with the fifth step being the final capturing and naming of the themes. Through these initial steps, and the hermeneutic process of immersion in the

data, codes were identified and clarified until a point of saturation was reached, and central themes were identified (Patton, 2002). The sixth and final step was the production of the results, including the comprehensive reporting of themes and subthemes with their associated extracts. A full description of the four broad data themes and their sub-themes is presented in the following Results Chapter 4.

3.9.1 Trustworthiness

Qualitative data analysis is essentially about establishing meanings (Dey, 1993), and a process of establishing trustworthiness of meanings associated with the data is therefore important. Mays and Pope (2000) recommend six criteria to ensure trustworthiness: triangulation, member checking, clear description of processes, reflexivity, attention to negative cases, and fair dealing. Triangulation involves fairness reflected through the use and comparison of different data sources or data types (Guba & Lincoln, 1989; Stiles, 1993). Member checking involves taking data back to participants to check for accuracy, while reflexivity and attention to negative cases mean to check the data and any assumptions for potential bias. Fair dealing is about ensuring that a representative range of voices are heard. These steps need to be carefully attended to in order to ensure the quality or trustworthiness of the qualitative research process (Mays & Pope, 2000). Each is evaluated in Chapter 5 where the strengths and weaknesses of the study are presented.

3.9.2 Ethical Considerations

Ethical considerations are strongly aligned with trustworthiness, and can be divided into macro and micro ethics, macro referring to the more formal institutional ethics and micro to the more performance-based, real life aspects (Kubanyiova, 2008). Macro level ethical approval for this study was obtained from the UCT FHS Human Research Ethics Committee – HREC REF 188/2012 (Appendix 5). The micro level was foregrounded at each stage of the research, as issues such as informed consent, confidentiality and consequences of participation in the study had to be considered (Flick, 2014; Kubanyiova, 2008; Kvale, 1996). Informed consent includes informing participants about the purpose of the research and any potential risks and benefits, making sure that participation is voluntary and that participants understand that they can withdraw at any stage of the research process (Kvale, 1996). In this study, educators and interns were approached individually, and students were approached through their classes. In each instance the study was explained and it was stressed that participation was voluntary and that there would not be any repercussions for those who chose not to participate, and neither would there be any form of remuneration or other benefit for those who chose to be involved. Informed consent was further assured as each interview and

focus group began with participants being given the consent form (Appendix 3) in which the study was explained and the option to withdraw at any point was detailed. The consent form was in English only. Although English was not the home language or first language of every participant, it was recognised that the language of instruction at UCT is English, and all participants were fluent in English. Participants were encouraged to ask questions of clarity before signing the consent form and beginning the interview or focus group.

Confidentiality in research ensures that personal data that can potentially identify subjects is not included (Kvale, 1996). It was therefore specified in the consent form and stressed in person that confidentiality would be maintained, and that any private or identifying information pertaining to participants would not be included in the thesis report. This was extended to include information pertaining to places of employment of intern participants. This was at the request of the intern participants. Information shared by participants therefore remained entirely anonymous. In the focus groups, where there was the possibility of participants themselves revealing details about one another to others outside the study, this was highlighted at the start of the focus group, and focus group participants were specifically requested to respect the privacy and confidentiality of others by not sharing this information outside of the study focus group.

Consequences are linked to the ethical principle of beneficence, which stresses that the research benefits should always outweigh the potential for harm (Kvale, 1996). Participants were made aware of the value of their contributions. It was made clear that the information they shared would be used for the purposes of a PhD study and that the information gained would be used to assist curriculum development within the FHS at UCT, and also potentially more widely. Issues of informed consent, confidentiality and related consequences were therefore carefully considered throughout the study.

3.9.3 Researcher's own role and potential bias

Bias on the part of a researcher is a legitimate source of concern in any research, but particularly when using a qualitative methodology, because qualitative research is essentially a collaborative, interpretive effort that draws on both the researcher and participants (Finlay & Gough, 2003). Bias therefore needs to be minimized through a process of reflexivity, in order to increase the validity or trustworthiness of the research findings and to improve the reliability and credibility of the research (Finlay & Gough, 2003; Mays & Pope, 2000). This is done through awareness of self and a process of introspection (Jootun, McGhee & Marland, 2009; McGhee, Marland & Atkinson, 2007). The process of reflexivity adopted in this study began with the researcher being interviewed at the start of the

study in order to facilitate the opportunity for reflection on preconceived ideas about the study topic. The interview was conducted by one of the thesis supervisors, Dr Catherine Draper. Issues related to the researcher's prior experiences, thoughts and feelings about professionalism in medicine and reasons for choosing this topic area were explored, providing opportunity for intrapersonal reflection. A summary of the interview can be found in Appendix 6.

A process of journaling was also followed throughout the research that encouraged reflection of personal thoughts and feelings and responses to the research process. Biases, values and experiences of the researcher were therefore continually explored (Creswell, 2014). Specific focus was that of functional reflexivity (Wilkinson, 1988), which draws attention to the researcher's role/s, and the impact of power and status on the research process, in order to improve the integrity and trustworthiness of the research process (Finlay & Gough, 2003). The potential power dynamic between the researcher and particularly the student participants was therefore important to explore. As a senior lecturer, course convenor, and chair and participant in various committees in the Faculty of Health Sciences at the University of Cape Town, I needed to be aware of the potential power dynamic introduced, particularly when conducting student focus groups. This may have been alleviated to some extent by students being interviewed in groups and having the support of one another. Care was taken to specify that participation in the focus groups would have no bearing on the students' academic performance.

3.10 CONCLUSION

This chapter has outlined the methodology used in this study, beginning with the rationale for framing the study within an interpretive paradigm, and then describing the conceptual framework that frames the study. Reasons for making use of associated qualitative methods were then described. Details of the setting of the study as well as methods, sampling, procedure and instrument were described, and the process of thematic analysis, ethical considerations and sources of potential bias explored. The following chapter presents the results of the research.

CHAPTER 4

RESULTS

4.1 OVERVIEW

As outlined in the previous chapters, the aim of this study was to explore how medical students within the FHS at UCT, interns who had graduated from UCT and were in the process of completing their internship, as well as educators of medical students at UCT, understood and experienced professionalism in medicine.

As indicated in Table 3, a total of eleven focus groups were finally conducted. Group sizes in the current study ranged from three to nine student participants, and most groups consisted of seven or eight participants. The greatest number of participants were from fourth year (22 participants) and the fewest were from sixth year (10 participants). All but two focus groups included male and female participants, and all but one of the focus groups included students from different racial demographics. These factors were not intentional, but rather as a result of the availability of student participants. This variation in participant profiles did not appear to impact on participation. The mood throughout the focus groups was positive. Students often arrived in a playful mood, joking with one-another. They settled quickly when they were given the documents outlining the parameters of the study, and remained attentive and respectful towards one-another throughout the focus group interviews. The one group that consisted of one racial grouping did not seem to be impacted by this difference. As the focus groups were conducted according to year of study, students were also familiar with one-another and this may have helped to ease any potential tensions.

Table 3: Focus group participants

FOCUS GROUP Year and number	MALE participants	FEMALE participants	TOTAL participants	Duration of focus group interview
YEAR 1				
Group 1.1	3	0	3	68 minutes
Group 1.2	3	5	8	57 minutes
Group 1.3	0	3	3	72 minutes
Total	6	8	14	
YEAR 3				
Group 3.1	3	4	7	52 minutes
Group 3.2	2	2	4	68 minutes
Group 3.3	5	4	9	75 minutes
Total	10	10	20	
YEAR 4				
Group 4.1	3	5	8	70 minutes
Group 4.2	3	4	7	80 minutes
Group 4.3	3	4	7	65 minutes
Total	9	13	22	
YEAR 6				
Group 6.1	3	4	7	65 minutes
Group 6.2	1	2	3	70 minutes
Total	4	6	10	
Overall Totals	29	37	66	

As described in the previous chapter, the initial plan was to gather data from interns through focus groups, but as this proved to be logistically challenging, individual interviews were organised. Of the 15 potential participants who were contacted, four agreed to participate in individual interviews, and final arrangements were made according to their availability. As indicated in Table 4, two of the intern participants were male and two were female. As the intern participants had been posted to different facilities across the country, it was not possible to conduct face-to-face interviews with all four participants. Two of the interviews were therefore conducted telephonically and two were done face-to-face, one in Cape Town and one in Durban.

Table 4: Intern interview participants

INTERVIEW	Gender	Internship placement	Method of interview	Duration of interview
1	M	Peri-urban-based hospital	Telephonic	68 minutes
2	M	Urban-based hospital	Telephonic	50 minutes
3	F	Urban-based hospital	Face to face	72 minutes
4	F	Peri-urban-based hospital	Face to face	65 minutes

As described in the previous chapter, educators were identified and approached based on their interest, experience and involvement in the design and implementation of the medical curriculum. As indicated in Table 5, six educators were identified as most suitable for this study, and all six agreed to be interviewed. Five of the educators were from the FHS and one educator was from the Faculty of Humanities. Three of the interviewees were male and three were female. Each educator participant, including the educator from the Faculty of Humanities, was directly involved in the teaching of medical students and/or the design of the medical curriculum. Different levels of academic seniority from facilitator to lecturer, through to full professor were represented.

Table 5: Educator interview participants

INTERVIEW	Gender	Academic appointment	Method of interview	Duration of interview
1	F	Professor	Face to face	68 minutes
2	M	Facilitator	Face to face	52 minutes
3	M	Professor	Face to face	80 minutes
4	M	Lecturer	Face to face	52 minutes
5	F	Associate professor	Face to face	65 minutes
6	F	Professor	Face to face	50 minutes

Four major themes emerged in the study and included understandings of professionalism, professionalism and emerging identity, the teaching, learning and assessment of professionalism, and professionalism in context. Although these four themes are presented as discreet areas in this chapter, there are, in reality, areas of significant overlap.

4.2 UNDERSTANDINGS OF PROFESSIONALISM

Evident throughout the study were differences of opinion amongst students, interns and educators as to what actually constitutes professionalism in medicine. Four key areas or sub-themes emerged including values, knowledge and skills, behaviour, and responsibilities associated with professionalism. As with the four major themes, these sub-themes and their associated ideas within understandings of professionalism are presented as separate, but are, in reality, inter-related.

4.2.1 Values

The first dominant understanding of professionalism in medicine was associated with personal and professional values. Values were understood to be about the core moral being of the individual. Aspects associated with ethics, as well as the ability to demonstrate respect, and to instil trust in patients were the core values that were described as evidence of what was seen as moral character. Students, interns and educators shared the view that these values were central to professionalism in medicine. As one of the final year students said:

I think it's almost like all the other stuff is smoke that obscures the real issues. (6th year student)

4.2.1.1 Professionalism and ethics

Although values were perceived to be associated with ethics, there was confusion amongst students, interns as well as educators about what actually distinguishes ethics from professionalism. A dominant notion was of ethics and professionalism as separate but overlapping concepts, rather than being one and the same:

And I think professionalism and ethics go hand in hand ... (1st year student)

I think they tie in together and I would think that ethics would be like a base and then professionalism would fit in with that, as opposed to ethics fitting in with professionalism, I think. (Intern)

I think the two [professionalism and ethics] are very closely intertwined. I think they are, however separate. (Educator)

While first and third year students did not share examples in support of their opinions, senior students and interns shared numerous examples from their clinical experiences to illustrate their opinions. The example that was used most often to support the perceived distinction between ethics and professionalism was linked to life and death decisions around resuscitation of patients and newborn babies. Decisions about who should be treated and resuscitated were understood to be about ethics, while professionalism was described as linked more to the action or demonstration of these decisions through, for example, interactions with patients and their families:

... the fact that some patients will get this treatment and some patients will get that treatment could be an ethical thing, not a professional thing, like you'd have some patients that you would resus and intubate and try and, you know, do CPR and there are some patients that you won't do that on and to me that's an ethical thing ... (Intern)

Basically at 24 weeks is when a baby's viable, like, it's just the definition by, like, World Health Organisation, but in South Africa, because of resources and all the, and, ja, resource, being scarce, the definition of viability is only 28 weeks. So it's, like, a whole four weeks later and if the baby isn't viable, you aren't allowed to resuscitate them, like, put them on a ventilator or give them surfactant or anything to help them survive until they get to 1000 grams or 28 weeks. So, I mean, being, like, [laughter] if you're a doctor here, you still have to be professional in how you handle the mother and the baby, but, like, the ethics, I don't know. (4th year student)

The understanding of professionalism as being about values was strongly associated with intrapersonal values and morals underpinning conduct and linked to, but separate from, ethics. It was centred on who a person is at their core and the values that define them, and ultimately how they enact these values:

I think the core of it, to me, is how you bring yourself, your personhood into your work and the integrity with which you do that and how that relates to your patients that you see and ja, the sort of values and guiding principles that you're trying to work by and with, and the things that you're trying to share with your patients and so that's the heart of it. (Intern)

I think for me it's about the values and attitudes and behaviours that inform professional practice ... (Educator)

There was a clear sense across the student, intern and educator groupings that there were two main values associated with professionalism in medicine – the values of respect and trust.

4.2.1.2 Respect

Respect was understood as being about the three distinct areas of respect for patients, respect for colleagues, and respect for self, and was strongly emphasised by students across all years. It was further understood as happening within a broad framework or context of respect for diversity and differences in culture and religion within South African society:

For me it's just always respecting the patient when it comes to, from the moment they enter consultation to the moment they leave. And, or even seeing them in the passageway, just always respecting them. (6th year student)

I usually think of respect, I think for me that is the first thing I think about, firstly having respect for yourself and then having respect for the job that you are doing and respect for the people that you are providing a service for, and I think that is the easiest way for me to pick up the word professionalism. (4th year student)

And nobody likes being disrespected, especially in South Africa, because there's a whole lot of cultures and religions, and everybody's different, and lifestyles and all these things. You need, as a health professional, to respect all of them. You don't have to believe all of them, you don't have to agree with all of them, but you at least need to respect them. (1st year student)

Respect for patients was described as the core concern of professionalism, with issues of patient confidentiality and privacy being paramount. Confidentiality was strongly linked to respecting confidentiality of patient information such as their diagnosis, while privacy was seen more in terms of respecting the physical privacy of individuals. Examples used to clarify and demonstrate these practices tended to focus on negative examples which were used to highlight instances where confidentiality and privacy were not respected. As illustrated in the following examples, students spoke of having frequently overheard doctors speaking to colleagues and students about patients without respect for patient confidentiality. In the first example privacy too was seen as a source of concern when patients' physical symptoms were pointed out in a very public way:

I was in casualty but it just so happened that it was circumcision Thursday clinic, and it is all in one room, and they are all kind of lying next to each other. The patients, most of them had STDs and STI or whatever you want to call them. And the doctors did 'hey look here, look at this one, this one has also got it'. And I just thought you know, you could just see how embarrassed they were and how they just like wanted to crawl under their blankets. They were talking to them, to each other 'oh yes this one also got it. All of these people have it'. (1st year student)

I feel like sometimes doctors are unprofessional in the way they handle confidentiality. You often hear doctors talking about patients in the hallway, in the lifts, in ... basically the way a hospital is structured is there's thin little curtains between a patient and patient. If the doctors just walk out of the one ward, it's not like anyone on that ward can't hear them anymore [laughter], so they'll start talking to another doctor about the patient ... (3rd year student)

Despite an emphasis on the importance of confidentiality, the parameters of confidentiality were described as challenging. One of the educators for example described having grappled with the ethics of knowing that a patient is HIV positive and wanting to respect confidentiality, but then being concerned that not sharing this information may be putting another individual at risk:

HIV/AIDS for instance has presented us with new kinds of conundrums ... Should we be encouraging people to come out ..., should we be secretive about TB, should we be ... you know, so those new areas ... the whole area of confidentiality. Should we be challenging that? the doctor is sworn to secrecy because of the patient-doctor relationship, but in that he is putting another person in danger. (Educator)

4.2.1.3 Trust

Trust was another compelling notion that came through in the student, intern and educator understandings of professionalism in medicine. The perception was of the doctor-patient relationship as a 'sacred space' (Educator), built around the need for patients to open up and share details that they would not normally share with anyone outside of their most intimate of relationships. The need for trust to be established was spoken of in terms of the uniqueness of the doctor-patient relationship, and seemed to provide an essential 'hook' for understanding professionalism:

You are vulnerable often as a patient. You are sharing things that you wouldn't share with a stranger generally, or maybe with someone who is close to you and so, unless you can trust that person to respect the confidentiality and sort of sacred space of that encounter, you are not going to make yourself vulnerable ... Trust is essential to any time that you are making yourself vulnerable. (Educator)

I think, like, the professional relationship is ... a special relationship because they put trust in you just upon meeting you, and, like, people are required to tell doctors things they wouldn't tell anyone else, just so that the doctor can help them. And I think that's a privilege, and I think to be professional you have to uphold that trust as far as you can. (4th year student)

Trust was described across all three groupings as linked to patient confidence in a doctor's ability to care for their patients – particularly regarding their knowledge and skills, but also their willingness to be open and honest about their own limitations. This honesty on the part of the doctor was seen as a corner-stone of trust in the doctor-patient relationship, and a core component necessary for the building of patient confidence in the doctor's abilities and the trusting relationship between doctor and patient:

You want the patient to say, this is my doctor, in terms of, with some level of pride that they have confidence in you because of the way you present yourself and that you're confident that you know what you're doing and when you generally don't, then you're honest about it, to ask for assistance. (Intern)

The way to obtain trust [with patients], would be to be completely honest in all aspects, not hide anything. (6th year student)

I was helping with this one young mom, and I just felt that I should say, you know, 'Hi, I'm a medical student and I've been doing this for a while, you know, I've delivered this many babies and, you know, I've done this and don't worry; you're going to be fine' kind of thing. And I could almost see that she had gained a bit of, you know, trust in me, and I think that helped a lot. (4th year student)

There were differing views on how trust is established. For some, it was viewed as something that is earned, while others were of the opinion that it is a given because of the nature of the doctor-patient relationship. Where trust was seen as earned, it was linked to the view that the doctor-patient relationship was a process, and that doctors are responsible for making patients feel comfortable with their doctor. Where it was seen as a more of given, trust was linked to patients knowing about and trusting the training and experience of their doctor:

Patients do not automatically trust you. It is your responsibility to make it feel that they can. It is not just the given. (1st year student)

Trust derives from the patient, doesn't it? It's the patient who says 'You've had the training, you have the experience, you have the knowledge, so I trust you'. (Educator)

Whether given or earned, it was widely recognised that there were challenges associated with patients trusting their doctors and that trust could easily be lost. The view that was most often shared was that it was the responsibility of the doctor to see to the maintenance of this trusting relationship. Fourth year students, in particular, drew extensively on examples from their time in obstetrics where managing patient care successfully was perceived to be linked to whether patients trusted their doctor:

I think patients come in with this expectation that you should be trustworthy and if you don't meet up to what they expect, then they lose the trust. (3rd year student)

In obstetrics, we have like seen that trust so easily destroyed and I mean, when like obviously as a nurse or doctor you have to do uncomfortable things to a patient in obstetrics and you know, it can be painful, but the mother who trusts the doctor will you know, withstand that and say, that is okay. Whereas the mother who has like lost all trust maybe due to that lack of professionalism where she does not actually believe that the health care professional has their best interests in mind or anything like that, they are the ones that are like screaming from pain and pinching their legs closed and don't want the doctors you know, to help them, so I think it's probably the doctors that usually destroy the trust. (4th year student)

Students, interns and educators reflected on their experiences with patients as well as their own experiences of being patients in explaining issues around building and sustaining trust. Two of the challenges that were described as potential stumbling blocks to building trust were of personal embarrassment about the medical condition on the part of the patient and therefore not wanting to be open about it, and increased patient access to information via the internet with patients then questioning the diagnosis and other information shared by their doctors:

I know that when I go to the doctor and they ask me an embarrassing question, I do not want to give the wrong answer like I could have done something wrong. (1st year student)

The whole world in which medicine is, and patients have changed. Patients are demanding, they read the internet, they don't believe the doctor. They don't trust the doctor. (Educator)

Students, particularly 4th year students who were at the start of their clinical training, expressed that they found being trusted by patients to be a complex issue while in their role as 'apprentices', and at a point in their careers where they were still studying and learning. For many students, the experience of being trusted by patients was seen as surprising, even daunting, given their lack of knowledge and skill. The perception of a number of students was that it was their white coat that served as an identifier that they could be trusted because it was equated with the values, medical knowledge, skill and expertise that gave them a certain authority:

I don't know, it seems like people put so much trust in you; it's really surprising how much trust they put in you right from the beginning, even when they know you're a medical student and not a doctor. (4th year student)

Everything is documented in there, their social history, everything about them is in this folder and we [students] just walk around the wards and we just page through people's folders, no one minds, you know, they inherently trust us just because we are wearing our white coats and you think, sometimes you don't even, you just like, 'morning, I am a medical student, I am just going to look through your folder', and they are like, 'no its fine', so I do think they like inherently trust. (4th year student)

If you're just honest and you say, 'This is my first baby, but the nurse is going to be here helping me the whole time' and you're just upfront about it, I think they're a lot more comfortable with you. Whereas if you're just skulking around, they don't really know what your role is, [laughter] you don't, they don't know your name, it's just, I think, it's just terrible for them. They're so nervous already; it just makes it even worse. (4th year student)

A lesser shared notion from a different perspective was the perception of doctors not always trusting their own patients. This was seen as a complex issue in professionalism, as the doctor-patient relationship was recognised as requiring trust on the part of both the doctor and the patient:

Practically we see doctors don't trust their patients, so very often they assume patients lie, kind of unnecessarily and stemming from that, that makes the patient feel victimized and then that does not help with trust issues, like for the patient to trust the doctor so it's a two-way thing, and to get that balance right, yeah that is what is needed for professionalism as a whole. (4th year student)

There is a lot of mistrust ... and therefore what do we do to make it easier for people to trust us. And I think the onus is on the professional rather than on the patient ... But our trust gets taken advantage of time and again, so we are becoming less trustful. (Educator)

4.2.2 Knowledge and skills

The knowledge and skills associated with professionalism was another dominant issue that emerged within understandings of professionalism in medicine. Medical knowledge, interpersonal skills, language, information and counselling, teamwork, and reflection were the main components within this sub-theme. A student encapsulated these areas of knowledge and skills as ‘tools within a toolbox’ (1st year student) for professionalism:

Well, I think that initially you must have people skills ... So people skills, I think your knowledge is really important, it must be in there, so think of it as a little textbook that goes into your toolbox. I really believe that your practical skills are important, obviously, and other things that you learn along the way, so dealing with difficult situations that you might not come across all the time, but once you've been through it once. It's everything that you learn, I would put into my little toolbox, and that's what I keep in my brain. So once I've learned something it goes in there. (1st year student)

4.2.2.1 Medical knowledge

Medical, scientifically-based knowledge and skills were seen by all three groupings as core areas of professionalism in medicine. The view was that these areas of knowledge and skill should be demonstrated in practice with patients, but also through the production of new knowledge:

You can only be a professional in what you are doing if you know what you are doing, you know, the examination part, taking history, you have got to know how to do those things, you have got to know how to, you know we are taught how to sit in the consultation room and that is professionalism, if you don't know those things then there is no way you are going to be able to be professional. (3rd year student)

I think professionalism in medicine is somehow linked, well not somehow, is directly linked with the production of facts. The production of a specific kind of knowledge which can be ... understood scientifically. (Educator)

4.2.2.2 Interpersonal skills

There was also a very strong notion that interpersonal skills are central to professionalism, second only to medical knowledge and its associated skills. Interpersonal skills were understood to be grounded in authentic patient-centeredness, empathy and compassion for patients:

Showing a genuine interest in the patient's illness. That is why we are here, if there were no patients there would be no doctors – the whole patient-centeredness, I think if we have that attitude then professionalism would be easy, it will just be the norm. (6th year student)

[Empathy is] about you taking yourself, your personal situation out of what the patient is saying, like, you come down to their level and you understand them at their, at their level whatever that is. You put yourself in their situation ... (3rd year student)

Dignity conserving care – like that phrase, to me, covers it all. When you treat someone with dignity, you treat him as a person and the kind of view how do you want to be treated if you were in their shoes. That to me is professionalism. (1st year student)

As one of the interns said:

We need to develop our own sense of compassion and intuition and conscience and be able to relate to people authentically and respond spontaneously and work with our own feelings and gut emotions about things. (Intern)

In describing interpersonal skills as central to professionalism, numerous examples of poor interpersonal skills were shared to illustrate this point that empathy and compassion were needed in working with patients. The example that was shared most often was that of women in the process of giving birth, and how students in particular witnessed a lack of empathy and compassion on the part of the staff:

Female (F): I think that is probably the worst thing; to see someone who's in pain and someone who's not getting help immediately (interrupted).

F: And think it's normal.

F: And to think it's normal. And I'm just like, that is not normal, that is not acceptable. There's, like, and even when the nurses came to her, they were just, like, 'push, push'. I was like, 'No, don't just push, push, tell her what you're doing is okay'. Like, the one nurse started shouting at her (interrupted).

Male (M): Reassure her, ja, nurses and childbirth, it's like ...

F: And I was just, like, 'No, you should tell her she's doing ...' Like I was the one who was telling her, 'You're doing a good job, like, you know, just carry on doing, like, just the baby will be okay and everything'. And afterwards it was, like, she thanked me as a student, this random person who was just there. (3rd year students)

I've found the patients were treated very much, like, almost one, they looked the same, they're all going through labour. It's a horrible thing, you know, and it's a horrible thing for you when a patient is screaming and whatever, and so they honestly get treated, like, slabs of meat who have to deliver babies and it appalled me. And when you actually just stop and think, hang on, this is for, you know, this may be the 700th delivery I've seen and done, but for her it is her first one and it is one of the most special moments of her life and me having seen 700 should not be, you know, that shouldn't be her problem. (6th year student)

Interpersonal skills were regarded as important in establishing a positive relationship for professionalism between doctor and patient. The first step towards this positive relationship was seen to be that of establishing rapport with patients by presenting a non-judgemental attitude while actively listening to the patient:

But I think if you are listening to the patient and you are sort of understanding where they are coming from and the reasons for, and if you are actually listening and, you know, being there with your patient, you sort of understand more the reasons for them wanting to go ahead with what they are doing, and you can help them in this specific way. (1st year student)

Often you'll get a patient who comes in for some medical problem and there's actually something else that's bothering them, you know, and unless you get that correct rapport with the patient and unless they feel comfortable with you they're not going to, they're not going to tell you anything. (3rd year student)

4.2.2.3 Language

A further skill in facilitating this positive relationship between doctor and patient was seen to be that of the use of appropriate language, understood as meaning accessible and respectful language. By respectful, the idea was of choosing language that would denote respect for both age and culture:

Like for professionalism, you do not expect when you consult with a professional like a doctor to be using slang and other ways of communication. The attire, it all goes hand in hand with each other; that is professionalism like in layman terms ... (1st year student)

Instead of shouting at that person and telling them you are going to kill your baby, you can just say you know what, your baby is not going to get oxygen so try your best to push your baby out you know, instead of shouting at that person and using sometimes you know wrong language yeah, strong language. Sometimes in other languages as well they need to know that they can't use that with the elderly as opposed to a young patient that is pregnant. (4th year student)

A lesser shared notion expressed by some students was that of English as being the language most strongly associated with professionalism. Students linked this to their own experiences of patient and societal expectations and stereotypes of who doctors should be within the South African context:

It's the way you talk and the way you dress and in some cases you find that people do tend to associate professionalism even with the language that you speak. If you speak your own language, then maybe you are not professional enough. You need to talk English. (4th year student)

In my culture for instance they normally associate English with professionalism. (4th year student)

4.2.2.4 Information and counselling

Providing accurate information and counselling patients about their options for healthcare were also seen as important interpersonal skills for professionalism on the part of doctors. This was an area that was seen as sometimes being compromised on the part of doctors with facts not always being clearly explained in a way that was accessible to patients:

They didn't explain to the patient why. I mean, that's part of being professional. Talk to your patient and be like, okay, this is what's happening, you know. (3rd year student)

Although emphasised as important, there was concern expressed, particularly by students, about how to balance their own personal moral and religious values with those of their professional responsibilities of providing accurate information and counselling. Students elaborated and used examples of termination of pregnancy to explain this personal and professional divide:

I would say as a doctor or professional you take a natural standpoint. You just stand back and give them information, leave the decision to them, because you do not want it on your hands that they did something and then they will come back and say but the doctor said that. (1st year student)

I am pro-choice, and even when I went into the second trimester clinic and I saw the first one come out and thought woah, I can't actually deal with this. But then they actually have excellent facilities so it's very easy for us to refer people to those facilities, and it is our job however you feel about abortion, just do your job to protect the patient. If you don't do anything they end up in the back streets with someone shoving a nasty bit of equipment in places they don't know, then you have actually failed professionally. (6th year student)

4.2.2.5 Teamwork

Another skill that was associated with professionalism was that of teamwork and the need and ability to be able to work in a team. As one of the educators pointed out:

You can't be a health professional without being connected to other health professionals ... We are all professionals in it together and are part of a team. (Educator)

Interns, in particular, spoke extensively about their experiences and the potential benefits of support from team members. It was spoken of as beneficial on a personal level with, for example, interns who may be posted away from home being able to depend on members of their team for support. On a professional level, the benefits of the team were seen to be linked to levels of knowledge and expertise, and being able to draw on senior and more experienced colleagues in dealing with challenging tasks, for example, breaking bad news to patients or their families:

It can be lovely when ... there's not a huge sense of hierarchy, so you can chat to your colleagues and talk about your personal lives with them and get to know them a bit more. (Intern)

I've had to break news about deaths, but generally a senior will be there to assist because you won't have been the only person involved in that case. (Intern)

4.2.2.6 Reflection

Finally, a skill that was described as important for coping with the demands of practice and central to professionalism was that of reflection. It was understood as part of the process of responsible medical practice, whereby students, interns and doctors take time to evaluate their own strengths and limitations in order to inform better practice:

And the reflecting is important, very, very important. Even if you slip up, it is important to acknowledge to yourself, okay I have messed up. (1st year student)

Reflection is part of professionalism. It's linked to being an IHP [Integrated Health Professional], just like we learnt in first year. (6th year student)

4.2.3 Behaviour

The third sub-theme associated with understandings of professionalism was that of behaviour. Although behaviour is a broad concept, it was most specifically understood in this context of professionalism in medicine as being about presentation and dress. These components were widely debated, and recognised as important by students, interns and educators. Educators however emphasised these aspects most strongly. There was concern that no matter the level of knowledge and skill, dress and how doctors present themselves are frequently understood as a measure of professionalism. This was because dress and presentation were perceived to be a proxy for the skills and knowledge expected of doctors:

I'd like to say we are put in boxes and if you don't come appropriately presented in what you are supposed to be in that box, you are not going to be considered professional in that profession. So in our profession we have to be dressed appropriately ... (4th year student)

Professionalism might just mean ... also dressing well, grooming yourself well so that you're presentable to the patient. (Intern)

I know a lot of people who are absolutely fabulous people and health professionals, but they are not regarded very highly, because of the way they present themselves. (Educator)

A fourth year student shared the following example to illustrate how 'appropriate dress' may have helped patients to see her as a professional with the related knowledge and skills, rather than focusing on her age and lack of experience:

I had it with one of the mothers whose baby we delivered on one of our calls. She was my age and the father was a year older than me, and I was a bit nervous about when they asked me, they were, like, 'How old are you'? And I was quite nervous to tell them because I thought their reaction might be, 'Oh, we don't want you. You could be, sort of, our age. We don't want you delivering'. But the mom's reaction was, 'Oh, wow, that's so wonderful, like, you're

my age, and you're already here'. And I think things like being dressed smart and in the white coat and [laughter] dressed up professionally, they see you as a young professional, not just a young person. (4th year student)

A strongly held view was of dress and presentation as being linked to the first impression that is created for patients. It was widely held that patients have expectations of how their doctors should look and that doctors, in turn, need to realise these expectations. Despite acknowledging its importance to patients, many students were of the opinion that dress and presentation were overstated in professionalism, and that dressing in a stereotypically professional way did not necessarily equal professionalism. For most students, dress reflective of professionalism was equated with dressing conservatively:

Suit, clip board, pen, quite harsh, very formal, business woman, super-efficient, no emotion. That is what I think of when I think professionalism. My stereotype is where you sort of have to step into a persona as opposed to being sincere almost. You have to put on that attitude. (4th year student)

People's perceptions of doctors are white coats, you know, walking straight, not smoking outside in the lobby or whatever, like, they, there's a specific picture that people have and also there's some, you kind of have to fit in with that for some, for a particular group of people that want that. They come to the hospital for that and you need to give them that. (3rd year student)

Neatness, modesty and cleanliness seemed to be shared criteria, but whether to wear white coats or ties was viewed differently reflecting wider debates within medical practice about the hygienic aspects and appropriateness of white coats and ties:

Neat, well dressed, well groomed, obviously with white coat on or without but very neatly dressed, professional. (4th year student)

Ja and it's also been proven that you can't wear a white coat because it's dirty, and then you still have some people who are attached to their white coats who wear it. (6th year student)

One professor of surgery, he says all guys should wear ties and that's silly because there've been studies to show ties are extremely unhygienic. (6th year student)

Educators focused on the need to wear a white coat in order to be identifiable and as a way of protecting the clothing underneath. Students shared the idea that doctors should be identifiable in terms of dress, but had varying views on what this dress code should include. There were differing views on the value of a uniform, such as those worn by other healthcare professionals, with some support for the wearing of scrubs:

It's a little bit disturbing that doctors are no longer wearing white coats in the hospital. There is no restriction to their footwear. ... I don't see their ID, I see no way of identifying them as a

medical professional You're not sure who you are addressing When I look at what patients expect, they expect a doctor to have a white coat. They have a completely different attitude with a doctor with a white coat (Educator)

I think doctors should have a uniform because every other working party in the hospitals does, the cleaners, the nurses, the OTs, the physios ... [over talking] everyone has some, and it gives you an identity as well. (6th year student)

When you're in your scrubs, which are basically like wearing pyjamas, at least you have that identity, you have your name on it, you, people know who you are, you know, that you're a doctor. (6th year student)

Students shared numerous experiences of how educators expected a stereotypically conservative style of dress and presentation. Experiences reflected the view that if they did not follow a more conservative, modest and reserved style of dress, there would be negative implications for how they were treated by educators or other members of the healthcare team. Although students seemed to be motivating for acceptance of different styles of dress and presentation, they were ultimately most concerned about the issue of how patients would perceive them and the implications of this:

Whereas sometimes people who just, you know, look a little bit arty, if I could put it that way, then people are like, no, you're not, you don't look like a professional and you aren't acting professional. But we've got a better rapport with our patient or we're, you know, actually more, putting more emphasis on the other aspects of professionalism, like engaging and keeping confidentiality and treating the patient with respect. (3rd year student)

M: We now have one guy in our class who wears dreadlocks, like, so many, like, sort of, consultants and profs and various departments made, it's just been, like, made such a fuss about it, and I really don't think it matters because the person, he is so, to me, so professional, and he's smart and, like, kind and I think that's surely fine.

F: But you can't enforce that view onto the patient that he's treating that really isn't okay with it, I suppose. (6th year students)

Despite dress and presentation being perceived as such strong measures of behaviour associated with professionalism, there was also the notion that behaviour was more than just dress and presentation. Other aspects of behaviour that were described were those that were seen to contribute towards building a relationship between doctor and patient such as manner of speaking, and the use of non-verbal cues in conveying caring and compassion towards patients:

But I think there's also, there's starting to be a bigger, a broader look at professionalism, instead of just that type of person that walked in that certain way and dresses that particular way, it's more the way you act and the way you speak and the way you put the hand on the shoulder and that, the relationship you have with someone and the sensitivity you have to their issues and their stories, instead of just treating them like a straight, you know, medical case, ja. (3rd year student)

Being a professional, which means, you know, behaving in a certain way, having a certain level of skill, for your level, you know, being able to display in your work field, having a certain attitude, wanting to be competent and confident and caring at the same time, but not arrogant about it, you know, like having the spirit of wanting to serve ... (Intern)

4.2.4 Responsibilities

There were many ideas that were seen to be part of professionalism in medicine that best fall under responsibilities, the fourth sub-theme within understandings of professionalism in medicine. Components of responsibilities included the need for a code of conduct, informed consent, acknowledging limitations, the need for adequate resources, enough time, and responsibility for reporting breaches in professionalism.

4.2.4.1 Code of conduct

A code of conduct was widely viewed as underpinning professionalism. Although there were differences in opinion as to whether a code of conduct is about a minimum standard or baseline for professionalism, or something more aspirational, there was agreement that it should be about ensuring good practice:

For me professionalism and doctors then would be, probably striving to be brilliant and one of the best, I don't know if that's, maybe that's the higher, a very optimistic view of professionalism. (Intern)

I think professionalism is being able to execute your job, but keeping certain standards and executing the job efficiently and not compromising how you treat people. (1st year student)

There is a certain code of conduct and a standing by which you are supposed to live up to. I think that sets you apart from any other profession. (3rd year student)

4.2.4.2 Informed consent

Attaining informed consent from patients for any medical procedures was widely seen as part of responsible and ethical practice for professionalism. There was concern however that this was not always being practised. A sixth year student described having witnessed both good and unacceptable practices for obtaining consent. Third year students also shared these experiences, and described a particular challenge where they had been reprimanded for not getting blood from a patient who had refused to give consent. The students generally seemed to struggle with what they saw as respecting the rights of the patient but also the desire to meet the demands of their educators:

There's one example where a doctor's been there and, you know, sitting on the patient's bed explaining everything, making sure they understand, doing it properly, and then other cases where it's been, the form's been filled in, the patient's been handed the form and been told [laughter] to sign on the line. And, like, that's unacceptable. (6th year student)

We were sent to take blood, the registrar just told us, she needs blood from this patient, go get it. And we went to the patient, we sat down, we explained to the patient that we're going to draw some blood now, we're not sure for which tests, does she have a problem with it? And she said, yes, she's too tired now; they've been stabbing needles in her veins the whole week as well, and she doesn't want us to take blood. So we stood up and left and we got into quite a lot of trouble because we didn't get that patient's blood. It's not a mining operation, it's a hospital, so you ask a patient for something. (3rd year student)

4.2.4.3 Acknowledging limitations

The third component was of the responsibility to recognise one's own strengths and limitations as a student, but also as a qualified doctor. Added to this idea of recognising one's own limitations was the need to see medicine as encompassing 'uncertainty' despite all the knowledge and skills that are part of the practice of medicine:

Don't pretend that you're capable of more than you know what you're there to do. Say, 'I'm here to do this' and you can go speak to the sister and say, 'Look, sorry, I just need to go check, or I just want to make sure'. (4th year student)

I think what professionalism requires most of all is an acceptance, and I think our young doctors, graduates don't easily recognise this, of the uncertainty of medical practice. It's uncertain. (Educator)

4.2.4.4 Resources

Adequate resources to facilitate professional practice was a further component described as part of professionalism, particularly regarding having enough staff and equipment. This was an area of greatest concern to interns who had experienced situations of inadequate resource allocations that they then felt had an impact on their own professionalism. They were largely of the opinion that doctors and other healthcare professionals were expected to do the best they could particularly in poorly resourced public health settings. This was illustrated by one of the interns who was extremely concerned about the lack of suitable space for conducting patient consultations. The intern felt that this had ripple effects for privacy and confidentiality. Although this was an area of concern primarily for interns, students also expressed concern about the ramifications of limited resources:

So you've got a long corridor and then there's tables about this size or maybe a bit smaller and on them is like a huge thing with forms, so it's not even a big table and then you've got two doctors with two different patients and then as soon as you've finished you call for the

next patient and then they come through the corridor past the other doctors with their patients and if someone forgot to close a curtain, cause it's just like a shower curtain, then you could see into the examining beds. So unless someone is good, then you're passing people, taking blood, putting up drips, you wouldn't get privacy at all, but biopsies or breast examinations or catheters being inserted, if a doctor hasn't been careful about closing that curtain, the new patients who come in could easily look straight in. I mean you're sitting here and if it's a senior who is next to you and you've got a question, you'll often just say, 'oh sorry, when you've got a moment' and then they'll be busy with a patient and then they'll stop with their patient so that their patient's family can hear exactly what's going on, you ask them and then it's like a huge big discussion and sometimes it's quite nice if you've got two patients who have both got ulcers that are quite obvious and might be getting better and then everyone has something to say and oh, I had that and it's getting better now. (Intern)

Utilitarianism makes sense on a public health level, but it doesn't make it easier knowing that when you're there, and you have to tell the parent this is why. (4th year student)

Going from that, that person that cares so deeply, you know, to just not being able to deal with, not being able to help, like it was just easier for him to turn it off and turn that professionalism, that caring, off. And that is just due to the mismanagement and the lack of equipment, and that is maybe the situation in a lot of places in South Africa where there is just nothing there, and it just disheartens you to the point where it is easier to not care anymore about your patients. (1st year student)

4.2.4.5 Time

Having adequate time to conduct appropriate interviews and interventions with patients was seen as an important aspect of professionalism, with a lack of time as one of the greatest challenges to a positive doctor-patient relationship:

The whole time thing really, it really, really affects your professionalism. (3rd year student)

This was a clear concern across all participant groupings but, as with resources, it was the interns who expressed the most concern and described examples of how, in their experience of time pressures, they had been forced to compromise on some aspects such as fully explaining procedures to patients in order to get informed consent from patients. A related concern shared by interns was of having witnessed experienced medical officers moving quickly through patients to the detriment of the patient care:

It is like the waiting room has like chairs full of people, and you are trying to push people through so you will come in and say 'what is wrong'? and the person will tell you what is wrong. You will not be asking 'how did you feel about this'? and you will not be reflecting whether ... You will not necessary have enough time to reflect on whether you treated this patient correctly quickly because the next patient is coming in. So I also think it is that and

that will lead to a degradation in professionalism, and maybe you might start the day on a high note and you have to deal with different people, different difficult people and so by the end of the day you are just pushing people through. (1st year student)

There's often a lot of misunderstanding because you want to do something quickly and so you'll just leave out things to try and make it understandable so that they'll sign, they'll do it, but if you explained it fully they wouldn't understand that much. (Intern)

Complaints relate to the quality that the same medical officers offer patients because they come in at 8:00, they try to rush through, get the line moving and at the end of it all they end up just doing like half of what they should for a patient, just for the sake of quickly, quickly getting them out of the way, getting them to the wards or getting them discharged, ja. (Intern)

4.2.4.6 Reporting

Responsibility for reporting unprofessional or inappropriate behaviour was a component that was described as essential to professionalism. This was stressed particularly by senior students and interns who recognised the importance of reporting lapses of professionalism. They however also reported that, despite having experienced channels of communication for reporting as fairly clear within hospital settings, taking responsibility to make use of these reporting mechanisms was experienced differently. The biggest challenge for students and interns was seen to be that of reporting senior colleagues:

I think, yeah, as we move up the hierarchy I think it's our responsibility to actually say, you know if things are not being done well in a certain hospital, we have now got the power as doctors to make a change and its, the system won't just change by itself, we have to actively do things to help it change in whatever small way that it is. (6th year student)

Where medical officers come late or they don't answer their phones your first port of call would be to call the intern curator at any time and let them be able to deal with the medical officer. If that fails, they can then move on to the clinical manager, ja. (Intern)

Where it does get difficult is when you have people higher up in the hierarchy. I personally wouldn't feel comfortable, like, asking a registrar, pointing out one of their faults; I wouldn't. I know you should, but I personally wouldn't. (3rd year student)

Within the context of the Faculty of Health Sciences at the University of Cape Town, the Professional Standards' Committee (PSC) was spoken about and acknowledged as the vehicle for reporting and overseeing professionalism while studying at University. Educators were clear about the role and function of the PSC. They described it as having proactive and reactive functions, with the proactive functions including the promotion of accountability within the faculty, in order to create a culture of trust. The reactive function was described as including being able to respond appropriately to

specific incidents of lapses in professionalism. It was also seen as a mechanism for whistle-blowing that did not result in victimization. This clear description was however not shared by students. Some students were confused about the role of the PSC, and some were also unsure of its name. There were also different views amongst students about the effectiveness of the Faculty's PSC, with some seeing it as somewhat powerless and ineffective, and others seeing it in a more positive light. For many students, there was also the realization that, although a PSC may exist, students themselves still have to take responsibility for actually acting on their concerns. This echoed the experience of interns in hospital settings. They also were unsure about exactly constituted professional and unprofessional conduct and were concerned that it was ultimately unclear and quite subjective:

I think med school has put some structures in place where you can complain to them and then, I mean, you aren't implicated in the accusations and stuff, and those people that you saw behaving unprofessional are spoken to, whether they're doctors or whatever the case. (3rd year student)

It is quite subjective because you know the professional society is there to hear people's complaints on what they see about the wards or clinical situations, and that depends on if that student reports it, that student feels it's not really appropriate for that situation. There is nothing really to measure that against, so to sort of definitively say okay that was unprofessional behaviour and that was not unprofessional behaviour and that complaint was warranted or unwarranted. So it is there, it exists, I mean people can actually go complain, but in terms of actually getting something done it is sort of a grey area as to how you approach that. (4th year student)

4.3 PROFESSIONALISM AND EMERGING IDENTITY

Professionalism and emerging identity was the second major theme of this study. Identity was seen as inextricably linked to understandings and experiences of professionalism in medicine, in that who a person is and becomes was seen to inform professionalism in practice. In further examining professionalism and identity, four sub-themes arose. The first of these was about who applies to study medicine and secondly who is selected into medicine. The third and most contested theme was about the journey from novice to that of professional. Two contrasting ideas stood out – that professional identity is intuitive and emerges out of who a person is, and that it develops over time through a journey of learning and practice of medicine. Finally, the fourth area was that of the divide between personal and professional identities and where the dividing line lies.

4.3.1 Who applies to study medicine?

A wide range of reasons for why students choose to study medicine were shared by the students, interns, and the educators. There was a strong notion from the educator perspective that students who choose to study medicine are of two distinctive groupings – the people person and the more scientific or academic individual. The former was described as someone who is intuitively good with people, is kind, and has integrity and empathy. The latter was understood as something of a polar opposite of the former and as someone who could be described as a high achiever. The notion that the former grouping, the people person, is most suited to medicine and most likely to apply to do medicine came through strongly, but there was also recognition that students from the latter grouping, with a more scientific aptitude and interest, are also attracted to medicine because of the potential for being part of cutting-edge research:

I've had a prejudice I hope never to be discarded that those that seek medical qualification are already made of the right stuff. Firstly, they're people-people and ... I think they just naturally have an empathy for that which is vulnerable I've never really been disaffected of that Pollyanna belief. (Educator)

We risk very much in going for that softer animal, we risk not finding a space for the young person who will shoot the lights out in pathology, say. (Educator)

Students, interns and educators shared the idea that those who apply to study medicine often have a desire to make a difference and help others, referred to by some as a 'calling'. This notion was supported by examples from prior personal experiences; for example, when a family member had fallen ill, leaving those around them feeling useless and disempowered. Taking up the study of medicine was seen, in these circumstances, as a means to being able to do something to help in similar circumstances in the future:

My mom had cancer twice when I was growing up and the consequences of that was she received chemo when she was pregnant with my younger brother, so I grew up raising a disabled younger brother. (6th year student)

Being around someone who was sick most of the time ... I am comfortable around sick people ... I like medicine and I like the body, I find it fascinating and I really enjoy it. (6th year student)

There were however other motivations for studying medicine that were shared, including the desire for status and money that were perceived to come with the practice of medicine, as well as pressure from family members or even school teachers and peers because of having achieved good grades at school. There was the notion across all three groupings that persons choosing medicine for less altruistic reasons, such as status or money, were perceived to practise more self-centred values that could be seen as inconsistent with professionalism and altruistic practice:

It's a profession where people know people earn reasonably well. They come from a poor family, so they must be a doctor ... Or because doctors are held in high regard. The third is, you get good marks and you can get a scholarship to go to medical school. The other is, that my best friend is doing it and I don't want to do it, but I want to be with my best friend. I mean there are myriad of reasons. (Educator)

And the other problem is that you have people signing up to be doctors, like getting to medical school just because they want to earn a huge salary, so they never take it seriously, for them it's just about the salary, it's just about studying, getting the degree, driving nice cars and living in a good house. (1st year student)

If you only want to do medicine because you only want the money and not because it is what you love to do. That is also going to become a very big part of your attitude, you are in for the money and whatever and not care about people. If your love is to help people and to serve others, your attitude from that will be different. (1st year student)

Interestingly there were opposing perceptions from students and educators about whether motivations for wanting to do medicine for less altruistic reasons had increased over time or not. The perception from many students was that the status and money associated with studying medicine were diminishing, and the perception therefore was that the choice to study medicine was increasingly aligned to the more altruistic desire to make a difference. Educators, on the other hand, were more of the opinion that students increasingly came to medicine for less altruistic reasons:

Nowadays doctors really aren't held in as high esteem as they were years ago; it's not glamorous ... They used to put them on a pedestal, this amazing person, this paragon of truth and justice, [laughter] this country, you just, I think now more than ever you get into medicine because you see the needs of the community and that you really want to make a difference. (4th year student)

People come to medicine for all sorts of bizarre reasons that were perhaps much less common in the past ... Not all of them relate to actually wanting to be a doctor. (Educator)

4.3.2 Selection into medicine

An area that attracted significant attention was related to who is and should ultimately be selected into the medical programme, and the implications of this for professionalism. There were differing views, including the idea that selecting students with stronger intrapersonal values and good interpersonal skills should be selected over those with a more scientific aptitude. The idea that this selection could be best facilitated through an interview process was one that was widely shared and supported, particularly by students. Concern was however also expressed that those applicants with a stronger scientific leaning should not be pushed aside:

There should be an interviewing process, so that you can get a sense of how someone thinks, and who they are, and I think that will be more of the professional side, to see who a person is. (1st year student)

I worry, and have always worried about an admissions policy that looks only for the touchy, feely, communicative individuals because the reality is that the Nobel Prize winners are probably people you wouldn't want to know terribly well. They aren't ... they're geeky scientists. They're profoundly bright and may not be good communicators ... And I think if we were to err too much on the side of the soft, empathic, communicative individual, we might lose out on our top medical scientists. There is that risk I believe. (Educator)

There was extensive discussion around the need for students applying to do medicine to be sure that this was what they actually wanted to study. This was of particular concern to first year students in relation to the limited number of students who are accepted to study medicine in South Africa, and the length of the degree programme. The vision was therefore to select the most motivated and committed students as they were perceived to be most likely to embody professionalism:

If you're not sure about if you're wanting to do medicine, so somebody then comes in for about five years, and they decide, okay, no, this is not for me, they've literally wasted a space for someone who actually wants to be here, and medicine is very much an in-demand field. So that person's literally not necessarily wasted their time, but they've wasted a potential spot of somebody that could actually become a really good doctor, and that person's been sitting, waiting and waiting and waiting. (1st year student)

I think that possibly the ones that want to be here, and they wanted to follow the stream, are probably going to be ones that will develop professionalism a lot earlier than the others, to be honest. (1st year student)

Linked to this notion of selecting motivated and committed students was the idea that students who may have come from previously disadvantaged and particularly rural backgrounds may be more committed to their studies, and therefore more likely to succeed and embody professionalism. This was based on the premise that students who had to struggle to attain a place at university would be more motivated and dedicated to their own success. There were however concerns expressed by some educators that selection of students from rural areas was not in reality having the desired outcome. The perception of some educators was that students from rural areas were wanting to stay on and practise in the city rather than return to their rural homes:

It will be different for people who get into medicine from a low SES, because they are kind of the one in the million who beat the odds. They will take things a little bit more seriously, compared to someone who got in, and can pay for it without a bursary ... I think the lower SES people who do want to be here will be more professional because it's what they've wanted to do, and they fought for it, and all that, where compared to someone who can be here regardless, probably won't take it as seriously. That's what I feel. And I think people

who work for it, and who have worked for it, will probably embody that professionalism a little bit more. (1st year student)

The whole reason for choosing students from deprived backgrounds who come from the rural areas is that you have to go back there. It is the last place in the world they want to go. Most of them will tell you, I've spent my life in the rural areas, I am not going back there, let the White man go back there or somebody else who hasn't been in the rural areas, you know ... So are we training people for doing what is needed in the country or are we not? (Educator)

There was also extensive debate about whether university applicants should be encouraged to study other degrees and gain life experience between leaving school and entering university to study medicine. This idea was strongly supported by some of the first year students who were of the opinion that applicants with a prior degree and life experience should be given priority for selection into medicine, as the perception was that maturity that comes with age and experience would be beneficial in tackling the demands of medicine and the years of formal study, and mature students would also be most likely to embody values associated with professionalism:

People are really young when they start this degree straight out of high school, and that's only what I've realised now, is that at 24, which is the age that I'm turning this year, you graduate, and I don't know anything about life. (1st year student)

You'll probably get better medical students coming out of a group that has already done something, and in that case you'll probably have better professionalism, because at that stage they've started developing that sense of respect, which they're lacking from high school, and they've already started to develop as a person. (1st year student)

4.3.3 Novice to professional

As described in the introduction to this chapter, the transition from novice student to qualified medical professional on the journey to professionalism was a highly contested area of discussion, and was another major issue within the theme of professionalism and emerging identity. It was described and framed within two main ideas. The first was that of professionalism being something intuitive and therefore part of who the person already is when they enter university and come to study medicine. The second was that of professionalism being linked to professional identity formation and part of a developmental journey associated with the process of learning and the practice of medicine.

4.3.3.1 Intuitive professionalism

Where professionalism was understood as arising from something more intuitive, personal values were highlighted as the core of professionalism and professional identity. This idea that professionalism is grounded in personal values was strongly supported by students across all years:

Being a health professional, it is something that you are 24 hours of the day so you can't put on a facade the whole day and then conduct yourself in an unprofessional manner. It is something that you either have or you do not have. (1st year student)

Being a doctor shouldn't define you, you shouldn't be professional because you are a doctor, but rather being a doctor just brings out the person you are inside. (3rd year student)

Interns and educators also supported this view with interns sharing experiences from their internship to illustrate this understanding, by describing situations where their own value systems were what defined their professionalism in practice, particularly in challenging situations:

It also, I think, comes down to you as an individual. I for one have decided, like if you're not going to be there and you will not show the type of empathy, the type of commitment that you're supposed to to patients, I will not let that be the way that I will continue. You know I have experienced professionalism in a certain manner and I will continue that, even if I'm alone in casualty. (Intern)

Where did good ethical people come from? First of all, they come from where they come from. By the time you come to medical school at the age of 18, your personality, how you think about yourself, how you interact with other people, what kind of friends you make, how you behave with your parents, how you treat your sister or your brother or another person as a stranger in the street, those things are largely formed ... by the time you come to medicine you are pretty well who you are, okay. (Educator)

4.3.3.2 Professionalism as a journey

Understanding professionalism in medicine as part of a journey from novice to professional was also strongly supported by a range of students, interns and educators. This notion was linked to that of professionalism being about skills, behaviours and responsibilities that could be learnt. The question of when this journey begins was debated extensively, with the strongest support being for the idea that the journey begins at registration:

Well basically, I think of it as a journey of learning how to walk. You will stumble, you will first crawl, then you will eventually start standing and then sometimes you will fall down but then you will have to get back up again, that is why it is called practising medicine, it is a lifelong learning you never stop. (1st year student)

I think we start being a health professional when you start year one ... this socialization process doesn't start only in the clinics, it starts from when you sign that paper. (Educator)

So it's kind of ... I don't want to say you'll be a better professional, but it will help you as a person if you start now, it will be an 'easier' adjustment, especially when you get to a work environment, and you're seeing patients all the time, and you're seeing them outside of work. (1st year student)

This journey from novice to professional was typically seen as a lifelong journey, with professionalism in practice being something that develops over time through formal education as well as practical experience. One of the metaphors that was used was that of a tool box to describe this constant accumulated knowledge, skill and experience:

I believe that you can never be complete or perfect. As you said it is like a life long journey you have to learn every day. So I might have some foundation but I still have a lot to learn throughout life. (1st year student)

I see it as a toolbox, and throughout your career, all throughout your studying career, you just put different tools into your toolbox, and you just add to it every day so that you can use that when you are a professional, and you build up on it. (1st year student)

I kind of see professionalism as something we're, we're going to develop over the period of our education, medical education [general consent]. (3rd year student)

Professionalism comes with growth and experience. (1st year student)

There was also a strong sense that intuitive and lifelong learning of professionalism may in fact not be separate. From this perspective, professionalism was viewed as being learned as part of the journey of emerging professional identity and built on the values that are core to the individual. This notion therefore brought together the ideas of professionalism and professional identity arising from values that are intuitive and that of professional identity being learned:

It's a learned behaviour, like as you go through life you pick up many things that integrate with who we really are, or who we have been before. (3rd year student)

You should, as you go, pick up certain qualities because the society in which we live builds us, and right now we are in a society where we are doctors with other doctors, with patients around us so it's time for us to integrate these principles within our being. (3rd year student)

4.3.4 The personal-professional divide

The fourth subtheme within professionalism and emerging identity that emerged was that of where professional and personal identities lie in relation to one another, and the implications of this for professionalism. This idea had strong links to the previous sub-theme. Where emerging professional identity and professionalism were seen as linked to intuitive, personal values, the view was of the role of the doctor as a full-time commitment with little or no separation between the personal identity and professional identity. This idea was extensively supported and was viewed as linked to

the need for patients to be able to trust their doctor as a role model for good health and responsible conduct:

If you think about being a health professional, it's something that you are 24 hours of the day so you can't put on a facade the whole day and then conduct yourself in an unprofessional manner. It is something that you either have or you do not have. (1st year student)

Professionalism is not like okay in the walls of the practice only. It becomes part of you, it comes into your person, not necessarily just your career. You, you are a doctor so you will be professional at all times. It is not like you are doctor who is professional when you are in the theatre only. It is pinned to you as a person, it is not pinned to your role you play. (1st year student)

Patients trust them because they don't see them like at night or like Friday night somewhere else out in a club and stuff like that, drinking and stuff like that, so I think those kind of things also shape who we become as a professional and what we are thinking is professional. (4th year student)

In contrast was the notion of professional identity as learned and acquired over time and therefore separate from that of personal identity. The idea was that the two identities are part of every doctor's makeup and should be understood as clearly separate:

I don't think that being a doctor is what should define you ... I mean before you are a doctor, you are somebody else. (4th year student)

A professional would understand where their private life and professional life ends and so professionals shouldn't, there really isn't a place for bringing disputes with spouse problems at home, not that we don't understand the human condition that people have these problems but I don't think there should be a place for that in the work place. The work place should be the work place and the private life should be private life. (6th year student)

I think you should be able to separate your personal issues and work. Because if you are going to let your personal issues interfere with your work, then you are not going to be able to do your work properly. (1st year student).

Despite support for the notion that personal and professional identities should be separate, there was recognition that keeping these identities separate was, in reality, difficult. Difficulties were most strongly linked with situations that potentially challenged personal beliefs and values. Termination of pregnancy was an issue that was frequently used as an example by senior students and interns. A number of interns and students shared experiences of individual intuitive values clashing with professional practice, because of potentially being personally pro-life and anti-abortion in a country where abortions are legal and therefore must be available. The choice as to what to do in this situation and others of a similarly moral nature were seen as situated with the individual and their personal values:

I think a lot of interns have to deal with that, with the question of abortion but at my hospital the hospital doesn't allow it, so it made it, I haven't had to think about it, it's been a nice and easy thing for me because ja, I think if I had been confronted with it, it would have been a tricky one. (Intern)

At the end of the day it's about you as an individual and how you decide to conduct yourself within the system. You can see all these abuses that are happening and all this unprofessional behaviour and decide either to follow it or to stick to what you know. (Intern)

F: So the thing that is coming to mind is abortion, so you can sort of do your duty by referring a patient and tell them, I am not going to do it but these are your options. But then there is a very large grey zone between actually being helpful and assisting them to get this over somewhere else and doing the basic – I am not going to do it, you have a right to do it, these are the places that you can go to.

F: To be fair, when you are a doctor you do sign up to assist your patients and your job is to refer the patient.

M: Which is a form of assistance.

F: You don't have to do anything. You can just refer the patient. That is your job as a doctor. But there are different degrees of being helpful – you cannot look into the fact that the patient is not particularly literate or isn't able to access the particular set of options that you are giving them, like you can help them in a way that will actually be helpful or you can help them in a way that ticks the boxes and you can, there is that range of options available to you and perhaps being on the one end would be more in line with your principles and being on the other hand be more in line with your professional principles and then it's just murky. (6th year students)

A perception that was shared by some participants was that making space for personal identity formation was important and had benefits for the student. It was also described as having benefits for the doctor-patient interaction. The idea was that a doctor would best be able to understand and work in a more holistic way if they recognised and valued all aspects of their own identity:

If you don't have your own interests and you don't have, you know, a holistic view of the world, you're not going to treat your patient as a holistic person. You're going to put them into a little box of, they have a medical problem, let's treat them medically. (3rd year student)

The question of where to draw the line between personal and professional identities attracted significant debate. Questions that stood out strongly were of where one draws the line between these personal and professional identities, and the potential impact of one on the other. Students in particular seemed to struggle with where the line between the two should be:

I guess I'm asking what's the definition of professional behaviour outside of the medical field, like, when you're out there do you have to technically be, or when does it stop? I'm just, I don't know, maybe it's just a silly question. (6th year student)

You do all this and then you still need to go back to your own life at the end of the day, you know, and it's like, it's either, it's like so many people have described it to me as, your life is medicine and when you go home, you still, you've got, like, a few hours to, kind of, catch up, you know. (3rd year student)

If you are going out with the community members and you are getting drunk every night, you are driving drunk or you know, doing other irresponsible behaviours, that is also unprofessional because when you come to work and those same people are going to come be your patients then they are not going to take you seriously, so I mean then there is a line, but where do you draw that line? (3rd year student)

The personal-professional divide was further divided into issues of professional and socio-cultural identities, student and intern identities, and student and professional divides. The line between professional identity and socio-cultural expectations of individual identity was seen as a challenging area to negotiate. The roles were seen at times to be in conflict:

In some cultures they say okay we understand that you are a doctor at work, but here you are now a wife. Now you must behave in a certain way, not as a doctor. (4th year student)

Even at home they regard you as a doctor and they also, for instance you'll find that even the way you prepare food in our culture you'll find that we don't mind maybe to leave maybe say the food open even if the flies would come and sit there, you just remove the fly and you continue eating, but as a doctor you would say oh that food is now contaminated [laughter] and I will take it away you see, so it depends. (4th year student)

Interns saw the line between student and intern roles and the shift in identity as potentially challenging. They expressed the idea that more was required of them professionally as interns because they were now seen as part of the healthcare team with a responsibility to contribute:

I think professionalism is more important now because now there is that movement from being a student to your working life, now you're actually employed. There is just this sense of responsibility upon you, so you have to watch the way you dress, the way you speak, the way you treat your colleagues, your patients. (Intern)

You are expected to be a professional at all times within the hospital environment because now you feel more a part of the staff, although you are still training. (Intern)

Students grappled with a related question of where to draw the line between their student and professional identities. For students in their third and fourth years of study particularly, it was about feeling that they, as students, were still evolving as individuals in their personal capacities and were also not, as yet, professionals. They therefore felt they needed more space to explore and express their individuality beyond their emerging professional identities. Some students saw a particular contrast between themselves and students studying in other faculties. They felt that while others

were encouraged and challenged to explore their own personal identities, the FHS at UCT put constraints on their personal identity formation. A notion that was expressed by many students was that the Faculty was deliberately pushing students towards a particular professional identity at the cost to their own emerging personal identities. They expressed the view that so much emphasis was put on behavioural aspects of professionalism that the real interpersonal essence of professionalism had been lost to rules and check lists associated with conduct. Some students expressed finding this frustrating and limiting:

We are moulded into being someone even though you don't want to be that person. You are put into a box and said you are going to be the doctor, you are going to be this role. At the same time I'm sure everybody has, I don't know, an artistic side or other people like sports, but then you are forced to narrow all of that down and say, even if I like art I can't do that anymore or even if I like sport, I can't do that anymore, I have to only do this and sort of work around it. (4th year student)

I find as though sometimes people put a lot of pressure on us to conform to a set image and by doing that they kind of throw the things by the wayside, the important things of rapport with your patient and interacting with your patient, because who's to say that someone who looks, you know, maybe has a few piercings, the hair is a bit untidy, they wear baggy clothes, isn't going to be a good doctor, you know. (3rd year student)

I used to be like a crazy tuning DJ, [laughter] now things have changed, things have changed ... (4th year student)

If you look at other students, right, [general consent] they're supposed, they're all, like, everyone places a lot of emphasis on finding yourself and living life and you come into med school and everyone's kind of like no, you're going to be a doctor. (3rd year student)

This struggle with the line between student and professional identities was taken further, particularly by third year students. Some shared the idea that being young meant they struggled at times to make the distinction between their personal and professional roles. Others however felt the opposite and that they could move between the two roles as required:

I think for the students it's less easy to define that difference between the tick list [professional] and being the person because I think right now we are still so caught up in being ourselves and being young, and a lot of that is associated with so called unprofessional behaviour. (3rd year student)

I was told you can't make, you can't walk around barefoot on medical campus grass in break time and I was like, what? [laughter] Cause I mean, like, there's, and it's like what are you trying to shape? This is the type of person I am [general consent] and I'm going to be professional when I speak to a patient. (3rd year student)

I have to disagree with the fact that professionalism has to extend everywhere cause, I mean, a lot of people that we study with and myself, I mean, when I'm, say, out, I'm definitely not being professional, you know what I mean? It doesn't mean I'm not professional when I walk into the wards. (3rd year student)

I know a lot of people have this attitude that while I am at varsity, while I am seeing patients I will be professional but in my own personal life, it's not a problem, I will do what I like. Maybe while you are a student it is not such a huge problem, but if you are becoming a doctor in a community and then you are going out in that community and you are not acting your life the way you are preaching to your patients while you are working, then you are kind of, I feel like that is also a bit unprofessional. (3rd year student)

4.4 TEACHING, LEARNING AND ASSESSMENT OF PROFESSIONALISM

The third major theme that arose in the interviews and focus groups with students, interns and educators was that of the teaching, learning and assessment of professionalism. This was debated extensively, with students and interns reflecting on their thoughts, feelings and experiences of the teaching they had received, and what they had learnt during their time as medical students in the Faculty of Health Sciences at UCT. Educators, on the other hand, reflected on their thoughts, feelings and experiences of designing, implementing and assessing curricula, with outcomes specifically linked to professionalism within medicine. Two major areas were most clearly evident across all three groupings, and included the formal curriculum, and what is often described and understood as the 'hidden curriculum'. The formal curriculum included everything that was formally taught and assessed within the MBChB curriculum, while the 'hidden curriculum' included aspects that were not explicitly intended, but reflected the teaching environment, culture and experience behind what was explicitly taught.

4.4.1 The formal curriculum

The formal teaching and learning of professionalism in medicine was most strongly perceived to be linked to the divergent understandings of professionalism based on individual values on the one hand, and knowledge, skills, behaviour and responsibilities of doctors on the other.

4.4.1.1 Values

Where students, interns and educators were of the opinion that professionalism was most persuasively embedded within the values and moral character of an individual, the view was that professionalism could not easily be taught. The notion was that a person's character and the values they hold are already established as part of who they are long before they are admitted to university, and that therefore they will be unlikely to change as a result of formal education:

The lecturers and the facilitators in our curriculum try to create integrated health professionals, but a person's character and personality is pretty much set by the time you reach university ... you know what I mean, no-one's really going to change what their values are. (3rd year student)

We are beguiled and fooled by the concept that we can tell them [students] what we want to through medical education, whereas in actual fact we can't change them and ... we can probably do some good things, but we shouldn't overestimate what the curriculum can do. (Educator)

4.4.1.2 Knowledge, skills and behaviour

Where professionalism in medicine was viewed as being about knowledge, skills, behaviour and responsibilities of healthcare professionals, students and interns clearly associated what they had learnt about professionalism in medicine with the formal taught curriculum. This teaching and learning was strongly associated with the professionalism-related courses that students had been exposed to in their first three years of study in the Faculty of Health Sciences, particularly the 'Integrated Health Professional' (IHP) framework with its three dimensions of knowledge, empathy and reflection:

We're actually doing a lot better now, where people are actually teaching us, you know, and the correct way to treat a patient. And since first year we've been, you know, we've had courses like BP [Becoming a Professional], BaDR [Becoming a Doctor], and Becoming a Health Professional where they, like, you kind of, you learn the skills. (3rd year student)

We learned about it in BP. I mean with reflection being one of the areas, and knowledge, empathy, reflection. IHP, the three components ... We can't forget. We can never forget. (4th year student)

The softer aspects of professionalism like your listening skills or your personal development or your ability for your self-reflection, those things I value deeply and I feel like the teaching at UCT did develop those things within me. (Intern)

4.4.1.3 'Soft' skills

The interpersonal and reflective skills that are central to an 'Integrated Health Professional', and are an area of focus of the early years of the formal curriculum, were frequently described as the 'softer' skills within the formal curriculum. There was a great deal of support from both students and interns for the teaching of these 'softer' interpersonal skills associated with reflective practice, including recommendations for more emphasis on these aspects in the senior years of the formal curriculum. Opportunities for the integration of self-reflection in the context of clinical practice were seen as important and useful, because of the ethical and moral challenges perceived to be inherent in clinical practice. Students and interns therefore recommended extending and integrating 'softer' skills beyond the first three years of the formal curriculum into the senior clinical years:

I don't know if there is enough emphasis placed on ... the type of person I would want to be.
(3rd year student)

I almost feel like we had a lot of reflection in our early years ... but in our latter years [there were] not definite opportunities for growing professionally. (Intern)

In contrast to this recommendation for further integration and extension of 'soft' skills, was the recognition that not everyone, particularly educators, recognized the value of teaching and learning of these 'softer' skills associated with professionalism. Some students and interns shared how certain educators were openly negative and disparaging of the time given to the development of inter-personal and reflective skills. There was also the view that some students did not seem to see the value of learning 'soft' skills during the early years of the curriculum. Interns particularly emphasised the need to carry the teaching and learning of these 'softer' skills through to the clinical years in an iterative way that would bring theoretical teaching and clinical experience closer together:

We have had in the past conversations regarding what she [the educator] refers to with great scorn, the touchy feely stuff. (6th year student)

UCT was, you know, taught us about empathy, caring for people, but I mean this is something that is required ... Courses like Becoming a Professional, you know, Becoming a Health Professional, are important but students don't always view it that way. (Intern)

4.4.1.4 Language and culture

A further area of teaching and learning associated with professionalism was perceived to be that of languages, particularly African languages spoken by patients. Learning African languages was described as important for communicating with patients and establishing rapport between doctor and patient. There was however some concern about a gap in this teaching, related to what was

described as culturally related or appropriate conduct. Students and interns, in particular, were of the opinion that the additional teaching and learning of culturally appropriate conduct would help to enhance the development of the key areas of respect and trust between the doctor and patient:

I don't know much Xhosa but the little bits that I have picked up have been such a wonderful thing to have, to be able to say 'hello' and 'how are you' and ask a few questions. (Intern)

I think part of being professional is being culturally aware of what is respectful in different cultures so that you can act in a respectful way towards people, and I think maybe in our degree that is not emphasized enough on learning about other peoples' cultures. I mean we do a bit of languages and within that you do learn what those languages consider respectful, but there needs to be more emphasis on learning about the cultures. (3rd year student)

4.4.1.5 Human rights and ethics

Learning about human rights and ethics was a further area that was identified as important and relevant to professionalism in medicine. Although described as important and relevant by all three groupings, educators, in particular, expressed concern about whether they themselves really understood professionalism, human rights and ethics, and the differences between them. The view was that there was confusion within the existing curriculum and a need for clarity in understandings, so that educators would be able to teach professionalism, ethics and human rights as distinct, but related, areas within the MBChB curriculum. A further notion held by some educators was that only educators trained in ethics should teach about ethics. This view was however not widely supported:

Ethics is a sub branch of philosophy ... If you want to teach ethics, you must understand about ethical theories. You must understand what it means to be ethical ... because it is not just, you know, read this code and read that thing and this is ethical and that is unethical and it is black and it is white. So you need skilled ethics teachers [to teach ethics]. (Educator)

If they think that human rights is the same as ethics, they are deluded. Human rights are important, but ethics is different. And it encompasses human rights. (Educator)

4.4.1.6 Teaching

For students, interns and educators, the question of who should teach was reflected most strongly in discussions of the challenges of learning from registrars in hospital settings. Registrars were perceived to be stressed and exhausted, to the detriment of teaching the values and skills associated with professionalism. A further issue was concern about the extent to which certain educators understood and valued the 'new' MBChB curriculum that was instituted in 2002 at UCT (see Methodology chapter), and its attention to interpersonal skills and reflective practice. Student learning of professionalism was seen by some to be limited and potentially compromised:

I don't think they [some educators] actually understand how we are taught medicine now. (6th year student)

Now, the difficulty we have in the hospital is that most of the teaching of the young medical students take place by registrars. Registrars are highly stressed individuals ... [Students] are seeing a guy under stress so they see him on a bad day, any day, but that's what they become ... (Educator)

Students, mainly sixth years, were of the opinion that students should have the opportunity to evaluate their educators, and expressed frustration that this was not the case. It was their opinion that if students were being taught, assessed and evaluated by educators, they should in turn have the opportunity to give feedback and evaluate their educators. The view was that a process of on-going evaluation was particularly important and useful when looking at the teaching and learning of professionalism in medicine:

We are thrown into a group of senior individuals and we are the bottom of the food chain and they all evaluate us, they get together on a Friday at the end of a block and they grade us but we actually never get a chance to evaluate them. (6th year student)

I also think it's important that we have a method of rating a person as a professional because all of us, every block we go through, we get a certain amount of our marks are allocated to how we conduct ourselves, how professional we are, what our interactions are, how we work in a team, all things that a good professional can do, but on the other hand or the other side of the coin, we never get to rate the people that we work with. (6th year student)

4.4.1.7 Assessment

Assessment or the measuring of professionalism was a notion that also attracted interest. How professionalism should be assessed appeared to be linked to how one understands and therefore teaches professionalism. There were two opposing views – the one for assessing professionalism more broadly with attention to values underpinning behaviour, and the other for assessing skills and behaviour and that which is measurable. This former view was linked to the notion that professionalism should be assessed on an on-going basis, in order to give recognition to it as something that should be part of practice at all times:

How do you measure how kind somebody is? How do you measure how communicative they are? How do you measure if I put my hand and touch you, whether I am touching you in one way or touching you in another way? How do you measure that and how do you value that? How do you interpret what the person felt? Who you are and what qualities you have and how you bring that to bear on the practice of medicine are not things we can measure easily. (Educator)

It's not enough to just say you have to do this to pass your exam. You have to have some kind of checks and balances in place to make sure that people actually are empathetic and professional when there isn't someone marking them. (6th year student)

The latter understanding of professionalism in medicine as skills and behaviour-based was seen as having the advantage of being measurable. There was support, although limited, for the idea of a tick list for the demonstration of professionalism. The notion was that there needs to be a shared understanding of professionalism within the Faculty, with formal opportunities for acknowledging its importance such as a 'white coat ceremony' (as already done at some other universities) when students move into their clinical years of learning. Explicit criteria for the teaching and assessment of professionalism were seen as potentially valuable as a means of adding clarity to the teaching and assessment process, but also a means of differentiating the faculty:

I think that maybe we should develop a tick list by which we assess professionalism, say, did the student greet the patient when they came in for this particular oral, did they introduce themselves properly, did they, you know, wash their hands ... There must be some guide by which the students can know that they are behaving correctly. (Educator)

I think ultimately the university should define the check list but I think they should do it because they should view it as an opportunity of differentiating themselves from anybody else. (4th year student)

4.4.1.8 Concerns

In evaluating the overall experience of the teaching and learning of professionalism within the FHS at UCT, students, interns and educators shared a range of concerns. The first concern from the student and intern perspective was linked to the earlier description of FHS having a very specific idea of professionalism that was closely aligned to issues of behaviour, particularly dress and presentation, rather than deeper values associated with professionalism. Students, in particular, expressed the desire for professionalism to be understood as more than dress and presentation, and wanted opportunities for more eloquent engagement as a faculty, in order to really grapple with what professionalism means:

But one thing I've definitely noticed within our class is that the grapple with professionalism is that it feels sometimes like medical school is trying to shape us into that picture [general consent]. (3rd year student)

In medical school there, like you said [pointing to another student], there's a lot of focus on appearance as opposed to behaviour. (3rd year student)

I think the problem lies in the fact that especially in this faculty we are taking a word that is already so loaded with other meanings and we are trying to adapt it to our specific situation. What I think we should be doing is defining its particular set of values – confidentiality,

compassion, empathy, ethical practice – as well as being competent in what you do and try to instill that within the graduates from here. (4th year student)

A further concern was that the student experience of learning professionalism through the formal medical curriculum alone was too narrow, and that other subjects from areas such as humanities could be beneficial to student learning about professionalism. This view was shared by some students and educators, and linked to the idea that doctors need to understand the practice of medicine in South Africa within its wider historical and socio-political context:

The challenges that new professionals face here, the challenges of rebuilding this country. The challenges of this new group of people who are going to be the future leaders. Those are the things they need to try to understand in terms of the history and sociology and the oppression and the freedoms that have developed. (Educator)

I think it's also good to really take upon yourself to really expose yourself to other things, maybe not even medical things only, but other skills that can help you through college to become a professional. (3rd year student)

Despite these concerns about the very specific focus of the teaching, and the view that a broader perspective may be helpful, most students and interns were of the opinion that their university education had provided, or was providing the ground work for their understandings of professionalism. Students and interns shared the idea that university could not ultimately prepare them for all aspects of practice, but that the university was preparing them as best as possible. There were examples where interns in particular had to deal with very difficult situations, but it seemed that they had come to trust that what they had been taught in the formal curriculum was sufficient. The impression was that, while certain aspects were well covered, other aspects of their learning could only be learnt through time, their internship experiences, and practice:

Although I have come across a lot of unprofessional, sort of, encounters, I do think that the norm is of professionalism and people know now what is professional, what is unprofessional. I think it has a lot to do with the curriculum. (3rd year student)

The empathy, the personal reflection, the continuous learning, to be open to learn more, like wanting to increase your learning curve, that kind of thing, being eager to learn, being hardworking, I think they instilled that very well for us, from UCT. (Intern)

I think initially it was very overwhelming and like there was a situation at the very beginning of the block where there was a person who miscarried and she miscarried into the toilet and I was there to catch like this little foetus, I didn't really know what to do and I had to now like tell the mom this is her baby and the baby is dead, but it's like really small and I'm carrying it from the toilet back to her bed with the placenta still intact, like it was just one of those crazy things ... like you can't learn that at varsity. (Intern)

We often look back and we're like, well, if we didn't need to do it, maybe it's better to learn it now in any case and ja, I think when you're an intern you're going to be doing so many calls for your life, why start so young. (Intern)

Educators and interns were particularly concerned that the impact of formal education should not be overestimated. There were differing views from their perspective about changes that had been made to the curriculum, and whether these had been beneficial or detrimental to the teaching and learning of professionalism. Some interns honed in on what they experienced as a lack of congruence or a discrepancy between what was being formally taught and the realities of practice. The general perception however was that formal education could not always prepare students for realities of practice:

The context is so extremely different that you have to have your own sort of inner context of this is how things need to be done, because sometimes the structures aren't there or the senior doctors are not sort of modelling that ideal context for you or the hospital just doesn't support it. (Intern)

Students observe the behaviours and the attitudes of senior clinicians and they look up to those clinicians because they admire their competency, their clinical skill, and if they see them acting in ways that are unprofessional, disrespectful, they might or would assume that that is part of what being a professional is all about, that learning about professionalism is fine in theory, but in the real world this is what you need to do to get things done, and so there's this lack of congruence with what they have learnt. (Educator)

This lack of congruence was experienced differently from a student perspective and was linked more to frustration that Faculty explicitly outlined certain rules of conduct for professionalism, said there would be consequences for not adhering to these rules, but then the consequences were not carried through in practice. The message was perceived by students to be confusing and sometimes unfair, with students then thinking that professionalism as described in these rules of conduct was optional, as it did not seem to be taken seriously by faculty:

I think there's so much emphasis in med school on, like, what we look like, but the way some people behave, I think, you know, and they're not necessarily reprimanded for it ... (6th year student)

So it's just like, oh next time dress better, there is no consequences for not acting professionally. It's almost like an option. You get taught as a class, guys come on, be professional, there is, nothing happens if you are not professional. (1st year student)

A widely held view was that professionalism should be integrated more fully into the curriculum rather than viewed as a subject on its own, and that its teaching and learning should be part of an iterative spiral educational experience. Concerns were however expressed about how to do this

given the changing nature of the medical curriculum, the student body and those who are responsible for teaching:

INTERVIEWER: ... where should professionalism be in the curriculum?

INTERVIEWEE: Everywhere ... [laughing] ... I would like to see every course within the faculty having an element of professionalism, that is taught formally and ... so re-enforce, re-enforce all the time. (Educator)

You know, so the milieu in which we are trying to train people, the society, the medical school, the hospital, the teachers, all of those things have changed so much that it is hard to know what we really can do that would be best to train medical students in the way that we like to ... there is a lot that we have lost one way or another. There is probably a lot of things we have gained ..., but I don't think it is all better by any means. (Educator)

A further concern that was expressed by students was what they perceived to be the potentially negative impact of their own learning needs on patients. Third year students in particular discussed this at length, in terms of the pressures they experienced to meet their academic requirements. Some students felt very ambivalent about their own role, feeling that student learning was at times put before the needs of patients:

I remember we, it was during perinatal health, and we were practising, like, abdominal palpation with a mother ... And we started palpating her and she was clearly in pain and she didn't want us to be doing it, but she had no say and the doctor kind of made no effort to kind of, I don't know, rectify that. And to me that, that's not professional at all, like, fine, you're teaching students but at the expense of a patient? Like, how, how do you justify that? (3rd year student)

You're like a predator and you watch for patients [laughter]. The moment, when a patient comes in, you run and you claim that patient. (3rd year student)

4.4.2 The hidden curriculum

The hidden curriculum, and that which is assimilated while at university but is not part of the formal curriculum, was a theme that emerged strongly in relation to professionalism in medicine. It was most evident in how students and interns spoke of role models, or those educators, faculty members and healthcare professionals who they observed and perceived to influence student learning.

4.4.2.1 Role models

Role models were discussed with great passion, with varying opinions as to their impact on students and interns, from very positive to ambivalent through to very negative:

And the times that, like, after our tuts we're like, ah, that doctor was amazing. And it's normally because they're looking the part and they are, they are behave, they're talking to their patient, they're not just talking to the students. They're, like, are you okay with this? Do you understand what is happening? And it's that, when you see that in one package, you're just like, wow. (3rd year student)

I had a medical officer who, for me, coming out of school [university] ... epitomized what professional behaviour was like and what is expected of us ... The commitment that she showed to patient care, to continue studying and providing the best of evidence-based medicine. (Intern)

You get the really bad ones who you learn from, I should not do that, and the really good ones, oh I can do that, but a lot of the time you just sort of see normal doctors who do some things okay and other things not okay but we think, okay they are doing that, its excusable. (4th year student)

Experiences of negative role models were shared extensively across all the years, but most strongly by sixth year students. Stories of overtly negative attitudes of anger and bitterness, and unprofessional interactions on the part of some educators, interns and other healthcare professionals were shared. Students described feeling awkward and unsure about what to do in these situations:

It's a damning indictment of the system that he is telling that story and we are all going, 'Oh my God' [laughter] [over talk]. There are such few people, I mean there definitely are role models but I think it's just so sad that I can definitely count very few. I can say there are lots of people I think, my God, I hope I don't turn out bitter and angry like, [laughing]. (6th year student)

I've seen, like, horrible things happening in the hospital where I was busy talking to the patient and the patient was complaining about their IV line that, you know, it was really painful and it wasn't flushing. And the doctor's like, 'No, no, its fine, it's working'. And he's like, 'Sorry, Doc, it's not, you know, this is really sore'. So the doctor ... was just pushing it in and it was extremely painful ... this is a, you know, a strapping, like, oldish man who was kind of wincing in pain. He didn't even ask him [the patient], you know, 'how are you'? Just dismissed him as, 'no, it's not sore, there isn't a problem'. (3rd year student)

Further examples that were a cause of concern and frustration to students were where they reported being told to do one thing, but then witnessing this conduct not being carried through and modelled by educators themselves. This concern was described as particularly problematic in situations when students felt pressured to be part of this unacceptable conduct:

It really does sound like a complete sham when I go to a clinical exam and someone says to me, prep the patient, I will fail you if you don't do it right. And you know for a fact that you have been on ward rounds with surgeons where people say, the patient's leg will be amputated at 10:00 tomorrow and in the meanwhile nobody says to the patient, your leg will be amputated. (6th year student)

I've been in a few situations where you're, sort of, torn between you know you're supposed to be professional, but there's a few times where there's been a lot of pressure by medical staff and older students above you and that that, sort of, are acting unprofessional and try and get you to, like, join in with them and that just, ja, that bugged me. (3rd year student)

Despite compelling examples of inappropriate conduct and attitudes displayed by some educators, there was also the sense that students found these examples, in some situations, to be sources of motivation to behave and conduct themselves in exactly the opposite way. The view was that students ultimately made the choice to follow the negative role models or to learn from these examples. This was however also recognised as potentially challenging, particularly if the exposure to negative experiences and role models was over a longer period of time:

But when you see a doctor that looks good, they've got the prof in front, but they treat their patients like absolute hmmm, then you kind of, you start seeing the different images of professionalism, which is I think really, really helpful for us to see. (3rd year student)

It makes me worry, oh my gosh! When I leave am I going to disregard everything that I've learnt. (4th year student)

I had some very good doctors that I was with in groups and ja, I think I also, if I saw someone doing something badly, I'd make a mental note not to do it like that. (Intern)

Educators shared concerns about the implications of negative role models. An explanation for negative role models was linked to changes in teaching methodologies over time, particularly the loss of teaching 'firms', and implications of fewer opportunities for working and learning together as a team of senior and junior colleagues:

In my era the students used to come to our homes, we used to have them for a lunch or at the end of the year, or you know. You took a tutorial group, you got to know your students. The sense of belonging and the sense of being a junior member of a family that you one day wanted to be a senior member of, seems to have fallen away. (Educator)

Right through my career and right through until perhaps the late '90s, I was part of, and then head of the family that is called a Firm. And this is a group of consultant staff, registrar

trainees, interns and senior students and it is, it's a family unit ... they could watch you modelling practice ... And handling families, and dealing with tough news and so on and so forth. And you could watch them modelling practice ... Then we began to remodel the curriculum ... So we lost that role modelling possibility. (Educator)

4.4.2.2 Power and powerlessness

A pervading sense of powerlessness on the part of students was strongly evident, particularly from some of the sixth year students, who described feeling completely disempowered and unable to do anything to change the system of negative role models. There was a clear indication that many students shared the same concerns but did not know what to do, and often ended up just accepting what they saw and experienced as beyond their control:

It seems this system is just really quite corrupt, because we see all of us have the same complaints and I bet if we went around to every single one of us, we would have the same issues, and I am sure the same issues apply to the guys who are behind us, the guys who are in front of us and we all recognize, I am sure, a lot of the same people we are talking about are probably the same people, and no one does anything about them. (6th year student)

No one is going to pass through that system and emerge a professional because the way we learn is being surrounded by role models, people that you emulate and you take on qualities about them and if there are no positive role models, then you end up with a sort of toxic system ... I think people get better in spite of us not because of us. (6th year student)

This sense of powerlessness extended to students feeling uncomfortable in situations where they felt their educators themselves had demonstrated a lack of professionalism and were perceived to be 'untouchable' even by other educators, leaving students feeling unsure about what to do in that situation, and concerned about the potential impact on their marks if they reported what they perceived to be inappropriate or poor conduct:

They think that, okay, no, because we're in the brotherhood of medicine, it's okay to make a few inappropriate jokes and I think that just harbours unprofessionalism, and it's something that really bothered me with some of the lecturers making inappropriate jokes [laughter]. It may have been funny, but I do not think that it was acceptable at all. (3rd year student)

I think the frustrating thing is like we, at the end of the block, we actually won't say something to our supervisor who happens to be below in the chain of command or whatever you want to say, of that person but he said, like she is untouchable, you can't [student sighs], there is nobody who can stand up to her, she is the highest there is. (6th year student)

Some students also reported feeling intimidated and humiliated and ultimately powerless to do anything as a result of how educators sometimes treated students, whether individually or as a class. This included frustration at being labelled negatively as a class when students felt it was about

individuals who had behaved badly, and situations when students felt that they were expected to demonstrate respect for their educators but that this was not reciprocated:

There are some professors or whatever who intimidate me so much that I won't want to ask a question. (6th year student)

In our class, one person does something wrong, and they tell us that everyone, we are being rude. If you take out that one person, or that one doctor, and actually work on them, then you can make a change because one person is enough to give a bad influence. (3rd year student)

The tut gets cancelled, and no-one tells us, like, half an hour later someone will come and say, 'Oh, it's cancelled'. It's not reciprocal. (4th year student)

The perception of being powerless was extended to what students witnessed between educators themselves. Examples were shared of educators who were seen to make fun of colleagues who modelled professionalism. Educators echoed issues of feeling powerless. They spoke of a faculty- and university-wide lack of respect for quality teaching, and a sense that they were powerless to do anything about it:

I had the registrar that I was, I was in their firm for semester six and he was so brilliant. He was fluent in Xhosa, Afrikaans, English, like, everything cause he'd stayed in Khayelitsha for a year or so, and he just treated the patients so well and he spent so much time with them, which is, like, you don't see that in Groote Schuur a lot. And the other doctors made so much fun of him, the other registrars [laughter], they, like, called him a fool. How can you be made fun of for [over talking] behaving properly? (3rd year student)

I think the first thing is to say that there are two kinds of teachers. There are those for whom the glass is half full, and those for whom the glass is half empty ... And there are teachers who like to point out the absence of knowledge. And I've always thought that's the wrong thing to do. You acknowledge what the student has and build upon that. (Educator)

The university doesn't value teachers ... Nobody, nobody is really putting a value on teaching, the university and the students can see that. (Educator)

4.5 PROFESSIONALISM IN CONTEXT

In the focus groups and interviews, students, interns and educators frequently linked their thoughts about and experiences of professionalism in medicine to wider issues and contexts in which they were learning and working. There was recognition across all three groupings that the practice of medicine and its associated understandings and experiences of professionalism could not be seen in isolation from certain global and South African-specific issues. Professionalism in context therefore emerged as the fourth major theme.

Context was clearly recognised as complex and ever-shifting, with numerous components potentially impacting on professionalism in medicine. These included the broad areas of commercialisation of medicine, changes in access to information, communication and the impact of social media, generational differences, the feminisation of medicine as a profession, and hierarchy within the practice of medicine. Two areas were further seen as specifically relevant to the South African context – the South African healthcare system, and the South African patient population. Again, these areas need to be understood as interrelated although they are presented as separate components.

4.5.1 Commercialisation of medicine

A significant theme within issues of context was that of the modern-day commercialisation of medicine. Perceptions amongst students, interns and educators were of a global shift towards a more competitive, litigious and market-oriented society with associated implications for professionalism and the practice of medicine. This commercialisation of medicine was viewed as a source of concern to many participants, as it was seen to have a potentially detrimental effect on professionalism. The view was that medicine was increasingly becoming a commercial commodity to be bought and sold, with some doctors prioritising money, efficiency and their status in society rather than the more altruistic aspects of professionalism, including the ultimate well-being of their patients. This change was seen to have had a negative impact on professionalism and the doctor-patient relationship:

You know medicine has now become a commodity. It is bought and sold in the market place. And if your goal is to earn money, you can become the kind of doctor who can earn a lot of money and you can make money your goal ... The commercialization of medicine has changed the practice of medicine in all honesty. (Educator)

The focus has been shifting from medicine as being a service to the people that is the primary goal, to medicine being more of a status, like in ego boosting. (4th year student)

The commercialisation of healthcare, there seems to be far more emphasis on efficiency but often at the expense of giving time to patients. (Intern)

Linked to the perception of medicine having become commercialised or commodified, was the impression that patients expect not only excellence from their doctors but also, as with any commodity, the assurance that nothing can and will go wrong. Should anything go wrong, the concern was that patients could potentially view their doctor's professionalism as compromised. The worry, although not widely shared, was that there was potential for increased litigation when everything did not go according to plan:

I learned recently about a case of litigation against an obstetrician because a Mongol (a baby with Down Syndrome) was born, and what he'd failed to do somewhere along the line was an amniocentesis [that] would have offered this woman the opportunity for an abortion. So it was a crime of omission if you like ... We expect so much, we expect excellence ... Excellent outcomes, nothing must go wrong, you know. (Educator)

In an increasing litigious medical practice world ... I think that we have to equip our professionals to know that there are great risks out there, a whole litigation against them in this uncertain medical practice. (Educator)

4.5.2 Access to information

Another contextual concern was related to increased access to information. It was widely recognised that access to the most current medical information is important for professionalism, because evidence-based practice is a core component of good medical care. Students, interns and educators were of the view that speedy and efficient access to medical information, thanks in particular to the internet, was having a positive outcome for professionalism and evidence-based practice:

I'll go see a patient and not be sure what's going on, go to a clinical lab, sit on my phone and Google it. And I think it's the most amazing thing because, you know, before you'd have to cart these huge textbooks with you [laughter]. (3rd year student)

In the past we had to wait for information or go and research it for days. Now it is practically instant. The internet has changed everything. (Educator)

There were however two areas of concern about access to information via the internet. The first concern was about the way in which information is accessed during doctor-patient consultations. Accessing information while consulting with patients was viewed negatively by some, because the doctor or student using technology at the bedside could be perceived as disengaged from the patient. The use of technology was seen, in these circumstances, to have a potentially detrimental effect on the patient's perception of the doctor's professionalism. Educators in particular cautioned about the need to prioritise the person and not the technology when dealing with patients:

I love technology, but I think you lose that like human, that person to person interface. If a doctor is standing there with their tablet in their hand ... making their notes, they're so focused on making their notes, instead of treating the person. (1st year student)

I think medicine is evolving in more and more highly technical ways, and towards technical solutions, but I think we've got to be careful about the softer understanding of the vulnerability at the end of the smart technology. (Educator)

The other area of concern was about patients who were accessing information via the internet and using this information to self-diagnose. The worry was that the information available on the internet was not always accurate, and could mislead patients to the point of second-guessing and no longer trusting their doctors' medical knowledge, diagnoses and expertise. With trust understood widely as absolutely central to professionalism, the idea of patients not trusting the information given by doctors was viewed as problematic:

The whole world in which medicine is, and patients have changed. Patients are demanding. They read the internet, they don't believe the doctor. They don't trust the doctor. (Educator)

With the information access, I think it affects professionalism, not from the point of view of the doctor, but from the point of view of the patient where they, kind of, tell you what their diagnosis is and you're, like, no, it's not cancer. Wikipedia says it's cancer but it's not cancer. (3rd year student)

Although the impact of television on professionalism in medicine was not widely discussed, the notion was shared by some students that certain television shows had had an impact on how they and other students understood professionalism. Concern was related to images of doctors displaying uncaring, judgemental and self-centred behaviour that had been popularised in certain television shows, and that students saw these characters as role models for how they should conduct themselves:

[TV shows] expose all these things they say doctors do in hospitals, yeah. So I think that actually lowers our standard of professionalism generally because you find students watching those series and movies, and they see doctors such as that and then they are like, okay we don't really need to take professionalism and things seriously. (3rd year students)

4.5.3 Communication and social media

Communication, and how it has evolved and changed with the inception of social media, was an area that attracted significant attention from students, interns and educators alike. Interest was about how social media had effected professionalism in medicine. Facebook and WhatsApp were the social media platforms that were described as most widely used and integrated into the personal and professional lives of students, interns, educators and healthcare professionals generally. Two main benefits of social media were identified, with the first being the ability to consult with senior specialists and colleagues in order to share and access information quickly and efficiently. The second benefit was described as that of having a supportive space to share experiences and concerns with peers, and to reflect on practice, an area that was viewed by many as relevant to professionalism:

We use WhatsApp a lot but that's great because you can take a photo of an X-Ray and send it to your second on call who is at home and they can say, oh, it's actually extending into the joint and we need to do an operation, keep them in hospital. (Intern)

After a day in some departments, and you just have an issue with it, you just vent on your status. (6th year student)

You feel like you're in the same boat cause I've also been working for 12 hours and I'm also tired and I know what you're saying. (Intern)

A number of concerns related to the use of social media were however also recognised. Foremost was concern about the line between that which was appropriate and that which was inappropriate to share on social media. This concern was widely understood as linked to respect for privacy and confidentiality. The following example was shared by medical students about a post on Facebook related to the death of a baby in a hospital. The respect for privacy and confidentiality of the patient and the family had been completely broken, resulting in a breakdown in trust between doctor and patient, therefore bringing the professionalism of the doctor into question:

Somehow a picture of the baby was posted on Facebook, apparently, and it said the child had died ... and when we phoned the family and said, oh, we just wanted to let you know that the baby had died, the family said well we know that already, we saw it on Facebook. (6th year student)

Concern for respect for privacy and the line between what should and should not be shared was also extended to patient respect for the privacy of doctors, as it was noted that patients could more easily source private information about their doctors through social media. It was also noted that patients had been known to use social media to vent their frustrations about their medical experiences in a very public forum, and that this could have negative repercussions for the perceived professionalism of the doctor. Educators particularly saw this as a new or modern phenomenon and a challenge for professionalism in medicine:

Facebook is just so, it's so big, everyone has it, everyone ... and on the one hand you want to say that, well, doctors have the right to a private life and everything like that, but the fact that social media is out there and it's so accessible and, I mean, ... patients are Googling, Facebooking their doctors. (6th year student)

A patient puts on Facebook 'this doctor messed me up in this way', so how do you deal with it? How do you protect the individuals involved and yet allow people to express themselves? Much more difficult than my time when I was a student. (Educator)

A further concern was about the potential for medical doctors, but particularly students, to unknowingly share personal information and experiences when making use of social media. This concern was expressed most strongly by senior students, interns and educators. An example that was given was of an intern who shared on Facebook that s/he had spent their money on a drinking binge. The concern was that sharing personal information might be seen to reflect poorly on the professional values of that individual intern, and therefore their professionalism in their medical practice. The need and responsibility to self-censor to avoid situations that could be seen as reflecting poor values and professionalism in practice was therefore seen as important, with suggestions for a need for clearer parameters to facilitate more responsible use of social media platforms:

Social media has created a whole set of new challenges ... health professionals and others are using social media to perhaps disclose details about their patients, to say things about colleagues that they wouldn't say in person and without a proper code of conduct. (Educator)

If you're known to be a UCT medical student, but you don't, you know, you don't censor what goes onto Facebook, like, that could affect you. (6th year student)

What becomes OK to put on Facebook becomes regulated by what's OK in the environment and ja, if I ask myself if I was a doctor and I was treating people from my own community who had access to my Facebook page what would I want them to see. (Intern)

4.5.4 Generational differences

There was a strong sense, particularly from students and interns, that different generations of doctors reflected different generational values, resulting in confusion and diverse understandings of professionalism in medicine. Students and interns were of the opinion that the 'older generation' of educators and practitioners had a more conservative view of professionalism that valued appearance above all else, as opposed to valuing the being and conduct of the individual practitioner. This was reflected earlier through the different understandings of professionals. Students and interns were of the opinion that these differences could result in misunderstandings, conflict and confusion between educators as representatives of one generation, and students and interns as representatives of another generation. There was however the acknowledgement that generational differences were not something new, but were part of how people viewed one-another:

I think the older guys, you know, the older profs will probably look at us and think you know, it's definitely going down the drain, they don't dress in suits anymore, [laughter], because that is professionalism to them, but again back in the day the way they expressed professionalism was probably I am the doctor and if I say you do this then you do it or else. (6th year student)

Politeness and being respectful, punctuality, there tends to be more of a focus on that in the older professionals, and dress code and how it makes your patients feel that you are a doctor and you're there to help ... but ... my experience of it was always that there was a sort of harshness and a sort of dogma about what's right and wrong and ja, more of a judgmental attitude and more of a separation between patient and doctor and less of a concern for the context from which patients come ... (Intern)

4.5.5 The feminisation of medicine

A less widely shared sentiment was brought to the fore by educators about the feminisation of medicine and its potential impact on professionalism, which was expressed as both positive and challenging. A perceived benefit of increased feminisation of the profession was seen to be that of improved communication skills across the profession. The view, although not widely expressed, was that women are better communicators, and that this had therefore had positive implications for professionalism. The main challenge that was shared was the perception that female graduates tend not to stay in the profession because of their desire to raise families. It was however recognised that experiences may be different across the world with some medical practices adapting to better assist women within the profession by introducing practical solutions such as shift sharing to accommodate those who cannot, or would prefer not to, work long hours so typical of the medical profession. The perception was that better accommodating the needs of doctors in practice would have positive implications for professionalism:

Another burden along the way, is the thrust towards the feminisation of the profession There are vulnerable domains if the feedstock is female, because women naturally go into family life and have to run families and homes and so on. Now in more evolved countries, like the United Kingdom, they have realised that a 60% intake [of women] and a 60% output means that we have had to ... we have to change in training terms and make space for these women. (Educator)

Now women are increasingly going into surgery, the world over fortunately. So dare I suggest that even those domains are going to be more communicative as that changes? So we need to look after and encourage our female colleagues. (Educator)

4.5.6 Hierarchy in medicine

There was a very strong notion amongst students, interns and educators that medical practice and professionalism exist within a hierarchy with power as its central tenant. The hierarchy was seen to play out through unequal relations and power dynamics between doctors and patients, within the healthcare team itself, and between educators and students. The perception was that this hierarchy and power dynamic was extremely problematic:

But the hierarchy in medicine, I think, is one of the worst problems with professionalism. (3rd year student)

It should be an equal thing but I don't think it is at the moment. (4th year student)

4.5.6.1 Doctors and patients

The difference in power between doctors and patients was understood as resulting from differences in knowledge and experience, and evidenced in how some doctors were seen to treat patients. As described earlier, the doctor's knowledge and skills were understood by study participants to be reflective of professionalism. The problem was seen to be linked to how some doctors were perceived to use the power that their knowledge and skills afforded them. Students, in particular, described witnessing negative interactions between doctors and patients that reflected what they saw as a lack of professionalism. An example was that of minimising or dismissing patient pain and discomfort:

There is a big power gap between what anybody can know about themselves and what a doctor can know. A professional is characterized by many, many years of in depth study of a topic that nobody can study outside of that environment. You can go to the internet, you can read books, you can pretend, you can do virtual learning, but you can never learn in depth and learn it in an environment where it is being practised in the same way, as you can if you are being trained and learning in the healthcare profession. So the gap between the patient and the doctor is infinitely wide. (Educator)

I see these doctors in the hospital who, I think every doctor I've seen that I thought of has been unprofessional, other than just being busy, I think the main problem is they're on this ego trip where they, where they think that, you know, now they're in this position of power where they can do these things and that's not how it should be. (3rd year student)

The patient says, 'I'm in so much pain, please give me painkillers' and they say, 'No, you can't have painkillers and don't think this is pain; the pain's still coming'. And it's very much a power play that I saw in practice, and it was a relationship that I found was impossible to mend. (4th year student)

4.5.6.2 The healthcare team

The next area of hierarchy and power relations that was viewed as problematic for professionalism was described as experienced within the healthcare team. Teamwork had been identified as an aspect of professionalism, and yet students described experiences of extreme hierarchy between nurses and doctors and medical students, while interns shared numerous examples and experiences of the hierarchy of medicine as evidenced in their relationships with medical officers. In some cases this was reported positively, when the relationship with the medical officer was seen as one of support, but more often it was experienced as problematic. Interns expressed the expectation that

medical officers should be role models of professionalism for their younger colleagues, but this was reported as seldom being the case. They shared examples of medical officers who did not arrive at work on time and, in some cases, leaving interns to their own devices. Interns reported that they felt powerless to do anything about it and that they were concerned about implications for patients if they were not adequately supervised:

No, a week ago a nurse was shouting at me for a very, for no reason, and then the patient, the woman who was in labour, she, I was quite close to her, and then she said, she just, kind of, whispered to me, 'Sjoe, they really treat you badly, hey'? And I just wanted to start crying, but you can't when you're about to, like, deliver her baby [general consent]. (4th year student)

If you check within the group of medical officers, we have around 10 of them, and in that 10 you have those that display those professional attributes that we were taught at school, so at 4:00 when the call starts they will be there with you, they will do what they get paid to do, which is to be there with you and to teach you ... but the other half of medical officers will display those not-so-good, or should I say they will display a lack of professionalism by actually doing whatever they please at whatever time ... It becomes a bit worse as you progress through the years. (Intern)

In terms of the quality of care that we give to patients, it becomes compromised when you expect interns to singlehandedly manage patients. (Intern)

4.5.6.3 Student experiences

Finally, there was a strongly expressed sentiment that students were feeling that they were at the bottom of this hierarchy. They described a cycle of power from consultants to registrars to medical officers and then on to interns and students:

It's quite a profound hierarchy; I think, I think I remember speaking to somebody about it as well. I have a huge problem with that hierarchy thing because it's such a set order that an intern will tell you what to do or shout at you. The consultant would come around and then shout at the registrar. It's such a continuous, yeah it's just like a step down thing and it shouldn't be like that. If we all treated each other with the same amount of respect whether they'd be older or younger than you, it'll be easier to work with someone and be professional at the same time. (4th year student)

It's belittling, it makes you feel like you are this small and you actually shouldn't be here, like you are here playing games like as if you're the child and they're the adults saying no, no, no, don't do that or they try like, or they just ignore you and push you to the side ... I don't know what it is, but they somehow seem to think that they don't have to respect us as people not even as professionals but just as people. (4th year student)

Some students shared experiences where they felt that senior colleagues had also approached them unprofessionally, leaving them feeling very uncomfortable:

As students who are, our numbers are, you know, you put your numbers up for [laughter] because we have to for calls and things like that and I've been contacted by a doctor before saying, 'Let's organise a tut or whatever' and then I'd, we'd, you know, and kind of started off as work things and then he's continue to sms me and say, 'Let's go for drinks sometime. What are you doing'? And to me that's not [laughter] professional; that's a violation of what, of my details and my information, kind of thing. (6th year student)

I just remember one of the doctors on a ward round, I was wearing a dress and I usually don't wear dresses and the doctor just, like, in the middle of the ward round was, like, 'Oh, wow, you're wearing a dress' and made me feel very uncomfortable, like, oh my God, I'm going to die. I just felt it was really lacking professionalism. (6th year student)

There was a pervading sense of powerlessness from students as they described their experiences of the hierarchy within the healthcare team. For students, the view was that this hierarchy and unequal relationship within the team should not exist, but that they were powerless to do anything about it. There was extensive concern that their grades would suffer if they complained about senior colleagues and their lack of professionalism. Students were left questioning why this hierarchy, the unequal relationships and humiliation of students was allowed, and whether senior colleagues could themselves not benefit from some interpersonal skills development training themselves:

I feel like, because they are in power, then, like, I can't do anything much about what they are doing, like, they already ... like, I don't have, what they do to, I don't know what actually they will do if you report, but the thing is they continue working and then you continue to meet up with this person, so it, even if they did something wrong, it's hard to go back to that same time as you were before. So I feel like it's not right that they get to do that, but this is how things happen. (3rd year student)

M: Even with anyone in hospital, if they treat you badly or they're treating a patient badly and you complain, the chances that your marks are going to, that you, like that, those fears are what, like, [over talking].

F: Ja, that stops you from doing anything. (3rd year students)

Often us as students, we're seen as nothing and somehow we just seem to accept it as being that way and it shouldn't actually be that way. Just because you have a bigger degree doesn't mean you should be respected more. I think that in itself is unprofessional and if you actually respect everybody, even those lower than you, or who's supposed to be lower than you, that makes you more professional. (4th year student)

The whole like Integrated Professional thing, maybe you should sell the idea to them [senior staff]. BP for already professionals, [laughter] compulsory course. No it's true actually, I have seen a consultant make a registrar cry in a ward round ... Why would they do that to somebody and why is that okay in front of that patient, in front of all of us? (6th year student)

4.5.7 The South African context

While aspects that were described above were seen to be part of the reality of 21st century medical practice globally, there were two areas that were perceived to be specifically reflective of the South African experience with implications for professionalism in medicine. These included the South African healthcare system, and the South African patient population.

4.5.7.1 The South African healthcare system

The South African healthcare system was described in terms of an ever-widening divide between private and public healthcare, with experiences in the public sector described as less than optimal. The perception was that this divide was impacting on the professionalism of doctors in public healthcare facilities, because doctors did not always have access to the resources they needed. The perception was therefore that what was referred to as a 'baseline of professionalism' in medicine was being compromised:

I think often in the government sector the baseline is not very good, but I don't think it's always an individual thing, I think it might be circumstance ... With private healthcare, so there I think the baseline is really there. (Intern)

The big divide between the public and the private sectors, it is enormous, you know. [Doctors] in the public sector feel that they are not able to do what they would like to be able to do for patients, the infrastructure isn't there, the medications aren't there. The patients present late and they are very sick, and they see a lot of things being done for patients in the private sector that can't be done in the public sector, so it is a bit demoralizing to work in the public sector ... the disparities between what some people can get in South Africa are very wide and widening. (Educator)

Issues of compromised professionalism within public healthcare were described as most strongly linked to frustrations around limited resources including personnel and supplies. Concern was expressed by interns in particular about being short-staffed in public healthcare facilities. The perception was that compromises were being made on the quality of medical doctor being appointed in certain public healthcare facilities. Stories were shared of doctors being kept on when they had clearly demonstrated a lack of professionalism, such as consistently arriving late or not arriving at all for work. The perception was that this was because there did not seem to be an alternative, and a 'tolerance' for a lack of professionalism had become acceptable in public healthcare facilities:

There's so many doctors that don't show up for work. In our first three months there we heard the stories about ... who is an alcoholic and he only comes to work three times a week but when he comes they are so grateful to have someone at this hospital ... because no one

wants to work there, that they keep him on and they keep paying him a normal salary and they don't report him. (Intern)

So there's also tolerance of this sort of poor practice because resources are short, because they are short-staffed. (Intern)

Lack of supplies, including medicines, within public healthcare facilities was seen to have the effect of leaving some doctors as well as other healthcare professionals feeling demotivated and frustrated, to the extent that they no longer seemed concerned about their own professionalism:

You find that certain medication that you want to order, certain procedures that you'd like to do, but because everything seems to be out of stock all the time, you just end up losing faith in the system. (Intern)

Other frustrations I think relate more to, they are more systemic things, like lack of equipment and lack of supplies, working supplies and that in effect gives people the leeway to effectively do nothing in the workplace. (Intern)

Linked to this idea of differences in the baseline of public and private practice was the notion that expectations of patients were often different depending on their socio-economic status and whether they were paying for treatment. An idea that was expressed was that the more patients were paying, the more they expected of their doctors, particularly related to the demonstration of professionalism in how doctors treat their patients:

The thing with that is the expectations of patients. I think, I don't know if it differs, but I have a feeling, I feel like it differs, like me as someone who's paying a lot more expects a certain level of professionalism, and ... they expect more of a doctor, or a nurse. And lower SES would expect less because they're paying for less, but it would be really nice to see that it was kind of spread throughout, that everybody's getting the same. (1st year student)

4.5.7.2 The South African patient population

With professionalism described as a key component of the doctor-patient relationship, a significant amount of attention was given to discussing the South African patient population. The South African patient population was described most strongly in terms of diversity of socio-economic circumstances, cultural practices and language. Although these contextual realities may not be unique to the South African context, they were perceived to make practice within South Africa challenging. This was because of the need to establish a positive doctor-patient relationship based on empathy, trust and respect, with patients who may be from very different socio-economic backgrounds, different cultural backgrounds, and speak different languages.

I: Does it make a difference that we're in South Africa?

M: It definitely does.

F: It should because we look at the patients who we're treating and you have such a diversity of patients ... (3rd year students)

We have a very wide degree of, like, the SES ... You need to be aware of those things, cause you treat someone, they're just going to go back to the same situation, they're going to get the same disease, they're going to come back in a few months later. (3rd year student)

In sharing understandings and experiences of the diversity in cultural practices, a student used the example of how certain cultures within South African society choose to take their placenta home after giving birth, and this may be viewed as strange by another cultures. The view was that trust needs to be built through being open to and accepting of differences, so that patients in turn feel open to trust their doctor:

Some cultures believe that they should, you know, take their placenta home with them, and, I mean, we're on, being in that environment as well and it seems a bit weird, everyone in there and asking them, 'Would you like to take, you know, the afterbirth home with you'? And most of the people are, like, no, no, no, but for the people that do believe in it, I mean, it's quite a strong thing; they'd want to take it, and it means a lot to them. And, I mean, for medical science it's important, you know, to examine it and all of that. But for the people that believe culturally that they should take it with them it's important that you ask that question, that you give them that choice. (4th year student)

A further concern related to diversity across the South African patient population was that of different languages. Students referred to the challenges of being able to understand and relate to patients across South African society, because of the number of different languages spoken in South Africa. This challenge was extended to patients from neighbouring countries who might not speak one of the eleven official South African languages. The following example illustrates:

I saw one lady ... I couldn't really communicate with her properly because of the language barrier, and you could see she was, kind of, isolated in the ward because none of the sisters could really talk to her. She was, you know, really isolated. (3rd year student)

This diversity within the patient population, including that of socio-economic status, culture and language was seen to be mirrored by doctors themselves, who were described as having moved from being a more homogenous group dominated by white male practitioners, to a more heterogeneous community reflecting differences in race, gender, belief systems, cultural practices, languages and religion, but also more reflective of the South African population

And maybe it's the fact that it's now so much more diverse and you've got all sorts of different colours and all sorts of, you know, and all the men and women and things involved and, like, you, there's no physical picture to place to doctors anymore because everyone looks so different and is so different and has the, you know, different beliefs and religions and things like that, so that you can't, kind of, put the doctor in the mould anymore. And I don't know if that maybe has an effect on the, you know, how you see it. (6th year student)

Diversity within the patient and doctor populations was seen to have a potentially challenging impact on professionalism, because doctors would not necessarily know how to respond in a culturally appropriate way or share the same language as their patients. The need to demonstrate professionalism through being respectful of patient diversity was seen to be important when working in such a diverse, heterogeneous society:

I just think the unique thing about South Africa is the, like, the absence of homogeneity, like, there's so many different languages and cultures and influences and economic classes. So as a doctor trying to, kind of, dish out this professional image; it's bound to have to change in some way depending on who you're interacting with. (3rd year student)

I do think it is really important in a South African context, especially now that all kind of shades of people are seen as being equal, like, the idea of respecting them has changed from being a paternalistic one, like, I am the doctor, you must respect me, to something that's more interactive and also includes language to some extent [general consent] and culture, because one culture's notion of respecting someone who's older than you would differ from someone else's. And if you're not able to respect them then how are you able to be professional with them [general consent]? (3rd year student)

Linked to patient population were experiences of the practice of medicine in the South African context. The main issue here related to the high prevalence of HIV/AIDS and its impact on the practice of medicine. It was not an area that students spoke of in any detail, possibly because of their limited exposure to patients, or an acceptance that HIV/AIDS is part of practice in the 21st century and they have never known it to be any different. For educators and interns however HIV/AIDS was seen as having changed the practice of medicine to something extremely complex because of the possibility of multiple diagnoses in one patient. For one intern working in an area of South Africa that has a particularly high prevalence of HIV, the impact of HIV was felt strongly and was discussed at length. The magnitude of the HIV epidemic, as well as the perceived attitude and behaviour of patients, was a cause of frustration and concern to the intern who seemed to be struggling with maintaining professionalism with patients, while feeling frustrated and disempowered by the scale of the epidemic, and feeling that patient behaviour was not changing despite ongoing education and increased knowledge about how to prevent the spread of HIV:

I think this HIV epidemic has totally changed our practice in that many, many diagnoses are possible within one patient. Many, many infections are possible within one patient. (Educator)

I think a lot of the frustrating things that I found recently are like the people who are HIV positive, who became HIV positive when they were 17 or 18, after having life orientation and all of these things at school and that's what I've been frustrated about recently and then you talk to people working in different hospitals and then you all agree that it's awful and then you're grumpy about it and then you carry on. (Intern)

Trying to make sense of it, an intern linked cultural factors to the spread of the disease, but also went on to elaborate about the challenging socio-economic circumstances that may result in individuals making risky choices. The example that was shared was that of a young woman having unsafe sex with an older man and then having sex with someone of her own age, thus spreading the infection from the older to the younger generation, despite knowing the risks. In an almost resigned way, this same intern felt that a solution was beyond the scope of a doctor's role despite it affecting the doctors:

What happens is that you've got two single people who've had a relationship and sort of want to have a relationship but aren't necessarily together all the time, and I think that can encourage the multiple relationships and then I think there's like a lot of, ja, there's sort of older men and younger women and sort of money and there's a lot of that that goes on, and I think without solving education and the economic issues, those things will continue to happen because it's like if there is an older man who has got money who is willing to, who wants to sleep with a younger girl in exchange for something, then there's very little, ja, it sort of just happens and then apparently there's also been, so like the older men sleep with the young, the 18 year olds who then sleep with the 38 year old men and then that spreads HIV across five year gaps or 10 year gaps, and I think a lot of it has to do with empowering people and I think that's very difficult to do and it's not being done right, however it needs to be done. (Intern)

It's beyond the scope of doctors but it really affects us because it seems like people, despite being educated, still make decisions that have other things in their heart. (Intern)

A second area related to experiences of practice was that of human rights and patient rights, as this was seen as having emerged strongly since 1994 and the dawning of the 'new' South Africa. This was perceived as having had implications for doctors practising in South Africa, with increased awareness of human rights and patient rights on the part of patients being generally viewed in a very positive light. Changes in practice and therefore expectations of professionalism were seen to have a link to increased awareness and respect for human rights and patient rights. Respecting the rights of patients was described in relation to the need for doctors to explain information to patients:

I don't think, personally I don't think it's decreasing. I think that people are becoming more aware of what their rights are and how people should be treating you. (4th year student)

Well obviously in the past I think doctors didn't have, didn't feel it necessary to explain to the patients exactly what is going on with them, but now that we are in the biopsychosocial approach I think that more and more doctors are you know, are aware of giving that information to their patients. (3rd year student)

There's a lot more awareness about patient's rights, about confidentiality, about consent, which I think is professional or ethical, it kind of ties up to that and I think that when you, so I think that there's been an increase in that side of things, like explaining to patients what needs to be done. (Intern)

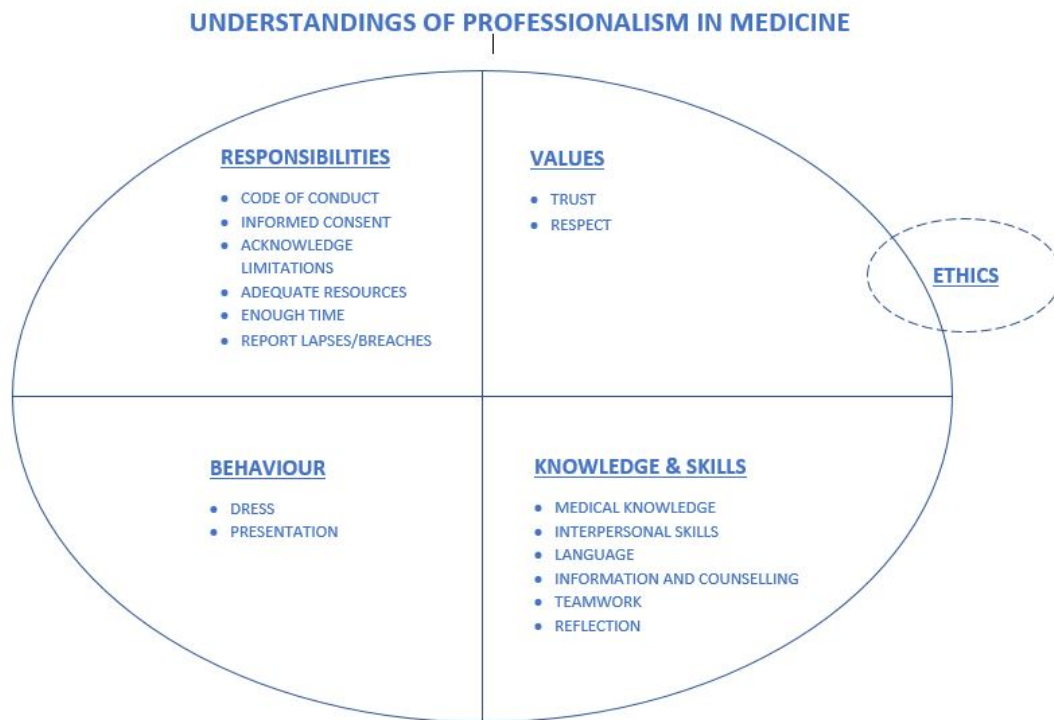
An educator described the following example of a patient being aware of his rights where students wanted to interview him and started to look through his patient records while he was out of the room. The patient was upset about this, particularly as the students were not dressed in a way that they could be identified as student doctors. He took a photograph of the students and proceeded to put the photograph on Facebook as a way of showing his annoyance at the situation:

An example, there were students in surgery who didn't have white coats on, or any form of identification. They approached a patient's bed and, because they were told that this is an interesting case, go and look at it, so they did so, they went and were rifling through the materials that were at the patient's bed, the patient wasn't there at the time, he had gone to the toilet, and when he came back he was wondering, who were these people who looked like young people going through his personal information, so he stood back some distance away and he took a picture of them. He then put that on Facebook. (Educator)

4.6 CONCLUSION

Results from the current study revealed four major themes: understandings of professionalism; identity and professionalism; teaching, learning and assessment of professionalism; and professionalism in context. Students, interns and educators shared and debated different views on what constitutes professionalism. As illustrated in Figure 4, four distinct sub-themes emerged as central to understandings of professionalism including values, knowledge and skills, behaviour, and responsibilities associated with professionalism in medicine. Values were most strongly focused around respect and particularly issues of trust, but were also aligned with ethics. There were six knowledge and skill components including medical knowledge, interpersonal skills, language, information and counselling, teamwork, and reflection. Interpersonal skills were seen as most strongly evident of professionalism after medical knowledge. Interestingly, interns also highlighted teamwork as a key area of knowledge and skill evident of professionalism, and 6th year students highlighted the value of reflection as part of professionalism. Behaviour, in turn, was clearly linked to dress and presentation with varying views on its importance. Finally, six distinct responsibilities were evident including the need for a code of conduct, informed consent, acknowledgement of limitations, adequate resources, enough time, and responsibility for reporting breaches or lapses in professionalism. Although these components were stressed as important by all participants, interns honed in on the realities of how limited resources and time could impact on professionalism. They also emphasised challenges with reporting a lack of professionalism in senior colleagues, a concern shared by senior students. Although these ideas are presented as separate, they have significant areas of overlap. As illustrated in the figure below, understandings of professionalism can best be represented as a series of overlapping areas rather than as different or separate ideas (Figure 4).

Figure 4: Understandings of professionalism



Professionalism and emerging identity was the second major theme that surfaced within this study. Students, interns and educators reflected extensively on their own development and perceptions of what it means to be a doctor. Four sub-themes arose including issues around who applies to study medicine, who is selected into medicine, the journey from novice to that of professional, and finally the personal-professional divide. Varying reasons for choosing to study medicine were shared, with a sense that those who choose to study medicine for more altruistic reasons would most likely reflect values associated with professionalism. Interviewing of applicants, as part of the selection process, was viewed as a potential means to select the most suitable medical students with intrinsic values and strong interpersonal skills reflective of professionalism. Limited spaces available for studying medicine were seen as a further reason for careful selection of the most suitable and motivated students. The journey from novice student to graduate professional was viewed differently, and was strongly associated with whether professionalism was seen as intrinsic or learned, and the divide between what could be considered personal and professional.

Two main issues arose in relation to the teaching, learning and assessment of professionalism in medicine – what can be called the formal curriculum and the ‘hidden’ curriculum. The issues most strongly associated with the formal curriculum focused on what was being taught and assessed, how it was being taught and assessed, and by whom. The area that stood out most powerfully was that of

the teaching, learning and assessment of what were perceived to be 'softer' skills, including those of interpersonal skills and reflective practice. Recommendations were made for pulling this teaching and learning of 'soft skills' across the whole curriculum, particularly into the more senior years, where practice was perceived to potentially benefit from further integration of interpersonal and reflective skills. Role models were clearly associated with the 'hidden' curriculum. Positive and negative experiences of role models were shared, with opportunities for learning from both, but most compellingly evident was a sense of powerlessness from learners to confront negative role models and effect change within the curriculum. This was also shared to some extent by educators themselves, who reflected that 'good' teaching was experienced as not valued.

The fourth theme of context was divided into a number of different areas of focus that were perceived to impact on professionalism in medicine. Numerous issues related to context more globally were recognised and highlighted by students, interns and educators with many examples being shared related to their experiences in practice and illustrating links to professionalism. These issues including the commercialisation and commodification of medicine, access to information through the internet, social media as a key tool for communication, generational differences, feminisation of the profession, and hierarchy within the profession. The South African healthcare system and its specific challenges, as well as issues of diversity within the patient population, were another two contextual areas of interest that were perceived to impact on professionalism in medicine.

The results from the current study have been described in detail in this chapter. Analysis of the four major themes and their subthemes are analysed against the conceptual framework detailed by Pellegrino, as well as other related literature, in the following chapter.

CHAPTER 5

DISCUSSION

5.1 INTRODUCTION

The aim of this study was to explore how medical students and their educators understand and experience professionalism in medicine within the South African context. The motivation behind this study was to seek clarity on professionalism in medicine in order to inform how it should best be taught, specifically within the South African context. The objectives were therefore to explore how aspects of being or character are understood and experienced; how aspects of doing or practice are understood and experienced; how global and profession-specific changes have influenced its understandings and experiences; how the SA context is understood and experienced in relation to professionalism in medicine; and how it is understood and experienced within the Health Sciences Faculty at UCT. The rationale for specifying aspects of being and doing in the objectives was linked to existing literature that presented a somewhat binary view of professionalism, with aspects of 'being' at one end and those related more to 'doing' at the other end of what can be viewed as a continuum of understandings of professionalism. The conceptual framework that provided a specific lens for examining professionalism in medicine in the current study was based on Pellegrino's virtue-based understanding that is positioned strongly within aspects of being. As described in the literature review, a third area has emerged more recently within the literature on professionalism – that of identity formation (Irby & Hamstra, 2016). It is interesting to note that although this was not a specific objective of the study, aspects related to emerging identity came through as a major theme within the results, giving support to its relevance in understanding professionalism. The objectives that looked to understandings and experiences within global, South African, profession and UCT-specific contexts positioned the study within layers of complexity. This notion of complexity has become more evident, with attention moving increasingly to understanding its influence on professionalism in medicine, including identity formation and that which is hidden such as reflective ability, appreciative enquiry and emotional intelligence (Hafferty, 2018). While studies and literature related to professionalism have increased in the last three to four decades, it has been predominantly the domain of first world countries with relatively little coming out of developing countries, including South Africa. This study therefore adds value to this topic of professionalism in medicine within the South African context.

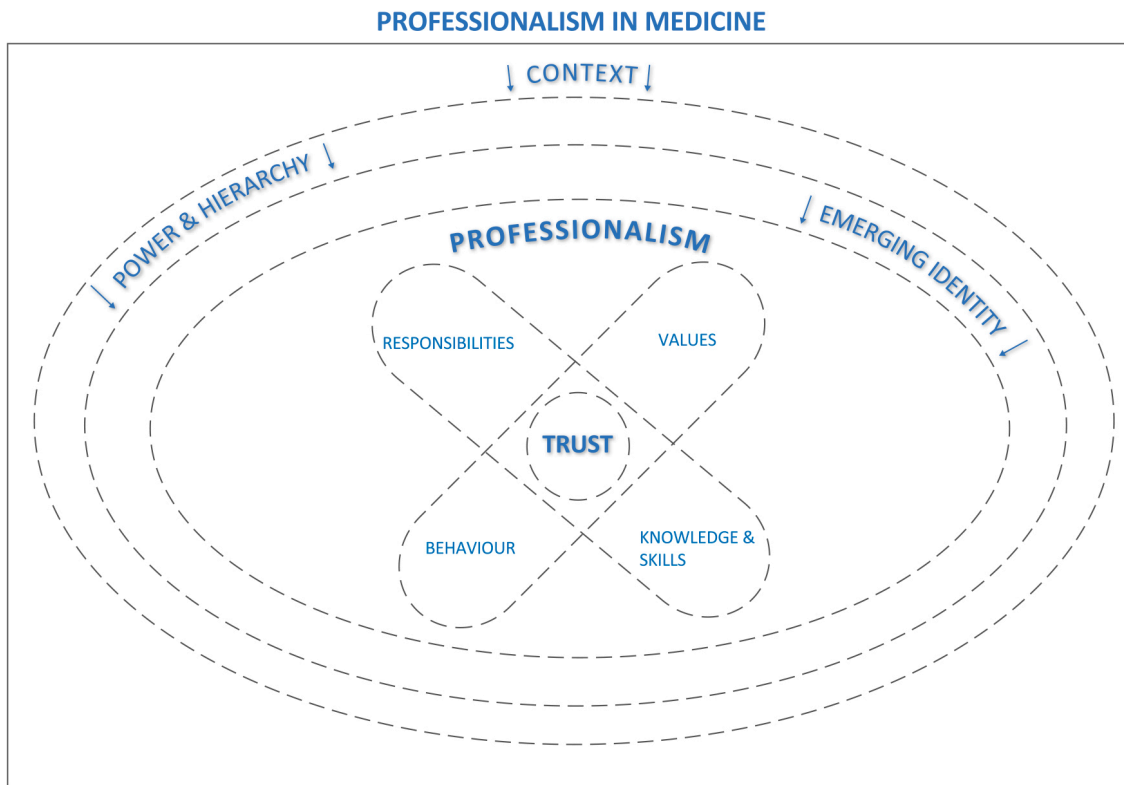
This chapter frames the results of the study presented in the previous chapter against the conceptual framework of professionalism as detailed by Pellegrino and his virtue-based perspective, as well as empirical studies and literature on professionalism. It then moves on to discussion of the process of reflexivity, ending with a review of the strengths and limitations of the current study process.

5.2 FRAMING THE STUDY RESULTS

In contrast to Pellegrino's clearly philosophical view of professionalism as the watchword for the act of profession within a virtue-based perspective, the results of the current study and wider literature tell a somewhat different story. As described in Chapter 4, results from the current study revealed four major themes as well as a range of related sub-themes. These included understandings of professionalism; identity and emerging professionalism; teaching, learning and assessment of professionalism; and professionalism in context. Further analysis of the results against the conceptual framework of Pellegrino's virtue-based view of professionalism, as well as broader literature related to professionalism in medicine, added support to a more complex, layered view of professionalism in medicine. This is illustrated in Figure 5 below.

Starting at the centre of the figure, professionalism is presented as the interplay of different aspects beginning with values, and then moving clockwise to knowledge and skills, behaviour, and finally responsibilities, all linked together by trust as the unifying notion of professionalism at the centre of the doctor-patient relationship. These components of professionalism are deliberately presented as overlapping and without solid lines, reflecting a more inclusive and fluid understanding of professionalism as shared by study participants, rather than the more binary view reflective of wider literature. Concentric circles are seen moving out from the core concept of professionalism drawing attention to the complexity of professionalism and its position within wider factors. The first circle is that of emerging identity, followed by power and hierarchy, and finally context. Arrows are deliberately pointed inwards towards professionalism in order to illustrate their impact on understandings of professionalism. These concentric circles are also illustrated without solid lines, again drawing attention to the more fluid, nuanced understanding of professionalism that emerged through the study.

Figure 5: Professionalism in medicine



What follows is an in-depth exploration of these four key areas of analysis illustrated above including understanding professionalism; emerging identity; power and hierarchy; and context. Each key area is analysed by comparing and contrasting the current study results with the position presented by Pellegrino as well as wider literature.

5.2.1 Understanding professionalism

As described in the previous chapter and illustrated in Figure 4, professionalism in medicine was seen by study participants to include a complex interplay of values, knowledge and skills, behaviour, and responsibilities. In Figure 5 (above), which represents a combined framework of the study results against Pellegrino’s conceptual framework as well as wider literature, these components are again specified as the core aspects of professionalism, but with trust moved from being one of a list of values to being the core of professionalism, and therefore uniting the four aspects of values, knowledge and skills, behaviour and responsibilities.

Trust was identified strongly in the current study across student, intern and educator groupings as the ‘hook’, or cornerstone of professionalism in medicine. Trust is the ‘firm belief in the reliability, truth and ability of someone or something’ (Oxford Dictionary), and can be divided into micro and macro levels with micro referring to interpersonal trust and macro to institutional or ‘faceless’ trust

(Giddens, 1990). The current study results largely focused on the micro interpersonal level, a finding that reflects that of Gilson, Palmer and Schneider (2005), who found that patient trust in providers in South Africa was influenced by interpersonal aspects. Fitzgerald, Collumbien and Hosegood (2010) also found that patient trust in providers depended on the healthcare provider behaving professionally. Russell's study in Sri Lanka (2005) further supported the notion that interpersonal relationships between healthcare providers and patients can influence trust and ultimately the health seeking behaviour of patients. This focus on the interpersonal level of trust in the current study draws attention to its relational aspect that is different from the other domains of values, knowledge and skills, behaviour and responsibilities that incorporate attributes of the individual doctor. The importance of the relational aspect was reflected in the interaction of the vulnerable patient who has to share information with the doctor, while the doctor's contribution to the building of the trusting relationship was seen as linked to the doctor being open and honest about his/ her limitations. The question of whether trust is a given or earned was an aspect that was debated in the current study with evidence of differing views, but the major concern was that trust could be easily lost, a view shared by Gholami- Kordkheili and colleagues (2013).

This view of trust as central to professionalism is aligned with that of Cruess, Cohen, Hilton, Swick, Sullivan and others, including Pellegrino, who describe it as central to the doctor-patient relationship. Sullivan (2000), for example, described trust as giving reality to the social contract and professionalism, bringing attention once again to the interpersonal relational aspect of the doctor-patient encounter. For Pellegrino the trustworthiness of the doctor to do what is right and ultimately good for the patient was seen to be at the core of the relationship (Pellegrino, 1995, 2002, 2012). This reflects the view that for him, trust was dependent very much on the doctor.

Macro institutional trust (Giddens, 1990) was not explicitly spoken of in terms of trust in the current study. Implicit concern was however expressed by participants, particularly by interns who described challenges within the public healthcare system related to resources as problematic. The underlying message was that they felt they could not always trust the institution or system to deliver on its responsibilities for care.

As illustrated in Figure 5, values were the first domain of professionalism. There was extensive support, particularly from students, for professionalism to be associated with who a person is – the 'being' end of the continuum, reflective of Pellegrino's own understanding of professionalism. Respect was seen as consisting of different aspects including respect for patients, respect for colleagues, respect for one's self, but also respect for diversity and difference of these groupings. This resonates strongly with the work of Chandratilake et al. (2010), whose study into the

importance placed by the general public on specific attributes of doctors, found that a three-facet model of professionalism emerged including overlapping domains of clinicianship (interaction with patients), workmanship (interaction with colleagues) and citizenship (interaction with society). This finding echoed that of Van De Camp, Vernooij-Dassen, Grol & Bottema (2004) who divided professionalism into inter, intra and public professionalism, and also that of Cruess and Cruess (2006, 2008), Hilton (2004), Hilton and Slotnick (2005), and Hilton and Southgate (2007) as well as Chin-Yee (2017), who highlighted the intra-personal or intrinsic attributes as core aspects of professionalism. Although Swick (2000) associated professionalism most strongly with behaviour, he too included respect as well as trust as part of his list of the nine behaviours for professionalism. The importance of respect within the current study therefore also reflected that of wider literature on the subject.

Returning to the diagrammatic representation of the results, the second aspect of professionalism was that of knowledge and skills. Study participants prioritised the importance of medical knowledge, but also emphasised inter-personal skills, language, information and counselling, teamwork, and reflection as key aspects of professionalism. Interpersonal skills were strongly linked to patient-centeredness, empathy and compassion, and as reflected above, can be linked to the micro level of trust (Giddens, 1990). Wider literature supports this view, with empathy, compassion, together with technical skill, often seen as the basis of the relationship of trust between patient and doctor (Bain, 2018), and good listening as a key skill for doctors (Masel et al., 2016; Montgomery, 2006). Bain (2018) described medicine “as a virtuous art, (that) fosters empathic listening, emotional sensitivity and the recognition of the uniqueness of each patient, in properly demarcating the patients’ biomedical, psychological and existential needs” (p. 4), a view that resonates with that expressed by Pellegrino. Numerous experiences of poor interpersonal skills were described by study participants, particularly senior students and interns, as being cause for concern, with history-taking, the explaining of information to patients, and counselling of patients reportedly needing attention. Finally, the ability to work in a team was seen as important for professionalism, something not emphasised by Pellegrino, and yet so central to the practice of healthcare, particularly within the primary healthcare approach (Coetzee, 2018).

As illustrated in Figure 5, the third aspect of professionalism was that of behaviour which, in the current study, stressed qualities of dress and presentation. This aspect of ‘doing’ caused the greatest contention, with educators viewing it as particularly important, because they saw appearance as the potential measure by which doctors are judged by the public, while students were largely of the opinion that appearance was overemphasised. There was a strong sense across study participants

that generational differences had resulted in different views of what was considered reflective of appropriate dress and presentation. Students expressed the view that the 'older generation' were more conservative in their views, and that for them conservative appearance equated to professionalism, as opposed to valuing the inner being and overall conduct of the individual practitioner as the basis of professionalism. Despite these differences in opinion across the respondents in the current study, neatness, modesty, cleanliness and being identifiable as doctors were shared criteria for professionalism. The view of the importance of being identifiable adds support to the study by Finn, Garner and Sawdon (2010) of student perceptions of professionalism at two UK medical schools, where it was found that students attached value to clothing as a means of identifying themselves as doctors and professionals.

The fourth aspect identified in the figure was that of responsibilities. The current study results included the need for a code of conduct, informed consent, having adequate resources, enough time, acknowledging limitations, and taking responsibility for reporting breaches or lapses in professionalism. Interns in particular shared thoughts and experiences about the realities of how limited resources and time could impact on professionalism in their experiences of practice, and also emphasised challenges with reporting a lack of professionalism in senior colleagues, a concern further shared by senior students. These concerns link once again to the central aspect of trust. There was also importance attached to the need to recognise one's own limitations, a view shared by Pellegrino. This was further linked to taking responsibility for reporting unprofessional or inappropriate behaviour. In studies by Teplitzky (2002) and Scheers and Dayton (1987), a comprehensive list of breaches of professionalism by students while at university was detailed, including issues such as plagiarism, falsifying information and cheating. This is of particular concern because breaches of professionalism at university have been widely reported to be indicative of breaches in later practice (Papadakis, Hodgson, Teherani & Kohatsu, 2004). A code of conduct and the taking of the Oath were viewed in the current study as a way of potentially promoting professionalism. In a study by Sattar, Roff and Meo (2016), differences in opinion between faculty and students about appropriate sanctions for breaches of professionalism were revealed, reflecting a difference between faculty and students about what constitutes professionalism in medicine, and clear motivation for the need for a shared understanding.

A related aspect of understanding professionalism was that of ethics. This was an area that lacked clarity in the current study, with varying views on the relationship between ethics and professionalism being shared. For Pellegrino and his situating of professionalism within virtue-based ethics, the two are inextricably linked, but elsewhere the relationship between the two is viewed as

more complex, with some even arguing that doctors do not have the moral reasoning and ethical theory to adequately engage with these existential questions, and should therefore avoid the risk of taking any sort of moral or ethical stance (Salloch, 2016; Vogelstein, 2016).

As described above, areas of alignment were evident between Pellegrino's understanding of professionalism and the current study. These were most apparent in the framing of trust and associated values, and the importance of doctors recognising their own limitations, all aspects important to 'being'. Differences were however also evident. Trust was identified as the core of professionalism, and areas beyond those of values were clearly identified under the domains of knowledge and skills, behaviour and responsibilities. These areas brought attention to the need within the current study for a more practical, measurable, behaviour-based understanding of professionalism to be given equal attention with values. This particularly reflected the position of educators who were tasked with assessing professionalism. They also brought attention to the concept of professionalism as a complex notion.

5.2.2 Professionalism and emerging identity

As illustrated in the diagram, a series of concentric circles surround professionalism, indicating that a range of aspects influence this core understanding of professionalism. The first of these circles is that of emerging identity. As described in the Literature Review, there has more recently been a shift towards including emerging identity, or the journey from student to professional, as a third framework for understanding professionalism in medicine (Irby & Hamstra, 2016). This process of socialising learners is described as taking place through integration and participation in medicine's community of practice, through teaching and learning within the formal curriculum, and through the observation of positive role models (Cooke et al., 2010; Cruess et al., 2014). Implicit in this understanding is that professional identity is acquired over time as students are assimilated into the community of practice of medicine (Monrouxe, 2016; Shaw et al., 2018; Wenger, 1998) through a process of individual and collective socialisation (Jarvis-Selinger et al, 2012).

Returning to Pellegrino, he understood personal and professional identities as indivisible because, for him, a doctor needs to be a virtuous person, someone of strong moral disposition whether in their professional or personal life. The current study results revealed a more complex picture, with some support for Pellegrino's view of a virtuous, moral identity as intuitive, and some support for identity formation being part of a journey from novice through to professional. Where students, interns and educators viewed professional and personal identity as one, the role of doctor was understood to be an all-encompassing commitment with no room for the division of professional

and personal identities. The contrasting experience of professionalism as being part of a journey was aligned with the view that skills, behaviour and responsibilities of professionalism can be learnt.

Although Pellegrino saw professionalism as part of one's personal and professional being, he also acknowledged the role of medical school and medical education as potentially influencing the further development of the virtues associated with professionalism. Medical education in its broadest sense is "about the transformation of the self into new ways of thinking and relating. Helping students form, and successfully integrate their professional selves into their multiple identities, is a fundamental of medical education" (Goldie, 2012, p. e647). In terms of formal teaching, Pellegrino was of the opinion that medical schools need to take responsibility for what they teach, but that ultimately each individual must take responsibility for their own 'moral compass' (Pellegrino, 2012). He recognized the value of lectures and courses in ethics and humanities, and the integration of critical reflection as opportunities for engagement with issues of professionalism over students' years of study (Pellegrino, 2002). The current study adds support to the value of teaching and learning of professionalism through the formal curriculum. Emphasis was placed on the formal teaching and learning of empathy, listening and reflective skills, as well as opportunities for learning to work in small groups and teams. There was also the suggestion that these skills be carried through iteratively from the early years into the more senior years, and that they be valued more explicitly by educators across the curriculum. In a study by Monrouxe, Rees and Hu (2011), it was found that students differed in their understandings of professionalism across years but also across different teaching contexts. Interesting however was that where early patient contact and conversations about professionalism were part of the formal curriculum, students had a more complex understanding of professionalism, as opposed to those students who were exposed to a purely lecture-based programme. This was also reiterated in a descriptive case study of radiography students that supported the need for a clear understanding of professionalism that reflects more than a tick list of do's and don'ts with more time for reflective thinking that can impact behaviour (Nortje & Hoffmann, 2018).

The hidden curriculum was however the aspect that came through most strongly in the current study in terms of its impact on emerging identity and professionalism. Positive role models reflective of the hidden curriculum were seen as important in professional identity formation, a view shared by Goldie (2012). Students and interns shared a range of experiences related to role models, from positive to what they perceived to be widespread negative role modelling of professionalism. The current study's emphasis on role models as sources of learning of professionalism added support to Pellegrino's position that the teaching and learning of professionalism takes place through "practice

and that the best practice is to follow a model of the virtuous person” (Pellegrino, 2002, p. 383). He saw ‘virtuous’ role models as central to the teaching and learning of professionalism, but he also believed that negative experiences could potentially shape student behavior in both positive and negative ways (Pellegrino & Thomasma, 1993), a view shared by students in the current study, and further supported by results from the 2007 study at the University of Pretoria (du Preez, Pickworth & van Rooyen, 2007). Passi and Johnson (2016) drew attention to the fact that role modelling is both a conscious and a subconscious process. They conducted focus group interviews with students, and interviews with consultants and students, to identify specific phases from exposure to the modelled behaviour, to evolution that includes judgement of the value of the behaviour, and then model-trialling that ultimately result in the assimilation of behaviours. Based on concerns about the potential influence of negative role models, du Preez et al. (2007) recommended that a charter of principles and commitments for professionalism be created that could ultimately provide clear guidelines for professionalism for students as well as faculty and clinical role models (du Preez et al., 2007).

Students in the current study were of the opinion that the Faculty provided a good grounding for professionalism, but reflected concern that Faculty put too much emphasis on superficial aspects of dress and presentation, and not enough on the deeper more important values and behaviours of professionalism. Students were clear that a shared understanding of professionalism needed to be carried through the curriculum, and that professionalism be explicitly taught, a view shared by Paice, Heard and Moss (2002), who recommended peer group discussion as a useful method. They also drew on Wright and colleagues (1998) in identifying the most important qualities of role models, including having a positive attitude towards juniors, showing compassion for patients, and demonstrating integrity (Paice et al., 2002). Role models are discussed again in the next section on power and hierarchy.

Although assessment of professionalism attracted limited interest within the study, support was evident for professionalism to be measurable and integrated throughout the curriculum, particularly from an educator perspective. How this should be done remained largely unanswered, but it has been given increased attention in the wider literature (Wilkinson, Wade & Knock, 2009). Delpont, Kruger, Van Rooyen and Pickworth, for example, described the usefulness of an outcomes based approach for the teaching and assessment of professionalism at the University of Pretoria (2015). Reflective writing has been identified as a powerful means of supporting professional identity formation and assessment (Wong & Trollope-Kumar, 2014). Making use of Miller’s pyramid (1990) to

assess different levels of outcome has also been described as potentially useful in shifting attention from 'knowing' to that of 'doing' and therefore that of demonstrating professionalism (Burch, 2015).

The importance of emerging identity was further emphasised in the current study in relation to who applies to study medicine, and who is selected. These were not areas explicitly addressed by Pellegrino, although the implication in his writing was that individuals who are selected to study medicine should be people of virtue, suitable to join the 'moral community' of medicine. He did not however say how this selection should be done, although he was in favour of medical students first doing a prior degree before entering medicine, a position supported by some of the first year student participants in the current study. The challenge of selection has been the recognition that no single tool can entirely predict future behaviour and professionalism (Bagg & Clark, 2017).

There was clear support within the current study for professional identity formation being an important aspect of professionalism in medicine. This is a shift from Pellegrino who saw professional and personal identities as indivisible, and reflects the complexity evident in Figure 5. The importance of formalising educational opportunities within medical curriculum was also highlighted in the current study. A point of similarity between the current study, Pellegrino, literature and studies on professionalism, was that of the hidden curriculum and role models as critically important in the development of professionalism. Some attention was also given within the current study to assessment of professionalism, an area not focused on by Pellegrino.

5.2.3 Professionalism, power and hierarchy

The second circle in the diagram is that of power and hierarchy. Pellegrino's view was that doctors are members of a moral community, but that they also have extensive power and therefore need to pay attention to the moral direction of the profession (Pellegrino, 2010). Issues of power and hierarchy were of greatest concern to him in terms of the doctor-patient relationship and what he saw as the power imbalance inherent in this relationship. He viewed this imbalance as existing because when patients find themselves in need of help, they are at their most vulnerable and dependent. He therefore took exception to the use of terms such as consumers, because of this uniquely vulnerable state of the patient who is not just accessing a commodity (Pellegrino, 2012). The current study shared this concern about the difference in power between doctors and patients, specifically described as linked to differences in knowledge and experience, and how some doctors were seen, at times, to treat patients in a paternalistic way, particularly when interacting with persons from lower socio-economic circumstances. Power and privilege are reflective of South Africa's history of legalised discrimination demonstrated through colonialism and apartheid, but

these issues themselves are not unique to South Africa. Concern for the power differential between doctors and patients was central to Freidson's (1988) work on professions, and his concerns about the impact of power through issues particularly of status that he saw as so much a part of medicine. Although it was a lesser shared notion, it is significant that some students perceived their patients as associating doctors who are white, male and speaking English as synonymous with professionalism, a notion that can be understood as reflecting a colonial stereotype of medical practice.

Pellegrino was further concerned about medical schools' enormous power to positively and negatively impact on medical students (Pellegrino & Thomasma, 1993). This concern about power and hierarchy within the faculty was also expressed within the current study, particularly related to the hidden curriculum and role models, as described in the previous section on identity. The number of empirical studies related to the hidden curriculum have increased over the past few years with studies focused on gaining an understanding of hidden curricula (Azmand, Ebrahimi, Iman & Asemani, 2018; Crowe, Clarke & Brugha, 2017; Gauferberg, Batalden, Sands & Bell, 2010; Lempp & Sealle, 2004; Malpas, 2011). Iranian undergraduate students for example participated in interviews in order to determine elements that affect student professionalism at the bedside. Experiences of hierarchy and role modelling were two aspects that stood out as significant (Azmand et al., 2018). Student experiences of being torn between what they are told is appropriate and what they see being modelled is echoed more widely in literature on professionalism (Lempp & Sealle, 2004; Malpas, 2011). An example is that of a study conducted with third year medical students at Harvard Medical School, where power and hierarchy was one of the main concerns shared in student reflections on their experiences. The issues were primarily linked to student-educator and patient-doctor relationships, with students reflecting feeling "disempowered and disrespected... (with) intense pressure to 'know their place' in the medical hierarchy" (Gauferberg et al., 2010, p. 1711). This is further evidenced in the study by Crowe et al. (2017), who interviewed 50 doctors who were going through specialist training in Ireland and shared experiences of "hierarchy, anger and fear, intimidation, and disillusion" in their training with senior colleagues (p. 70). These feelings of powerlessness, intimidation and humiliation in the face of negative role models and negative experiences were also shared in the current study, especially by final year students. This was also highlighted in Hafferty's paper in which he drew attention to the 'politics of inclusion and exclusion' and the need to better understand how formal and hidden curricula result in heteronormativity and minimal attention to marginality (2018). For many students, these feelings of powerlessness were linked to the idea that their grades would suffer if they complained.

The current study also focused on issues of power and hierarchy within the healthcare team, particularly those described by interns in their experiences with medical officers. Power dynamics were reported positively when support was given, but negatively when a definite hierarchy was evident in the team and unequal relationships were experienced. This dynamic within the team was seen as an extension of the hierarchy and power dynamics between doctors and medical students, running from consultants to registrars and then on to interns and students. This was also reflected at the Canadian Medical Association's annual general meeting in 2017, where bullying and intimidation were called out as serious issues within professional practice and within the training of doctors, and described as part of the culture of the profession (Vogel, 2017). Medical students from UCT were surveyed in 2009. Of the 223 student respondents, 183 (82%) reported having witnessed patient rights abuses and professional lapses by nurses, midwives and doctors. Students attributed the abuses to "stressed health workers, overburdened facilities, and disempowered patients" (Vivian, Naidu, Keikelame & Irlam, 2011, p. 1). This survey says a great deal about what is going in the healthcare system, but also what students are being exposed to in their training. Critical incident techniques that offer students the opportunity to give feedback on aspects of professionalism and performance to doctors have reportedly been used successfully in assisting doctors to improve their own professionalism (Albardiaz, 2012). This has the potential to break down some of the hierarchy experienced by students.

Shaw et al. (2018) have made an interesting contribution to the understanding of the impact of experiences of lapses of professionalism, evidenced through the demonstration of power and privilege, by drawing on work by Monrouxe et al (2017) and Edmonson (2010). Shaw described how students potentially responded to experiences of witnessing lapses in professionalism with emotional desensitization and increased distress, but also with that of resistance. The current study reflected more distress rather than desensitization on the part of students, whereas interns seemed to be reflecting desensitization as illustrated in the example of the intern who felt overwhelmed and frustrated by patients with HIV/AIDS. The student movements at UCT described in earlier chapters could be seen as examples of resistance (Mangcu, 2017). As Draper and Louw (2007) concluded, a lack of congruence between individual and institutional values and beliefs can lead to resistance on the part of students, which is certainly being experienced increasingly at UCT (Hodes, 2017; Mangcu, 2017).

In the 2016 study at the College of Medicine at the King Saud University in Saudi Arabia, students and faculty members were asked to comment on what they viewed as appropriate sanctions for potential lapses in professionalism. What emerged was that there were divergent views about what should be done, that reflected varying understandings of professionalism across students and faculty members. What was clear was that a shared understanding was needed (Sattar et al., 2016), which is exactly what was being addressed in this study. Kohn, Armstrong, Taylor, Whitney and Gill (2017) reported on a cross-sectional study designed by medical students in Houston, Texas in which barriers to reporting of unprofessional behaviour were researched. Results revealed that 70% to 90% of students were likely to report major violations, but that less than 30% were likely to report minor or moderate transgressions. Barriers to reporting reflected that of previous studies, and included students feeling uncomfortable to report given their position within the existing medical hierarchy, as well as concerns about possible negative repercussions on grades or future opportunities, a view reflected in the current study. Recommendations from the Kohn et al. (2017) study included that methods of reporting be simplified with improved feedback on any reporting, and that a neutral group be set up to assist students in managing their concerns.

Power and hierarchy came across as a major concern within the current study. This reflected Pellegrino's concern for dynamics within the doctor-patient relationship, but also other aspects of student-faculty experiences, and experiences of hierarchy within the healthcare team. Attention to these key areas was clearly evident more widely with the increase in studies about power and hierarchy and the attention being given to solutions.

5.2.4 Context and professionalism

The outer-most aspect illustrated in Figure 5 is that of context. Again, arrows link this key aspect to the other areas that impact on professionalism. Pellegrino expressed on-going concern about the changes he had witnessed in the practice of medicine, particularly the shift towards commercialised business models of healthcare with a focus on profit. For him, key areas of concern further included "the malpractice crisis; the excessive income and free-spending lifestyle of some physicians; the bottom-line, the marketplace, the 'pay before we treat' policies of hospitals and some doctors; the depersonalization of large group prepayment practices; physicians' growing preferences for 9 to 5 jobs and time off; the retreat from general to speciality practice; the early retirements" but he also saw this list as growing (Pellegrino & Thomasma, 1993, p. 712). In Pellegrino's writing, contextual change is consistently viewed in a negative light, resulting in what he referred to as an ethic of distrust within medicine (Pellegrino & Thomasma, 1993), and presenting a perspective that is historical in orientation rather than forward-thinking.

While Pellegrino's writing represents a more western perspective, his concerns about professionalism in medicine can also, to a large extent, be seen as reflective of the South African context. Current study participants echoed concerns expressed by Pellegrino about the commercialisation of medicine and its potentially detrimental effect on the practice of medicine. Concern was that medicine is increasingly becoming a commodity to be bought and sold, with some doctors making money and status their priority rather than the well-being of their patients. The drive for profit and efficiency were seen as being prioritised, with implications for how much time and how many available resources could and should be spent on patients. This commercialisation and focus on profit was also seen as problematic by Hafferty and Castellani (2010), and Benatar (1997, 2013). Pellegrino (1985) described this tension between self-interest and altruism as the central paradox in medicine, and believed that ultimately doctors needed to choose between 'doing good' and pursuing profit (Geraghty, 2001), an area with which some students also seemed to struggle.

Communication and access to information, including social media, increased access to information via the internet, and other information and media platforms such as television and newspapers was an area that study participants focused on as having implications for professionalism in medicine. Social media attracted great interest, as it was reported to be integrated not only into the personal lives but also into the professional lives of students and doctors, and was viewed as both beneficial and detrimental in relation to professionalism in medicine. Study participants valued the benefits of social media, including being able to share and access information quickly, gain support in what was perceived to be a supportive space, and communicate more effectively and efficiently particularly within healthcare teams. These benefits have also been reflected as valuable more widely (George et al., 2013; Gholami-Kordkheili et al., 2013). Study participants however acknowledged detrimental aspects such as lack of clarity about the line between what is appropriate and that which is inappropriate in a professional setting. The privacy and confidentiality of patients and their families as well as that of doctors and students was seen as concerning, with a call for clearer parameters to facilitate more responsible use of social media platforms, a position also reflected in wider literature (Brown et al., 2014; Chretien et al., 2011; Jain, 2009; Mansfield et al., 2011). An example is that of a study of medical students' and residents' observations of professionalism at a Canadian University, where there was extensive concern about on-line posting, and the recommendation was that it needed to be addressed (Spiwak et al., 2014). A further study of medical students conducted by Finn et al. (2010) revealed that students believed that society was struggling with distinguishing between the identities of doctors as individuals and as professionals, and that this was further exacerbated by social media such as Facebook.

Having access to the internet was another area that was seen in the current study to have positive and negative effects, as information could be gathered quickly and easily but with the challenge that it may not be accurate or properly understood by patients, who may be motivated to challenge their doctors' diagnoses, a view also shared by Gabbard (2018). Despite these concerns, the use of technology and social media were recognized as integral to medical practice, lending support to the views of the power and usefulness of technology and social media expressed by Snyder (2011). These issues are reflective of varying contexts including that of South Africa.

Two components emerged within the current study that were viewed as reflective and unique to the South African context with perceived implications for professionalism. These included the South African healthcare system, and the South African patient population. The South African healthcare system was understood to be challenged by an ever-increasing public-private divide, with the public sector described as less than optimal, a view shared by student participants in the 2007 study at the University of Pretoria (du Preez et al., 2007). Limited resources, including being short-staffed, and a lack of supplies in the public system were examples of experiences of this divide described in the current study, particularly by interns, and in the study by du Preez et al. (2007). This has also been reflected more widely, with concerns about the abuse of the privilege of hours of remunerated work outside public service, and the fact that some doctors take on more private work than allowed to the detriment of their public service patients, colleagues and students in training (Benatar, 2014), a concern that was reiterated in the current study. These issues were seen as resulting in doctors, particularly in the public health system, feeling demotivated and that their practice of medicine was being compromised. These factors were viewed as impacting on the 'baseline of professionalism' in medicine in South Africa.

The South African patient population was understood and experienced by study participants as diverse and complex. Patients from lower socio-economic circumstances were seen to be particularly vulnerable because of the often impoverished circumstances in which they lived, and different cultural practices and languages were seen to add to the complexity of the communities in which doctors' practice, a situation also reflective of the heterogeneous makeup of the South African medical profession. Challenges were identified such as doctors not necessarily being aware of culturally appropriate interactions or being unable to speak the languages of their patients, making it more challenging to demonstrate the respect required of doctors in their interactions with patients and communities. A further challenge within the South African context was that of the prevalence of HIV/AIDS. As reflected in the results section, interns reported challenges to their professionalism in working with patients with HIV/AIDS. This was linked to feelings of being overwhelmed by the scale

of the problem and frustration with patients who seemed to contribute to the spread of the virus. Although reflecting a South African developing world experience, this diversity of student and intern experiences of their patients, and the communities in which they lived, supported the findings shared in a study in Australia at the Sydney University School of Medicine, which identified the need to move beyond individually-focused understandings of professionalism to incorporate socio-cultural aspects of professionalism in medicine (Langendyk, Mason & Wang, 2016).

Another South African contextual issue that was reflected by study participants was that of the changing context of the country post the 1994 elections and establishment of democracy in South African. The constitution and particularly human rights reflected in the 'South African Bill of Rights' were seen to have had a positive impact with both doctors and patients having a clearer understanding and expectation of one-another's rights, an aspect that can be seen to be reflective of Figure 1, the Social Contract between Medicine and Society (Cruess, 2006).

Literature on definitions and understandings of professionalism are usually taken from a western context, and this western hegemony is typically seen as applicable across different contexts, a view that Pellegrino for one did not challenge. Increasing evidence is coming forward in support of the need for context-specific understandings of professionalism. In a study done with students in Taiwan and Sri-Lanka, some overlaps with western notions were evident but some distinct aspects were also evident. Dominant in the Sri Lankan understanding was individual attributes and rules which could be seen as reflective of colonial history. In contrast, professionalism in Taiwan was dominated by knowledge and patient-centeredness (Monrouxe, Chandratilake, Gosselin, Rees & Ho, 2017). In the case of South Africa, a study was done by Van Rooyen and Treadwell (2007) in which they asked 5th year medical students at the University of Pretoria to comment on the applicability of the Charter on Medical Professionalism for the South African context. What was evident was a greater focus on humanistic aspects of professionalism which were not part of the Charter. They recommended that a shared definition be created specifically for their faculty that was acceptable to both students and faculty. This view of the need for a shared view of professionalism that also reflects the context appropriately, is a view consistent with that in the paper by Jha, McLean, Gibbs and Sandars (2015). While the current study participants recognised some aspects as uniquely South African, they did not express concern that this context might need to be taken into account when understanding professionalism. This may be reflective of a Eurocentric focus within the teaching and learning at the FHS at UCT.

Concerns related to context were highlighted by Pellegrino, within the current study, and within literature more widely. The impact of commercialisation of medicine, social media and the internet,

but also the South African healthcare system and population with its complexities were seen as key areas of focus. These aspects together with the layers of emerging identity, and power and hierarchy formed the circles that highlighted the complexity of professionalism in medicine.

5.3 REFLEXIVITY

As detailed in the methodology chapter, bias on the part of a researcher is of particular concern when using a qualitative methodology, because of the collaborative nature of the research process (Finlay & Gough, 2003). Reflexivity is important for increasing the trustworthiness of the research findings and as a way of improving the reliability and credibility of the research (Finlay & Gough, 2003; Mays & Pope, 2000). Reflexivity implies a more personal engagement with the process of establishing trustworthiness. This section is therefore written in the first person, allowing for deeper personal engagement with areas that may impact the trustworthiness of the study.

I turn now to my journey through the PhD study process. As described in the introduction, I have had the privilege, since 2002, of convening the two first year courses that include professionalism as a key outcome. One of the biggest challenges of designing curricula related to the teaching, learning and assessment of professionalism in medicine has been the lack of a shared understanding of professionalism across the faculty. In approaching colleagues and students informally over the years, it was evident to me that there were very different views about what professionalism encompasses, from a being to a more doing focus, as well as different views on how it should be assessed. For the most part, it seemed that colleagues were including criteria related to professionalism within practical assessments but without explicit criteria as to what it actually encompasses. The assumption seemed to be that 'we all know what it is'.

As my own understanding and insights about professionalism in medicine increased in the lead up to and during this study, and I engaged more with literature on professionalism, it became abundantly clear that professionalism is generally poorly understood. No one shared understanding within the faculty or within the literature on professionalism was evident. Colleagues Madeleine Duncan, Trevor Gibbs and I had designed a framework called the 'Integrated Health Professional' (IHP) (Olckers, Gibbs & Duncan, 2007), in which knowledge, interpersonal skills and reflective practice are presented as being equally important areas of focus for professionalism. This framework provided me and the BP and BHP courses with 'hooks' for the teaching, learning and assessment of professionalism, by drawing attention to the 'soft' interpersonal skills as well as the more reflective intrapersonal skills of medical practice. Notwithstanding its usefulness, the core question remained – 'what is professionalism?' This provided much of my motivation for this study.

In 2011 I attended a course on bioethics at Georgetown University. My interest was obviously linked to that of professionalism and questions associated with, what I perceived to be, links with ethics. Edmund Pellegrino was one of the course facilitators and speakers. I had already been reading widely around his subject area of virtue-based ethics but became particularly interested in his work after attending the course. Despite what I felt to be the somewhat antiquated terminology associated with virtue-based ethics, the work resonated strongly with me. I could see the importance at faculty level of having to measure professionalism, but Pellegrino offered a lens into the moral basis of medicine at a time when voices concerned about decreasing professionalism in medicine were becoming louder. This is important to acknowledge as, while I consciously moved into a researcher role, my personal views sit strongly with professionalism as embedded within the values or virtues of a moral being because I believe that doctors should be ethical, moral and essentially virtue-based in their professional and personal lives. I therefore had to be very careful not to make Pellegrino the 'hero' of my work and to rather see his work as needing interrogation. I was careful to take on the role of engaged, active listener rather than sharing any personal opinions in the interviews and focus groups discussions. I deliberately floated ideas from the guide questions that drew on understandings of professionalism that reflected both being and doing, and facilitated the focus group and interview processes so that my own opinions were not foregrounded.

My role as convenor of the two first year compulsory courses related to professionalism meant that the students who participated in the study knew me from their first year in the FHS, and had all been part of my courses, while the educators who participated knew me as their colleague. A process of functional reflexivity (Wilkinson, 1988) was therefore of particular importance, as issues of power and status needed to be acknowledged (Finlay & Gough, 2003). Given my role and responsibilities in the faculty, I was very careful to approach students and interns in a manner that made it clear that there would be no benefits or negative repercussions of participating, or not, in the study. After the focus groups and interviews, I was very careful not to draw attention to individual's participation or any information that they may have shared. I spoke about the study purely in terms of its results as shared by the collective and not by individuals.

Before beginning the process of data collection, I was interviewed by my one supervisor. As described earlier, a summary of this interview can be found in Appendix 6. At the time of the interview my motivation for embarking on this study was to gain clarity on the subject and to develop a clear understanding of professionalism. I acknowledged my position as convenor in the faculty but also of feeling like an outsider because of my own background in social work rather than medicine. I shared that I saw professionalism as linked to the IHP and the domains of knowledge,

empathy and reflective practice, but acknowledged that literature seemed to be divided, with different areas of focus including that of emerging identity that was in its infancy at that time. I expressed interest in why it was that different understandings had emerged and speculated that these might be linked to personal value systems, diversity regarding social and cultural factors, different experiences over time, and what was taught at university particularly as reflected in interactions with role models. I acknowledged my own limited knowledge of studies and other literature related to professionalism. I saw professionalism in the South African context as needing to give attention to aspects of social justice, and expressed concern for a society that expects to pay for healthcare. I also expressed concern about medico-legal aspects that were arising that were drawing attention to professionalism. Ultimately my motivation for engaging in this study was expressed as wanting to 'untangle the mess' that I perceived to reflect the confusion around professionalism in medicine.

Reflecting on my journey through this study process, there is no doubt that my own knowledge has increased through extensive engagement in the topic, and particularly through the process of collecting and analysing the data gained through the interviews and focus groups. My own understanding has settled around an acknowledgment of professionalism as a multi-faceted and complex notion that cannot be understood in isolation from wider contextual issues. As I read the summary of the interview, I am struck by my emphasis on social justice, which surprisingly did not emerge as a theme linked to professionalism in the data. Rather, professionalism was linked to more discrete individual values, knowledge, skills, behaviour and responsibilities, which reflect the current teaching of professionalism within the FHS at UCT, but also possibly reflect the line of questioning that was used that drew attention to understandings within the continuum of being and doing. Despite this focus, however, participants in the study clearly positioned professionalism within wider issues of identity, power and hierarchy and context, reflecting the complexity of professionalism.

This process of reflexivity has highlighted issues that I feel are pertinent to this study process, and need to be acknowledged as I endeavour to increase the trustworthiness of the results and my own interpretive process. Further aspects of trustworthiness are detailed in the following section that explores the strengths and limitations of the study.

5.4 STRENGTHS AND LIMITATIONS

In order to evaluate the strengths and limitations of this study, it is useful to return to the six criteria that ensure trustworthiness including that of reflexivity detailed above. Other factors include triangulation, member checking, clear description of processes, attention to negative cases, and fair

dealing (Mays & Pope, 2000). Beginning with triangulation, within the current study, methods of interviewing and focus groups were used, and data was gathered across different groupings of different years of students, interns and educators to ensure triangulation. This was a strength of the study as three groupings of participants were included – students, interns and educators – thereby facilitating wider exploration of the topic from different perspectives, and increasing the trustworthiness of the study (Guba & Lincoln, 1989; Stiles, 1993). Interviews and focus groups were conducted with six educators, four interns and 66 students. A shortcoming regarding participation was that the distribution of students was not equal across years, and only four interns were able to participate. While focus groups had been planned for the interns, this had to be changed to interviews. Despite this change, the intern participants were engaged and shared deep reflective insights. A further limitation was that the study was conducted within one specific context. While depth of detail was ensured, triangulation across different settings was not possible.

In the current study, member checking was not done directly with participants but rather through the detailed checking of all transcribed data. A clear description of the processes was followed throughout, including the recording of reflective and logistical notes after each interview or focus group. This helped to provide an audit trail for the credibility of the research. Something that may be interpreted as a short-coming was that interviews and focus groups were conducted by the researcher implying a potential for increased subjectivity. This can however also be seen as a strength because of the benefit of being immersed in the study and familiar with the participants and subject area.

Negative cases or data that seemed to contradict other voices were given particular attention in order to search for different potential meanings. This data was reflected in terms of lesser notions or ideas. Finally, fair dealing was possible though the inclusion of a range of voices – from first year to final year students, to interns and educators. Students were sourced from different years and therefore reflected a longitudinal view of professionalism in medicine across different years within the MBChB degree. They however self-selected. This meant that they chose to be part of the study because they had something to share or potentially because they hoped to gain something from participating. Although it was made very clear that there were no benefits to participating, it is possible that students thought differently and believed there could be benefits to participation, which could have had implications for fair dealing.

The above steps helped to ensure the quality and trustworthiness of the qualitative research process (Mays & Pope, 2000). An item worthy of mention was the qualitative nature of the study. It meant that meaning could be explored in depth, which was clearly a strength of the study.

Reflecting on the overall strengths and limitations of the study, and what could be done differently in future, would be the inclusion of face to face as opposed to telephonic interviews for all interviews. Of the four intern interviews that were conducted, two were telephonic as these interns were working in remote, less accessible areas. Their participation in the study added significant value as they were able to reflect on their years within the FHS and the usefulness of the teaching and learning of professionalism they received. They were also able to reflect on the relevance of this teaching and learning for practice as interns working in diverse settings. The depth of the interviews was however limited by the researcher not being able to follow their body language and by poor, intermittent quality in the telephonic connections. It would certainly have added value to the study to have had face to face as opposed to telephonic interviews with all participants, and this is something that should be considered for future research.

CHAPTER 6

RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

The question of student, intern and educator understandings and experiences of professionalism has been explored against the backdrop of Pellegrino's conceptual framework of professionalism as well as more extensive literature on the subject. The thesis study is drawn to a close in this final chapter with the presentation of recommendations and the final conclusion.

6.2 RECOMMENDATIONS

Having explored professionalism in medicine from the perspective of students, interns and educators against the backdrop of wider literature on the subject, certain recommendations have become apparent. These are presented as those most relevant for the FHS at UCT and medical education more generally, and areas for potential research.

6.2.1 Recommendations for FHS, UCT and medical education

The current study has concentrated specifically on the FHS at UCT, and therefore the recommendations that follow are primarily focused on this specific context. The recommendations could however be seen as relevant and useful for other health science faculties and medical schools globally. Five key recommendations are detailed below including the need for a shared understanding of professionalism, focus on formal curricula design and assessment methods, the hidden curriculum, lapses in professionalism, and selection of students into medicine.

6.2.1.1 Create a shared understanding of professionalism

Firstly faculty, including both staff and students, needs to actively engage with professionalism and what it means with the goal of creating a shared understanding of professionalism. As will have become apparent from the literature and results of the study, there is currently no one shared understanding of professionalism in medicine. In order for faculty to move forward with plans for a shared understanding that can help to guide the outcomes, activities and assessments related to professionalism in medicine, faculty leadership will need to acknowledge the value and importance of a shared understanding of professionalism. A participatory process will need to be negotiated with staff and students, resulting in an inclusive and representative understanding of professionalism in medicine. A useful starting point could be Figure 5 that represents the results of

this study and wider literature. The components, as described in the results, could be used as a more detailed reference point for discussion. The focus on professionalism as a doctor to individual patient notion should be expanded to include doctors taking responsibility for improving healthcare for society as a whole, particularly in the South African context of deep inequality (Kling, 2017). An important proviso will need to be that any understanding of professionalism and its parameters be seen as ever-changing and therefore needing regular review. Contextual factors including changes inherent within society will need to be acknowledged and debated on an ongoing basis, resulting in an understanding that is always current and reflective of change. Another potential starting point for engaging with the need to have one shared understanding of professionalism could be the Oath taken at graduation. The Oath is the formal declaration of professionalism, and whether used as a starting point or not, will need to reflect and embrace the understanding of professionalism that is deemed reflective of faculty values.

6.2.1.2 Revisit formal curricula design and assessment methods

Having decided what professionalism means for the faculty, attention will need to turn to the formal curriculum and how best to imbed the teaching, learning and assessment of professionalism within the formal curriculum. The participatory process of creating a shared understanding of professionalism (described in 6.2.1.1) should ideally be followed so that faculty staff and students are included in the process of developing curricula and assessment instruments thereby facilitating buy-in to a shared understanding and experience of professionalism. Drawing on the model based on the current study (Figure 5), specific areas of values, knowledge and skills, behaviour and responsibilities will be potentially useful. This will need to include horizontal and vertical engagement with curricula across and within years of teaching, with a focus on the alignment of outcomes, activities and assessment methods through a combination of approaches that are measurable (Hodges et al., 2011; Stern, 2006), and give attention to individual, interpersonal, institutional and wider societal level aspects of professionalism (Rimal, 2018). An idea may be to implement near-peer learning for medical students, as has been done at Queens University in Canada (Cusimano et al., 2018). In this style of learning, senior students selected students from within their class who they considered models of professionalism and they were then selected to run group activities with junior students. Responses from both junior learners and senior student teachers were extremely positive, revealing a more complex understanding of professionalism from each grouping. Another idea is to explore the explicit integration of a stage appropriate golden thread for professionalism, drawing on ideas and experiences used at the University of Pretoria using both cognitive and experiential learning outcomes (du Preez et al., 2007). The Langendyk et al.

(2016) study results from Western Sydney School of Medicine could also be useful for this process, where an iterative, theory-led curriculum focused on personal and professional development (PPD) was created, that made use of transformational learning theory that includes instrumental task-orientated problem solving learning, as well as communicative or feeling-focused learning, where topics could be discussed through rigorous debate with peers.

6.2.1.3 Expose the hidden curriculum

Thirdly and most importantly is that the hidden curriculum, which reflects the culture and experience of faculty staff and students, needs to be brought to the surface and exposed, so that alignment between all aspects of teaching, learning and experience can be addressed. Draper and Louw (2007) conducted a study of student perceptions of medicine as a profession, and found that the hidden curriculum or institutional values and beliefs featured prominently. They recommended that educators should “‘unhide’ the ‘hidden curriculum’ by making the ‘hidden’ aspects more explicit” (Draper & Louw, 2007, p. e106), in order to facilitate congruence between individuals and the institution. Unpacking the hidden curriculum through a process of focusing on what is valued by the faculty regarding human-related and environment-related elements (Azmand et al., 2018) could prove useful for this process. This would need to be done through shared engagement, so that issues of marginality, exclusion, power and hierarchy that are so much a part of the hidden curriculum and culture of the faculty at UCT and elsewhere can be foregrounded. This is an area of concern also highlighted by Hafferty (2018).

6.2.1.4 Better manage lapses in professionalism

Lapses in professionalism will need to be better managed. Mak-van der Vossen and colleagues (2018) suggested a 3-phase approach for handling lapses in professionalism by students, including first expressing concern, then taking on a more supportive coaching role, followed finally by the role of gatekeeper for the profession and potentially guiding students out of the profession. This is something that could assist the process of creating clear parameters for the management of lapses in professionalism. The Royal Australian College of Physicians (RACP) has developed a framework or tool that encourages reflection on strengths and areas of professionalism that need development and further training – Supporting Physicians’ Professionalism and Performance framework (SPPP). Fitness to practice (FTP) policies are clear and remedial, rather than punitive policies are in place to deal with these lapses (Bagg & Clark 2017). This too could be useful as a means of developing strategies for managing lapses in professionalism in a more explicit way.

6.2.1.5 Make use of assessment tools for applicants

Finally, another area that is worthy of attention is that of assessment tools to assist with selecting students prior to admission to medicine. Although no one tool can entirely predict future behaviour (Bagg & Clark, 2017), a range of tools do exist and need to be evaluated. Issues such as emotional intelligence, including the key areas of self-awareness, self-management, empathy and social skills (Goleman, 1995) through simulations that deal with ethical dilemmas (Goldie, 2013), could be a useful point of departure.

6.2.2 Recommendations for research

Regarding research, a number of areas will be potentially useful to pursue. Firstly, this thesis study focused specifically on professionalism in medicine, but the research should ideally be extended to include all health professions, such as colleagues and students from audiology, speech language pathology, physiotherapy and occupation therapy, to name but a few, so that a truly shared understanding can be created that is representative of the wider faculty and all health-related professions. This has the potential advantage of addressing issues of power and hierarchy that have come to the fore in the FHS at UCT as understandings of professionalism are negotiated together.

Secondly, research on the teaching and learning of professionalism needs to be taken forward in parallel with any changes in curricula. The current study did not specifically aim to focus on the teaching and learning of professionalism, although this emerged as a strong theme within the study linked to that of emerging identity. This is therefore an area that needs further attention, and will ultimately provide opportunities for the formal monitoring and evaluation of any changes that could inform best practice and add value to debates within medical education.

A third area of potential research could include that of following students through their years of study in a longitudinal study, in order to better understand their development as emerging professionals and contribute to debates around professionalism and emerging identity.

Finally, an area that needs more attention is that of professionalism beyond the individual doctor-patient relationship, to responsibilities towards communities, and society in general. The PHC approach includes principles of community engagement and intersectoral collaboration that speak to issues of social justice that should be further explored in relation to professionalism.

6.3 CONCLUSION

Professionalism in medicine is a complex, multi-faceted, layered concept that is centred on trust. It cannot be understood from a purely 'being' or 'doing' perspective, but must be conceptualised within a context that brings attention to emerging identity and the power differentials that reflect a wider experience of being and becoming a doctor. Through detailed exploration of relevant literature and an in-depth qualitative study situated within the FHS at UCT, the views and experiences of students, interns and educators were explored in the current study within an interpretive paradigm and against the conceptual framework of Pellegrino's virtue-based understanding of professionalism. Pellegrino brought significant consideration to the area of professionalism in medicine during his decades of teaching, research and practice, and highlighted the virtues or values of professionalism within a 'being' understanding of professionalism. The current study has added to this view by bringing significant attention to a more complex understanding of professionalism that builds on this moral base of values and bringing prominence to the central role of trust, and the related domains of knowledge and skills, behaviour, and responsibilities reflective of professionalism in medicine are. Figure 5 provides an innovative and exciting basic model for the exploration of these aspects within varying contexts that reflect the potential diversity of experience across medicine and medical education.

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APPENDICES

1. Graduate Profile
2. Becoming a Professional (BP) and Becoming a Health Professional (BHP)
3. 6TH year family medicine course objectives
4. Faculty Charter
5. Consent Form
6. Guide Questions for FGS and Interviews
7. UCT FHS Human Research Ethics Committee approval letter – HREC REF 188/2012
8. Summary of interview of researcher

APPENDIX 1: GRADUATE PROFILE

Profile of the UCT MBChB Graduate

(adapted from the Global Minimum Educational Requirements (GMER) of the International Institute of Medical Education)

Submitted to SAQA 2006

The GMER-based seven competency domains

1. Professional values, attitudes, behaviour and ethics

For the achievement of high standards of medical practice in relation to the provision of care both to the individual and to the wider South African community, the professional values, attitudes, behaviour and ethics should include:

- 1.1 recognition of moral and ethical principles and legal responsibilities in medicine
- 1.2 the practice of professional values such as excellence, altruism, responsibility, compassion, empathy, accountability, honesty and integrity, and a commitment to scientific methods
- 1.3 commitment to a constructive relationship between the health care professional, the patient and the family with respect for the patient's welfare, cultural diversity, beliefs and autonomy
- 1.4 an ability to apply the principles of moral reasoning and decision-making to conflicts within and between ethical, legal and professional issues, including those raised by economic constraints, commercialisation of health care, and scientific advances
- 1.5 self-regulation and recognition of the need for life-long learning with an awareness of personal limitations, including limitations of one's medical knowledge
- 1.6 respect for colleagues and other health care professionals, and the ability to foster a positive collaborative relationship with them
- 1.7 an understanding of plagiarism, confidentiality and ownership of intellectual property
- 1.8 recognition of ethical and legal issues in medical issues and patient documentation
- 1.9 commitment to effective planning and time management
- 1.10 flexibility to adapt to uncertainty and change.

2. Scientific foundation of medicine

The graduate must possess the knowledge required for the solid scientific foundation of medicine and be able to apply this knowledge to solve medical problems. The graduate must understand the principles underlying medical decisions and actions, and be able to adapt to change with time and within the context of his/her practice. In order to achieve these outcomes, the graduate must demonstrate a knowledge and understanding of:

- 2.1 normal human body structure and function
- 2.2 molecular, cellular, biochemical and physiological mechanisms that maintain the body's homeostasis
- 2.3 abnormal human body structure, function and disease
- 2.4 normal and abnormal human behaviour
- 2.5 important determinants and risk factors of health and illnesses, and of interaction between humankind and the physical and social environment
- 2.6 the human life cycle and effects of growth, development and aging upon the individual, family and community
- 2.7 clinical medicine with respect to:
 - 2.7.1 the aetiology and natural history of acute illnesses and chronic diseases
 - 2.7.2 relevant biochemical, pharmacological, surgical, psychological, social and other interventions in acute and chronic illness, in rehabilitation, and end-of-life care
 - 2.7.3 the principles of drug action and its use, and efficacy of various therapies
 - 2.7.4 epidemiology, health economics and health management.

3. Communication skills

The graduate must be able to:

- 3.1 communicate effectively with patients, their families and communities
- 3.2 listen attentively in order to elicit and synthesise relevant information about all problems and understand their content
- 3.3 be willing and able to instruct others
- 3.4 interact with other professionals through effective teamwork
- 3.5 communicate effectively, both orally and in writing, with colleagues and other health care professionals
- 3.6 demonstrate sensitivity to cultural and personal factors that improve interactions with patients and the community
- 3.7 synthesise and present information appropriate to the needs of the audience
- 3.8 create and maintain good medical records.

4. Population and health systems

The graduate must:

- 4.1 recognise and understand important determinants and risk factors of health and illnesses in rural and urban South Africa
- 4.2 recognise and understand the interaction between humankind and the physical and social environment
- 4.3 understand his/her role in protecting and promoting the health of a whole population
- 4.4 understand the principles of health-systems organisation and their economic and legislative foundations
- 4.5 recognise important life-style, genetic, demographic, environmental, social, economic, psychological, and cultural determinants of health and illness
- 4.6 use the required public health skills to conduct a community health "diagnosis", develop an appropriate management plan, and evaluation thereof, relevant to disease, injury and accident prevention
- 4.7 recognise local and global trends in morbidity and mortality, the impact of migration, trade, and environmental factors on health, and the role of international health organisation
- 4.8 understand the need for collective and integrated responsibility for promotion of public health
- 4.9 have a basic understanding of the health care system in South Africa with respect to:
 - 4.9.1 laws, policies and design
 - 4.9.2 organisation and management
 - 4.9.3 financing and cost containment
 - 4.9.4 health care delivery
- 4.10 have a willingness to accept leadership when needed and as appropriate in health issues
- 4.11 understand the mechanisms that determine equity in access to health care, effectiveness, and quality of care
- 4.12 use national, regional and local surveillance data as well as demography and epidemiology in health decisions.

5. Clinical skills

The graduate must be able to:

- 5.1 take an appropriate history, including social issues such as occupational health
- 5.2 perform a physical and mental status examination
- 5.3 apply basic diagnostic and technical procedures to analyse and interpret findings, and to define the nature of a problem
- 5.4 perform appropriate diagnostic and therapeutic strategies and apply principles of best evidence medicine
- 5.5 exercise clinical judgment to establish diagnoses and therapies, taking into account physical, psychological, social and cultural factors
- 5.6 recognise and manage common clinical emergencies
- 5.7 manage patients in an effective, efficient and ethical manner, including monitoring and evaluation of outcomes
- 5.8 advise patients regarding health promotion and disease prevention
- 5.9 understand the appropriate utilisation of human resources, diagnostic interventions, therapeutic modalities and health care facilities.

6. Management of information

The graduate must be able to:

- 6.1 search, collect, organise and interpret health and biomedical information from different databases and sources
- 6.2 retrieve patient-specific information from a clinical data system
- 6.3 use information and communication technology to assist in diagnostic, therapeutic and preventive measures, and for surveillance and monitoring health status
- 6.4 understand the application and limitations of information technology
- 6.5 maintain records of his/her practice for analysis and improvement.

7. Critical thinking and research

The graduate must:

- 7.1 demonstrate a critical approach, constructive scepticism, creativity and a research-oriented attitude in professional activities
- 7.2 understand the power and limitations of scientific thinking based on information obtained from different sources in establishing the causation, treatment and prevention of disease
- 7.3 use personal judgments for analytical and critical problem-solving and seek out information
- 7.4 identify, formulate and solve patients' problems using scientific thinking based on obtained and correlated information from different sources
- 7.5 understand the roles of complexity, uncertainty and probability in decisions in medical practice
- 7.6 formulate hypotheses and collect and critically evaluate data for the solution of problems.

APPENDIX 2: BECOMING A PROFESSIONAL (BP) AND BECOMING A HEALTH PROFESSIONAL (BHP)

COURSE OUTCOMES

By the end of the year students will:

1. BP specific outcomes

- 1.1 have a working knowledge of how people interact and what facilitates good interpersonal skills between individuals and in groups
- 1.2 be able to demonstrate basic interpersonal and interviewing techniques
- 1.3 be aware of and understand the implications of stress and burnout on themselves
- 1.4 be aware of and understand the impact of HIV/AIDS on themselves

2. BHP specific outcomes

- 2.1 have a basic understanding of Primary Health Care - its origins, philosophy, links to wider healthcare debates (including National Health Insurance) and implementation in practice
- 2.2 have a basic understanding of disability as an equity issue
- 2.3 begin to value the contribution of different health professionals in the promotion, maintenance and support of health and health care of individuals, families and communities
- 2.4 have practical experience in applying the above knowledge, skills and values within a community oriented project
- 2.5 have a practical introduction to Basic Life Support Skills

3. Generic BP and BHP outcomes

- 3.1 be aware of the importance of professionalism in their interactions with colleagues, clients and the public
- 3.2 reflect an understanding of and respect for diversity/difference
- 3.3 have a basic knowledge of the concepts of Health and Human Rights and their implications for practice as a health professional
- 3.4 have experience and a working knowledge of how groups evolve and function
- 3.5 have developed basic information literacy (IL), digital literacy (DL) and academic literacy (AL) skills

APPENDIX 3: 6TH YEAR FAMILY MEDICINE COURSE OBJECTIVES

By the end of the block you are expected to be able to:

- Communicate effectively with your patients
- Know basic procedural skills done at primary level
- Conduct a comprehensive patient assessment (see notes on the 3 stage assessment)
- Formulate and implement a comprehensive, evidence-based management plan based on your assessment (including preventive and promotive health)
- Demonstrate that you understand and can apply the principles of Family medicine, Primary Health Care and Palliative medicine & that you consider ethics relevant to Family medicine & palliative medicine in decision making
- Identify and explore community issues impacting on district-based health care
- Utilise community resources effectively

(Please see appendix 1 for the “Division of family medicine core curriculum competencies for a generalist”. Use this document to guide you to make the most of this community placement)

SELF ASSESSMENT

Professionalism

	Poor	Adequate	Superior
Attendance and punctuality			
Takes responsibility for patient care (follow through, getting follow up etc)			
Works well and efficiently with others			
Initiative and participation – taking full advantage of available opportunities			
Honesty in admitting error, able to identify and confront own mistakes and learn from them			
Obtains confidence and co-operation of the patient			
Responds to feedback comfortably - able to reflect and implement change			
Comfortable with undifferentiated problems and uncertainty			

APPENDIX 4: FACULTY CHARTER



FACULTY OF HEALTH SCIENCES FACULTY CHARTER



PREAMBLE

Post-apartheid South Africa is emerging from decades of systematic discrimination that affected every aspect of society, including the health sector, resulting in profound inequities in health status in the population. Central to the reconstruction of South African society is the need to develop a culture of human rights based on respect for human dignity and non-discrimination.

Although there were significant attempts by staff, students and the institution to resist apartheid injustices, UCT was not immune to the racist, sexist, and other discriminatory practices and values that typified society under apartheid. As UCT grapples with transformation, we remain with the legacy of these discriminatory practices.

To overcome this legacy of apartheid and other forms of discrimination, UCT Health Sciences Faculty is producing this Charter as a basis for transformation of the institutional culture of the faculty to ensure that students and staff have access to an environment where they are able to realise their full potential and become active participants in the academic life of the faculty.

PRINCIPLES

DISCRIMINATION The Faculty will not tolerate any form of negative discrimination and will uphold the university's policy on non-discrimination.

SUPPORTIVE CULTURE The Faculty will foster a supportive culture, where diversity and difference is respected, in order to encourage students and staff to reach their full potential in their activities of learning, working, teaching, research and service in the faculty.

CAPACITY BUILDING The Faculty will strive to develop the skills of its employees and help to build the skills base of South Africans, in particular formerly disadvantaged South Africans, through various strategies at its disposal.

EMPLOYMENT EQUITY The Faculty will strive to attract and retain talented black professionals by recognising their abilities, affirming their skills and ensuring an environment that is welcoming and supportive.

FACILITATION OF LEARNING The Faculty will strive to uphold and encourage the highest standards of teaching, and strive to create an atmosphere conducive to learning for all students.

RESEARCH The Faculty will strive to uphold the highest ethical standards of research and ensure that research seeks to benefit the South African community.

SERVICE The Faculty will strive to ensure that students and staff uphold the highest standards of service to the community, including commitments to ethical principles and human rights.

CONSULTATION The Faculty will strive to consult with staff and students on major policy changes that affect them that may be undertaken by the faculty and seek to entrench transparency in its workings.

MONITORING AND EVALUATION The Faculty will endeavour to annually review its performance in the light of this Charter.

COMMUNITY PARTICIPATION The Faculty will strive to ensure participation of the community in decisions in the spirit of the Primary Health Care Approach adopted by the Faculty as its lead theme.

APPENDIX 5: CONSENT FORM

University of Cape Town

Consent to participate in a PhD research study

“Professionalism in medicine in South Africa – a focus on medical students and their educators”
HREC REF: 188/2012

Dear Participant,

You are invited to participate in a research study being conducted by University of Cape Town PhD student Lorna Olckers. The aim of this study is to explore how medical students and their educators at the University of Cape Town understand and experience professionalism in medicine within the South African context.

Should you decide to participate in this study, you will participate in a focus group. The focus group will explore your views and experiences of professionalism.

All personal information will be kept confidential by the researcher. The information obtained from you will be anonymous and your name will not be linked to any aspect of the study. Reports or publications about the study will not identify you or any other study participant. Anonymity of the focus group cannot be assured by the researcher as it will be the responsibility of participants to respect this aspect. This will however form part of the group contract.

For the purposes of accuracy, the researcher will audio-record the interviews and focus groups. The researcher will ensure that the recordings are stored in a locked filing cabinet and/or on a password-protected computer to which only the researcher will have access. Should a transcriber be asked to transcribe the focus group, s/he will not be given access to your name.

Participation in this study is completely voluntary. You may choose not to participate in this study, and this decision will have no negative repercussions for you. Should you choose to participate, you will be free to refuse to answer any question. You will also be free to change your mind and discontinue participation at any time without any effect.

Participation in this study may inform and lead to further research in the area of professionalism.

Any study-related questions, problems or emergencies should be directed to the PhD research supervisors: Dr Cathi Draper (telephone 021- 650 4570 or email Catherine.Draper@uct.ac.za) and Professor Steve Reid from the Health Sciences Faculty, UCT or the Faculty of Health Sciences Research Ethics Chairperson Professor Marc Blockman (telephone 0214066492 or 0214066338).

.....

Signed Consent

I have read the above and am satisfied with my understanding of the study, the possible benefits, risks and alternatives.

My questions about the study have been answered.

I hereby voluntarily consent to participation in the research study as described. I have also agreed to the recording of this interview / focus group.

Signature of participant

Date

Name of participant (printed)

Witness

* * *

APPENDIX 6: GUIDE QUESTIONS FOR FOCUS GROUPS AND INTERVIEWS

Focus groups with 1st year students

Process:

1. Welcome
2. Refreshments
3. Consent forms
4. Check recorder
5. Contract:
 - confidentiality
 - phones
 - duration
 - other issues?
6. Begin

Guide questions:

1. Perhaps we could begin with why it is you chose to sign up and come along today?

Now, moving on

2. Can you tell me about how you understand professionalism in medicine?

Where has your understanding **come from**?

There are two **dominant understandings** of professionalism

Being = see medicine as a moral endeavor. The focus here is on the Doctor as encapsulating professionalism through their very being.

Doing = what Doctors do (behavior, competence and conduct)

- What do you think about these contrasting views?

Trust is a word that comes up frequently in the professionalism literature. It has been described as “the essence of the Doctor–patient relationship”

- What do you think about this?

3. One of the reasons that professionalism has become topical is the idea that “**professionalism in medicine** is said to be **decreasing....” (or at least changing).**

- What do you think about this?
- What factors do you think have influenced this view? (www, changing healthcare systems, graduates themselves, exciting but sometimes ethically challenging advances in medicine)
- What do you think the situation around professionalism in medicine is in South Africa?

Thank you for your time. Is there anything that anyone would like to add or ask before we end off?

Focus groups with 3rd year students

Process:

1. Welcome
2. Tea and refreshments
3. Consent forms
4. Check recorder
5. Contract:
 - confidentiality
 - phones
 - duration
 - other issues?
6. Begin

Guide questions:

1. Perhaps we could begin with why it is you chose to sign up and come along today?

Now, moving on

2. Can you tell me about how you understand professionalism in medicine?

*There are two **dominant understandings** of professionalism*

Being = see medicine as a moral endeavor. The focus here is on the Doctor as encapsulating professionalism through their very being.

Doing = what Doctors do (behavior, competence and conduct)

- What do you think about these contrasting views?

Trust is a word that comes up frequently in the professionalism literature. It has been described as “the essence of the Doctor–patient relationship”

- What do you think about this?

3. One of the reasons that professionalism has become topical is the idea that “**professionalism in medicine** is said to be **decreasing....**” (or at least changing).

- What do you think about this?
- What factors do you think have influenced this view? (www, changing healthcare systems, graduates themselves, exciting but sometimes ethically challenging advances in medicine)
- What do you think the situation around professionalism in medicine is in South Africa?

4. If you look back on your three years as a medical student, what issues around professionalism have you experienced?

- What are your thoughts and feelings about these? *Examples?*

Thank you for your time. Is there anything that anyone would like to add or ask before we end off?

Focus groups with 4th year students

Process:

1. Welcome
2. Lunch
3. Consent forms
4. Check recorder
5. Contract:
 - confidentiality
 - phones
 - duration
 - other issues?
6. Begin

Guide questions:

1. I would like to begin with a more general question and that is why you decided to study medicine. (*role of Doctor, rolemodels?*)

Now, moving on...

2. Can you tell me about your understanding and experiences of professionalism in medicine?
3. There are two dominant understandings of professionalism. There are those who see medicine as being a moral endeavor. The focus here is on the Doctor as encapsulating professionalism through their very being.
In contrast, others have focused on what Doctors do (behaviour, competence and conduct) – what the Doctor does. What do you think about these contrasting views?
 - Trust is a word that comes up frequently in the professionalism literature. It has been described as “the essence of the Doctor–patient relationship.” What do you think about this?
4. Some say that ethics and professionalism are virtually synonymous while others see them as separate. What is your view?
5. One of the reasons that professionalism has become topical is the idea that “professionalism in medicine is said to be decreasing....” (or at least changing). What do you think about this?
6. What factors do you think have influenced this view? (*www, changing healthcare systems, graduates themselves, exciting but sometimes ethically challenging advances in medicine*)
7. What do you think the situation around professionalism in medicine is in South Africa?
8. If you look back on your four years as a medical student, what issues around professionalism have you experienced?
 - What are your thoughts and feelings about these? Examples?

Thank you for your time. Is there anything that anyone would like to add or ask before we end off?

Focus groups with 6th year students

Process:

1. Welcome
2. Tea
3. Consent forms
4. Check recorder
5. Contract:
 - confidentiality
 - phones
 - duration
 - other issues?
6. Begin

Guide questions:

1. I would like to begin with a more general question and that is **why you decided to study medicine**.

Now, moving on...

2. How do you understand professionalism within the context of medicine?
*There are two **dominant understandings** of professionalism*
Being = see medicine as a moral endeavor. The focus here is on the Doctor as encapsulating professionalism through their very being.
Doing = what Doctors do (behavior, competence and conduct)
 - What do you think about these contrasting views?
3. **Trust** is a word that comes up frequently in the professionalism literature. It has been described as “the essence of the Doctor–patient relationship”
 - What do you think about this?
4. Some say that **ethics and professionalism** are virtually synonymous while others see them as separate. What is your view?
5. One of the reasons that professionalism has become topical is the idea that “**professionalism in medicine** is said to be **decreasing....” (or at least changing)**.
 - What do you think about this?
 - What factors do you think have influenced this view? (*www, changing healthcare systems, graduates themselves, exciting but sometimes ethically challenging advances in medicine*)
6. What do you think the situation around professionalism in medicine is in South Africa?
7. If you **look back on your six years** as a medical student, what issues around professionalism have you experienced? *What are your thoughts and feelings about these? Examples?*

Thank you for your time. Is there anything that anyone would like to add or ask before we end off?

Interviews with Interns graduated from the Health Science Faculty at UCT

Guide questions: thoughts and experiences on professionalism in medicine in South Africa

1. **Consent to be interviewed:** recorded, transcribed, no names
2. Drawing on your experience as an Intern, how do you **understand professionalism** in medicine?
3. What have been some of the **highlights and challenges** you have experienced in terms of professionalism?
4. One of the reasons that professionalism has become topical is the idea that “**professionalism in medicine** is said to be **decreasing....**” (or at least changing).
 - *Drawing on your experience as an Intern, what do you think about this?*
 - *What factors in your experience have influenced this view? (www, changing healthcare systems, graduates themselves, exciting but sometimes ethically challenging advances in medicine, SA context)*
5. Looking back on your own **education and training at UCT**, what do you think about what you were taught and how you were **prepared for practice**?
6. Any **other thoughts or ideas** you would like to share?

Interviews with educators in the Health Science Faculty at UCT

Guide questions: thoughts and experiences on professionalism in medicine in South Africa

1. How do you **understand professionalism** within the context of medicine?

*There are two **dominant understandings** of professionalism*

Being = see medicine as a moral endeavor. The focus here is on the Doctor as encapsulating professionalism through their very being.

Doing = what Doctors do (behavior, competence and conduct)

- What do you think about these contrasting views?

Trust is a word that comes up frequently in the professionalism literature. It has been described as “the essence of the Doctor–patient relationship”

- What do you think about this?

Some say that **ethics and professionalism** are virtually synonymous while others see them as separate.

- What is your view?

2. One of the reasons that professionalism has become topical is the idea that “**professionalism in medicine** is said to be **decreasing....**” (or at least changing).

- What do you think about this?
- What factors do you think have influenced this view? (www, changing healthcare systems, graduates themselves, exciting but sometimes ethically challenging advances in medicine)
- What do you think the situation around professionalism in medicine is in South Africa?

3. What do you think about the **professionalism of medical** students within the Faculty?

4. What are your thoughts on how the Faculty is doing in terms of **the teaching and assessment** of professionalism?

APPENDIX 7: ETHICS APPROVAL LETTER



UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
Faculty of Health Sciences Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
e-mail: sumayah.ariefdien@uct.ac.za

20 April 2012

HREC REF: 188/2012

Ms L Olckers
School of Public Health & Family Medicine
Falmouth Building
FHS

Dear Miss Olckers

PROJECT TITLE: PROFESSIONALISM IN MEDICINE IN SOUTH AFRICA-A FOCUS ON MEDICAL STUDENTS AND THEIR EDUCATORS

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

Approval is granted for one year till the 28 April 2013.

Please would the researcher address the following before her research begins:-

1. Complete the conflict of interest statement in the application form (points 1-3 if she has no conflict of interest) and return to the HREC office for filing.
2. Include the contact details of the Human Research Ethics Committee in the consent form if participants have any questions about their rights and welfare in the research study.
3. Obtain permission from Ms Miriam Hoosain and Moonira Khan respectively in order to access staff and students for research purposes.

Please submit a progress form, using the standardised Annual Report Form (FHS016), if the study continues beyond the approval period. Please submit a Standard Closure form (FHS010) if the study is completed within the approval period.


Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

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Yours sincerely



 **PROFESSOR M BLOCKMAN**
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

APPENDIX 8: SUMMARY OF INTERVIEW OF RESEARCHER

INTERVIEW OR LORNA OLCKERS BY DR CATHI DRAPER (supervisor) 15 MARCH 2012

The interview took place when Dr Cathi Draper and Prof Steve Reid agreed to supervise my PhD.

Time: 45.13 minutes

Overview of interview:

CD: Why are you interested in professionalism in medicine?

LO: Interest has been brewing for some time. I convene BP/BHP, and professionalism can be seen as the umbrella theme for both courses. It is topical in the Faculty and has become increasingly topical internationally as evidenced in presentations at conferences and in journal publication particularly in the past decade. At conferences, terminology is fuzzy and there is evidence of a lack of shared understanding. Different 'flavours of the month' seem to emerge. My own general interest has been driven by my interest in understanding how people interact and communicate – which I see as central to professionalism.

CD: What do you see as professionalism in a doctor?

LO: I see it linked to the Integrated Health Professional (IHP) which we teach from first year – aspects of knowledge and skills, but also most importantly empathy and reflective practice – the who you are as a professional. Literature seems to be divided with some focusing on trying to create a checklist for professionalism and others on relationships and emerging identity.

CD: Do you have any key priority areas that interest you?

LO: The need for a common understanding and why it is that professionalism is understood differently. Do prior experiences influence understandings?

CD: Where do you think those understandings come from?

LO: From value systems – ethics, morals and home and community contexts including having health professionals in the family or having had particular exposure to the healthcare system. Also from what is taught at University – what is valued and demonstrated by role models because what is said and done are not always the same. Students in later years echo what is taught in first year, but identity evolves.

CD: What about social and cultural factors?

LO: Yes! They are linked to values that individuals grow up with, and are best understood along a continuum of values and experiences as SA is so very diverse and complex. I am loathe to make assumptions as everyone is a collection of experiences.

CD: Where does the literature around professionalism largely come from? The north?

LO: Mostly from Britain and USA and Europe. I need to expand my own reading to include work from other countries eg within South America and the Far East and of course Africa and South Africa. Not a lot has come out of South Africa – a study was done by the University of Pretoria that has been published in different journals but basically draws repeatedly on the same data. It is possible however that more has been published under ethics.

CD: Has anything struck you as different in South Africa?

LO: The main thing is around issues of social justice. It is a pillar in western literature but needs more unpacking in our context. SA has extremes of haves and have nots, private and public healthcare, different access to resources. There are links with human rights and overlaps into other areas that make understanding professionalism difficult. The challenge is that it then become undefinable and immeasurable but this is not unique to SA. We need a shared definition with all its complexity hence my interest in grappling with how people make sense of professionalism – not just the checklist, but identity and contextual challenges too. What are our students internalising?

CD: It seems medicine has become more of a business with legal issues emerging strongly?

LO: Doctor are being slapped from both sides. Private medicine is reflective of any western / first world country whereas our public healthcare reflects the experience of the majority of communities in SA. The reality is therefore complex. Students seem to choose which world they want to be part of but I am not sure when that happens. It does seem to be linked to the value systems of students themselves.

CD: What influenced your understanding of professionalism?

LO: Very interesting question. Probably my own experiences and values. I believe that communication and reflective practice are central aspect of professionalism.

CD: Have any particular experiences fed into your value system or beliefs?

LO: I think it has been a life-long process. My choice to study Social Work was grounded in my own beliefs in social justice. I believe healthcare should be free. It seems that there is something wrong with us as a society when we say that we have to pay for access to healthcare.

Two examples of my own experiences that jump out now for some reason:

My step-father had his leg amputated and it was extremely traumatic for him and for the family as a whole. My daughter and I visited him in Pietermaritzburg and it was very hard to witness his pain and how he was being managed. I remember one afternoon in particular when he was hallucinating and trying to get out of bed when we got there. There was no-one around to assist him. It felt as if asking for him to be assisted was asking for a favour from the staff. Trying to get information was challenging, and on top of that items of my Dad's were disappearing. I did not feel as if I could ask about any of it because I was afraid of repercussions from what seemed like an angry, resentful team. My sense was that they were exhausted and burnt out. I asked myself afterwards how this had happened. Surely they had come into healthcare because they cared about people and wanted to make a difference, or was I just being naive?

Another example was when I as a 14-year old and went to see a dermatologist about what I perceived to be bad skin. He gave me a tirade telling me that what I had was nothing compared to what he often saw. My sense was that he had not heard me at all!

CD: In the current curriculum, is professionalism something you teach or something that is promoted or a combination?

LO: It is both. It can be taught but it also needs to be reinforced by what is modelled. We cannot say one thing and demonstrate another.

CD: How is UCT doing?

LO: I think there is room for improvement. We have powerful role models but it remains a mystery to me why negative experiences and voices are always so loud and powerful. This is why I want to explore our student experience. Our students seem to start out with so much idealism but is this lost along the way? I want to know.

CD: Are there other things that could be added at UCT eg electives to contribute to professionalism?

LO: I think I will be better able to answer this after the research. My sense is that it all helps eg Rural Support Network (RSN) experiences that students have shared. What they see and experience is hard but their own learning is immeasurable and it reinforces what they get in theory in the Faculty.

CD: Do you think students self-select and are drawn to RSN type experiences?

LO: Yes, absolutely.

CD: Should it be compulsory?

LO: I think we need to move forward beyond what has traditionally been required. At the moment there is a lot of talk about tick boxes for professionalism but because I think it is tightly bound with values and ethics, it cannot just be about a tick list. We need to struggle with professionalism as student identity changes. There need to be points where we explicitly revisit professionalism but also informal spaces for exploring emerging identity and professionalism more closely. First year gives the tools but students do not have experiences to draw on – that comes later, hence the need to revisit the issues. It's messy. It frustrates but attracts me, and I feel it is worth digging into. Not being in the profession of medicine means I can ask naïve questions but it may also be challenging as an outsider. Also, I am a staff member and I need to keep that in mind in my interactions with students in particular.

CD: So, you are motivated by the need to untangle to mess?

LO: Yes!