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Reflecting on Professionalism: An Analysis of Bachelor of Clinical Medical Practice (BCMP) Students' Portfolios During Clinical Rotations

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Research Report submitted to the Steve Biko Centre for Bioethics, University of the Witwatersrand in partial fulfilment for the award of MSc Medicine (Bioethics and Health Law).

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Co-supervisor: Dr. Norma Tsotsi

September 2013

DECLARATION

I, Nontsikelelo Olga Mapukata-Sondzaba, hereby declare that this research (Reflecting on Professionalism: An Analysis of Bachelor of Clinical Medical Practice Students' Portfolios During Clinical Rotations) is my own original work. All relevant sources that are contained in this research have been documented and acknowledged. This research has not been submitted in full or in partial fulfilment of the requirements for a similar degree for academic or examination purpose at any other registered university.



10 September 2013

N. O. Mapukata-Sondzaba Date

DEDICATION

To the three men who continue to inspire me beyond the grave

1. Dr Andrew Truscott, who initiated the discussions and set us off on a lifetime commitment to learning about professionalism.
2. My father, for laying the foundation on responsibility and accountability.
3. My nephew “Q” for his selfless soul.

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I am grateful to the following people:

- Prof. Ames Dhai (Supervisor and Director: Steve Biko Centre for Bioethics), Dr. Norma Tsotsi (Co-supervisor) and Prof. Eleanor Ross (Research consultant) for their academic support, motivation and encouragement.
- Prof. Ian Couper (Chair of Rural Health and Head: Department Family Medicine).
- Friends, colleagues and family for their support and silent prayers.

Finally, I wish to acknowledge the 2011 class of BCMP students. Through their reflections, it has been possible to add yet another view to the on-going discussions on medical professionalism.

ABSTRACT

Background: Globally there has been a reported increase in consumerism as a main driver of de-professionalization in the practice of medicine with a corresponding increase in cases of self-reported breaches of professionalism and ethical misconduct by students. This trend has necessitated a renewed focus on the experiences of professionalism among students in health care practice.

Aim: The aim was to assess the Bachelor of Clinical Medical Practice (BCMP) students' experiences and perceptions of professionalism during clinical rotations with a view to making recommendations designed to enhance congruency between the teaching and practice of professionalism as exhibited during clinical rotations.

Methods: Following five-week attachments at purposefully selected clinical departments in designated District Education Campuses (DECs), final-year BCMP students were asked to reflect on Hatem's definition of professionalism. Students reflected on their time in three of the five rotations, namely: Paediatrics (Paeds), Emergency Medicine (EM) and Adult in-Patient wards (AIPW). The research involved a collective case study of the three settings and took the form of a retrospective, descriptive, analytical and review-based design of 71 student portfolios. Qualitative methods were used to assess in the first instance the BCMP students' ability to reflect critically and independently on moral and ethical issues (personal attributes). Secondly, quantitative elements were incorporated to evaluate the students' ability to reflect on the core values of professionalism (contextual attributes) as determined by the Health Professions Council of South Africa.

Results: With regards to personal attributes, the majority of BCMP students (n=54) reflected on the determinants of accountable and responsible practice. As they encountered a range of ethical issues/challenges, the most critical finding was the internalization of the Oath directly linked to students showing empathy to their patients. Many of the students (n=51) were motivated to exhibit model behaviour, and recognised the value of constant reflection as a skill. Just over a third of the students (n=25) reflected on feeling like "*guinea pigs*" going through a period of uncertainty to becoming "*teachable learners"* who accepted the responsibility of becoming future role models as members of their profession. Because of the shortage of health care workers and an increasing burden of disease, the BCMP students felt pressured into "*pushing the line"*. Professionalism with regard to contextual attributes was presented as positive experiences (53.8%) with the BCMP students developing a good work ethic as they were mentored, observed role modelling and functioned as part of a team. Comparatively, negative experiences of professionalism (46.2%) were context-specific as students had to navigate parents' or family interests; as well as traditional and cultural practices. The unprofessional behaviour of a few individuals resulted in access to health care being compromised, inadequate or in extreme cases denied, with student learning compromised.

Conclusions: Portfolios provided a medium through which the voices of the BCMP students could be heard. The internalization of the Oath could possibly be attributed to an integrated curriculum and early exposure to the clinical training environment. Students were drawn to health care workers who embodied a good work ethic and expressed a desire to emulate such behaviours. The role of clinical teachers is critical in graduating a morally competent, ethically reflective and professional health care worker.

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LIST OF ACRONYMS

AIPW – Adult in-patient ward

BCMP – Bachelor of Clinical Medical Practice

Clin Associate – Clinical Associate

DECs – District Education Campuses

EM – Emergency Medicine

HCP – Health Care Professional

HCW – Health Care Worker

HIV – Human Immunodeficiency Virus

HPCSA – Health Professions Council of South Africa

Paeds – Paediatrics

RHT – Refusing Hospital Treatment

SA – South Africa

UCT – University of Cape Town

Wits – University of the Witwatersrand

CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction

Medical professionalism as a set of behaviours that transcends personal values, beliefs and attitudes to incorporate ethical and moral principles is considered a covenant between society and the practice of medicine (Fleming and Moss, 2011). According to Cruess, Cruess and Johnston (2000), professionalism sets the standards of what a patient should expect from his or her health care provider and is considered an ideal that must be sustained. In the last decade professionalism has become a topical issue among academics, practitioners and professional bodies (Swick, Bryan and Longo, 2006). This interest is largely driven by the need to develop a framework for teaching professionalism, the changing relationship between the public and the medical profession, the fact that there is no consensus on a common working definition of professionalism and also, because there are no guidelines on the most effective ways of supporting health care students to develop high standards of medical professionalism (Swick, 2000; Irvine, 2001; Arnold, 2002; Passi *et al*., 2010). The desired health care professional-patient relationship demands that students are taught professionalism and communication, recognising that patients have rights and that health care providers have corresponding obligations to the patients (Baingana *et al*., 2010).

As part of this introductory chapter, the discussion includes a statement of the research problem. The context of the study was the recently implemented Bachelor of Clinical Medical Practice programme. The rationale for undertaking this study is presented as well as an overview of the research method. Limitations of the study are presented together with a structural overview of each of the chapters that inform this research report.

1.2 Statement of the research problem

Globally there has been a reported increase in consumerism as a main driver of de-professionalization in the practice of medicine with a notable shift from cooperation to competition (Reed and Evans, 1987; Pellegrino, 2000). The resulting decline in professional commitment as against a focus on accumulation of wealth has been reportedly influenced to a certain extent by the earning power of other professionals (Cruess, Johnston and Cruess, 2004). As early as 1973, the emergence of de-professionalization as a culture was predicted

by Haug (1976). She cited as contributing factors, among other things, internal factors such as super-specialization, mal-distribution of health care workers and external factors such as technology and increases in consumerism. Other examples of external factors that have been cited by other authors include:

- The depreciating value of the white coat (Swick *et al.,*1999);
- Advances in technology such as the use of telemedicine (Kekana, Noe and Mkhize; 2010) and,
- Effects of migration towards managed health care (Mueller, 2009; Pepper and Slabbert, 2011).

These factors cited above have undermined the public trust in health practice (Dhai and McQuoid-Mason, 2008). According to Mayosi *et al.* (2009), the factors referred to above are exacerbated further by varying degrees of mal-distribution, shortage or the advancing age of the current workforce and an ever-increasing burden of disease. While these challenges to professionalism are not limited to the medical profession, they have implications based on the assumed violation of the covenant between the practice of medicine and the responsibility to meet societal goals (Irvine, 2001; Mueller, 2009). The resulting imbalance is believed to be contributing to an increase in medical malpractice liability cases borne by individuals in private practice and by the public service provider. Of concern is the increasing number of doctors who have either been found guilty of professional misconduct or struck off the roll for unethical and unprofessional behaviour as well as current negligence claims being processed by the Medical Protection Society (Pepper and Slabbert, 2011).

One other factor that has exerted an impact on professionalism—particularly within the South African context—is the right of individuals to participate in public health sector strikes where at times a patient's right to life is compromised (Section 27 Press Release, 2010). These factors must be considered to take into account the fact that patients in the 21st Century are far more empowered as they have ready access to independent clinical information (Warner, 2004; Sethuraman, 2006). Not only are they aware of their Constitutional rights, but also they are willing to challenge the system (Dhai and McQuoid-Mason, 2010). Cases of self-reported breaches of professionalism and ethical misconduct by students such as cheating and plagiarism, as well as clinicians who display negative and disruptive behaviours, have been documented as a growing concern (Mueller, 2009; Curry, Cortland and Graham, 2011). These concerns were further highlighted by results from a longitudinal study undertaken by Papadakis *et al*. (2004) where they demonstrated a direct

correlation between medical students' unprofessional behaviour and subsequent disciplinary action by professional bodies. Based on expressed concerns, there would appear to be a need to preserve the honour of the medical profession through teaching, assessment and on-going research on professionalism (Stern and Papadakis, 2006; Mueller, 2009). The clinical training environment is identified as a critical component as it is the culture of the organization that fosters the attainment of professionalism (Mueller, 2009; Hilton and Slotnick, 2005; Irvine, 2001).

This study reflects on the experiences of professionalism as perceived by the first cohort of Bachelor of Clinical Medical Practice students during their clinical rotations. The stimulus for the research arose from the external factors presented as contributors to the de-professionalization of medicine as well as concerns expressed among faculty staff about moral degeneration as evidenced by the negative attitudes displayed by some students. As the Bachelor of Clinical Medical Practice was a new programme, there was a need to assess whether students were adequately prepared for the clinical environment. It was also deemed necessary to establish whether theoretical knowledge in ethics was reinforced as students were based in district hospitals for their training, and were expected to conduct themselves in a professional and ethical manner.

1.3 Context of the study

There is no doubt that faculty is where the seeds of professionalism are sown with the nurturing process continuing right through to post-graduate training (van Mook, *et al.,* 2009). In 2006 the Committee on Human Rights, Ethics and Professional Practice, a committee of the HPCSA (the Health Professions Council of South Africa), declared the responsibility of the HPCSA to be the promotion of the health of South Africa's population, the determination of standards of professional education and training, as well as setting and maintaining the standards of professional practice. The HPCSA has a mandate to ensure that faculties of Health Sciences include in their core curriculum, academic instruction on professional ethics, human rights and medical law. Other organisations such as the African Charter for African Union members, and the international councils, e.g. the American Board of Internal Medicine, the American Board of Colleges and many others, have similar expectations from their members. This HPCSA committee further stipulated that all education and training programmes must be academically rigorous and clinically relevant (HPCSA, 2006). In order

to address the socio-economic injustices, imbalances and inequities that formed part of the legacy of Apartheid, the South African government promulgated the Constitution in 1996 with its Constitutional imperative to improve the quality of life of all its citizens. The Bill of Rights of the Constitution affirms the right of everyone to have access to health care services. The National Health Act of 2003 provides the legislative framework for a health system designed to achieve the progressive realization of the right to health care (Dhai *et al*., 2011). However, severe shortages of human resources in the form of health care workers have made it difficult for many citizens to access quality health care. Moreover, the poor attitudes and unprofessional behaviour of some health care practitioners have compromised the quality of health care and negatively affected the image of the health care professions in the eyes of the public (Dhai *et al*., 2011).

Against this backdrop, the Bachelor of Clinical Practice (BCMP)—a three-year professional degree—accepted its first intake of students in January 2009 in response to a documented shortage of doctors, especially in the rural areas of South Africa (Pick *et al*., 2001). The BCMP programme is unique in its approach as training is based on the district health care model (Doherty, Couper and Fonn, 2012). Upon qualification these middle level health care workers are known as Clinical Associates (Clin Assoc). In the US they are known as Physician Assistants (PA), while in the rest of Africa they are referred to as Clinical Officers, a cadre of health care workers who substitute for, and/or complement, medical officers (Mbindyor, 2011). In terms of the Human Resources for Health (HRH) strategy (2011), Clinical Associates have been identified as one of the categories of health care professionals who will contribute to the strengthening of health care services in the district in the implementation of the re-engineering of primary health care (Doherty *et al*., 2012).

As part of an integrated curriculum as set out in Appendix A, the BCMP students are exposed to the clinical environment in one of the locally based District Education Campuses where they spend one afternoon a week in the ward in rotation one during the first year. An additional day is spent in the out-patients department from rotation two. In their second year, students spend two weeks of each eight-week rotation in medical school, while the rest of the time they are based in district hospitals in Gauteng and North West provinces. In their third and final year, only the first rotation is spent in medical school covering theoretical knowledge with one week of that rotation spent in simulated clinical training with fifth-year medical students. For the remainder of the year, students rotate through different sites,

undertaking learning in different disciplines supervised by university-appointed supervisors as well as other on-site clinicians. A course in bioethics was introduced into the curriculum in order to humanise the education and practice of these professionals. It also came in response to a request by the academic coordinator of the programme to address students following reported incidents of unprofessional behaviour among students in shared spaces. Through the infusion of human values and the humanities in health science education, it was hoped to achieve the ideal of training not only of scientifically competent but also "humanistically responsive practitioners" (Dhai, 2008:34). In meeting the needs of the BCMP students, the three basic actions described by Stern and Papadakis (2006) were applied, namely:

- Setting expectations;
- Providing experience; and,
- Teaching and evaluation as broad concepts of teaching professionalism.

In setting expectations, the students were welcomed to the faculty by the Vice-Dean and participated in an Oath-taking ceremony. The Oath is displayed in Appendix B. In their first contact session, all 25 students were asked to express their concerns and fears, as they were the first cadres to be accepted into the programme. Students were also introduced to the faculty rules and regulations. The exercise was undertaken to affirm their place in the faculty, engaging them so that they could understand their role in the delivery of health care services, thereby placing value in them as future health care practitioners. Students were also briefed on their scope of practice as determined by the HPCSA (http://www.twinningagainstaids.org/documents/CABoolketFinal_lowres.pdf).

In providing experiences in the follow-up contact sessions over a two-year period, students were introduced to ethical theories and major principles of ethics as the founding principles of professionalism and to behaviours that reflect professionalism. Students were also introduced to legal documents that support professionalism and promote the rights of individuals, including the Bill of Rights (the Constitution of the Republic of South Africa), the National Health (Act 61 of 2003), HPCSA Guidelines for Good Practice (Booklet 1, 2008), the National Patients' Rights Charter (HPCSA Booklet 3, 2008) and Batho Pele Principles (DPSA, 2003) as displayed in Appendices D & E.

The class was divided into groups to facilitate teamwork and reflective practice. Case reports and clinical vignettes were used to facilitate the process of attaining academic and professional integrity. An action-learning approach was adopted to foster professionalism by engaging students on (http://www.hpcsa.co.za/conduct_guilty_verdicts.php) significant and relevant content. This goal was achieved through perusal of local newspapers for cases where patients' rights were violated. Similarly, the HPCSA website (was also visited to source cases where judgements had been finalised against health care professionals as registered members. The two sources of information placed into context patients' expectations and the obligations of registered practitioners. Group discussions focused on a patient-centred approach described by Mueller (2009) and the role of BCMP students as future professionals. Their knowledge and understanding was assessed as part of the integrated curriculum as recommended by van Mook *et al*. (2009).

1.4 Rationale for the study

The unique nature of the BCMP curriculum required an approach that met the needs of an integrated curriculum. Such an approach had to provide for an accelerated transition from the classroom to the patient's bedside. For that reason there was a need to identify a process to fast track the students' ability to function and engage with a team of health care professionals in an ethical and accountable manner. Ginsburg *et al*. (2000) noted that professionalism based on ward conduct was not always a reliable form of assessment. They reported observer bias with students complaining about the unfairness of marks awarded. In 2010, Passi *et al*. in an article raised as a concern the absence of guidelines supporting the most effective mechanisms for medical students to attain high standards of professionalism. Previous research assessing students' perceptions of professionalism has focused on the experiences of medical students. For the 2011 final-year BCMP students, other than their teachers, they had no local role models to look up to as they prepared to become qualified practitioners. As the first cohort of students registered for the BCMP programme, they were part of the groundbreaking history of health care in this country, responding to the health and social needs as espoused in the Green Paper (HRH Strategy, 2011). However, the educational component did not only encompass formal lectures and seminars in bioethics and the biopsychosocial approach, but also included exposure to the practice and conduct of professionals at the various training sites.

Having taken the students through the theoretical instruction in ethics and professionalism in their first and second years of a three-year curriculum, the researcher was keen to evaluate relevance and suitability of current teaching and assessment methods. This was particularly relevant as the final year consisted of clinical attachment and self-directed study. Motivated by a unique instructional offering where students are based in District Education Campuses for their clinical training from the first year, it was considered important to establish the level of fitness of BCMP students to practise as ethically responsible and critically reflective health care practitioners. As members of this first cohort of Clinical Associates were approaching completion of their studies, it seemed relevant and timely to explore their experiences of professionalism at the various training sites prior to graduation. It was anticipated that as an outcome of the report, the researcher would develop a discussion document that would inform the BCMP students' training programme on ethics and professionalism. It was also envisaged that the study would have policy implications for the future training of this cadre of health care professionals.

1.5 Research questions

Based on expressed concerns relating to de-professionalization of the practice of medicine:

1. Do current teaching and assessment strategies as evidenced through exhibited personal attributes adequately prepare BCMP students to be reflective practitioners?
2. Are BCMP students able to meet their professional responsibilities by committing to the core values (contextual attributes) of professionalism?

Research Aim

To assess the Bachelor of Clinical Medical Practice (BCMP) students' experiences and perceptions of professionalism during clinical rotations with a view to making recommendations designed to enhance congruency between the teaching and practice of professionalism as exhibited during clinical rotations.

Objectives:

1. To assess BCMP students' experiences of ethical and moral standards in the clinical environment as reflected in the development of personal attributes;
2. To ascertain BCMP students' perceptions of professionalism in the clinical environment as reflected in contextual attributes; and,
3. To compare BCMP students' experiences in terms of attainment of professionalism in paediatrics, emergency medicine and adult in-patients departments.

1.6 Brief overview of the research methodology

This research focused on the BCMP students' experiences of professionalism during clinical rotations. Due consideration was given to the social contract as it determines the engagement of society (patients and their families) with the health care agency. This goal was achieved through employment of the three ethics principles (patient welfare, social justice and respect for patient autonomy) as determinants of the moral approach (Mueller, 2009) and attributes of professionalism as defining conduct of health care workers (HPCSA, 2006). Consideration was also given to the responsibility of health care workers to support, instil and impart professional values to students (van Bogaert, 2008:31, 45).

The main assumptions were that:

i. BCMP students are able to recognise good role models and declining professional behaviour in the workplace;
ii. They are able to recognise unprofessional conduct in the clinical environment based on their faculty experiences;
iii. Vulnerable patients are likely to experience the worst forms of unprofessional conduct.

This collective case study took the form of a retrospective, descriptive, analytical and review-based design. Qualitative methods with quantitative elements were used to assess BCMP students' personal reflections on professionalism and to evaluate their experiences of the

core values of professionalism as determined by the Health Professions Council of South Africa during their clinical rotations. Portfolios were chosen as the research instruments as they are considered to be one of the most valuable tools for assessing personal development and lifelong learning (Ziljstra-Shaw, Robinson and Roberts, 2011). As the reflections were context-specific, content analysis was employed to examine emerging themes, meanings and patterns that satisfied the three critical learning areas described by Stern and Papadakis (2006) to meet the research plan. As patient care is central to the process, students therefore needed to demonstrate an ability to apply an ethical approach as well as the ability to function as reflective practitioners. Given that the portfolios were selected as the research tools, the range of selected disciplines in turn reflected the kind of patients students were likely to work with as professionals.

1.7 Definition of key terms

Health Care Professional is used to describe the different categories of the health care workforce and reference is made to Clinical Associates as future health care professionals or workers. The terms *Health Care Professional* (HCP) or *Health Care Professionals* (HCPs) are used interchangeably with *Health Care Worker* (HCW) or *Health Care Workers* (HCWs).

Personal attributes of professionalism are the highest standards to which health care students are willing to commit so that they can develop through reflective practice the skills and abilities that include an understanding of ethics and the legal framework, critical evaluation and self-directed learning as described by Klenowski and Carnell (2006). Mueller (2009) is of the view that these skills enable students to be in a position to integrate acquired theoretical knowledge with professional experiences and promote patient autonomy, social justice and primacy of welfare. In this study, personal attributes were evaluated in terms of accountability and responsibility, critical reflection linked to professional development, as well as personal growth.

Contextual attributes of professionalism—also referred to as core elements in this study (HPCSA, 2008)—are the elements, attributes or domains that constitute a spectrum of behaviours that should be exhibited by all categories of health care professionals at the end of the training period. According to Swick (2000), contextual attributes are the desired

qualities in any doctor-patient relationship that need to be displayed in the contexts in which they practice. Cruess (2006) posited that these attributes bring honour to a profession that has long been associated with the physician as a healer in society. In this study, the contextual attributes were assessed in terms of the 13 core values of professionalism, namely respect for persons; beneficence; non-maleficence; human rights; autonomy; integrity; truthfulness; confidentiality; compassion; tolerance; justice; professional competence and self-improvement, and community.

The working definition for ***professionalism*** is taken from Hatem (2003) and is defined as:

''*The extended set of responsibilities that include the respectful, sensitive focus on individual patient needs that transcends the physician's self-interest, the understanding and use of the cultural dimension in clinical care, the support of colleagues, and the sustained commitment to the broader societal goals of medicine as a profession.*"

The term "***students***" is used as an inclusive term to incorporate all students registered and studying for programmes offered by the Faculty of Health Sciences at the University of the Witwatersrand. Reference is made to medical students to include Bachelor of Clinical Medical Practice students who are referred to as BCMP students. While reference is made to medical students, much of what is stated applies to all health care students.

1.8 Limitations

A number of methodological limitations were noted with many of them ascribed to the nature of the case study. Previous research focusing on professionalism has employed a direct approach in the form of focus groups or pre-populated questionnaires. In this study, students were asked to reflect on their experiences of professionalism and submit a one-page document for marking. The fact that the research material was a task intended primarily for formative assessment of the block led to inconsistencies in the manner in which students responded to the instruction and the length of the document. Some students submitted handwritten documents while others submitted typed documents of varying lengths. In hindsight, requesting students to submit, for example, a 1,500 word document would have been far more beneficial to the study in directing and controlling the level and degree of reflection (Hafferty, 2002; Asghari *et al*., 2011). It would also have been helpful to have

directed students to focus on specific aspects of professionalism in their reflections. Information on demographic details of the students was not included in the study as identifiers were removed to safeguard the interests of students. There was a concern that they might otherwise have been easily identifiable as the class was fairly small. Also, as they formed the first cohort in the programme, the students had engaged in many public activities in an effort to enlighten the public and other HCWs about the new category of health care professionals. The researcher was expected to honour the recommendations made by the university's ethics committee to protect the interests of the students. All of these factors had an impact on the final analysis as the researcher could not reach definitive conclusions though inferences were made, directed by the students' reflections. The study was limited to an ethical analysis. As such, observed legal issues were not included in the final report. However, the researcher is planning to capture legal issues as they are reflected on, and document and analyse them for future research and publication.

According to Pinsky and Fryer-Edwards (2004), portfolios foster development of professional competence whilst Ziljstra-Shaw *et al*. (2011) are of the view that portfolios are longitudinal tools for assessing professionalism. However, in this case the primary purpose was to meet academic requirements. The research component was a secondary undertaking and may not have necessarily addressed all the objectives. As the data collected as part of this research was informed by students' personal experiences and expectations depending on the sites at which they were based, there may have been inconsistencies in the reporting format, especially where repeated behaviours were observed irrespective of site and rotation. Similar findings are reported by Kaldjian *et al*. (2012) who noted in their study reluctance by students to report on controversial issues. Similarly, although students in the present study were assured of the confidentiality of their portfolios, it is possible that some students might have been reluctant to disclose negative experiences for fear of obtaining poor evaluations from teaching staff. In a similar vein, it is possible that despite being urged to be completely honest, some students might have furnished "socially desirable" responses on the assumption that such responses would earn them higher grades for their portfolios.

1.9 Outline of the research report

Chapter 1 outlined the research problem and provided the rationale for conducting the study. The BCMP programme was presented together with the adopted structural approach to meet the needs of the students in preparing them for their role in the provision of health care in South Africa. Prevailing professional factors and circumstances were presented as a background to the research, justifying the need to undertake the study. An overview of the research methodology was outlined together with the definition of key terms. The chapter concluded by presenting expected outcomes as well as limitations of the research report based on the brief and scope of the study.

Chapter 2 provides the theoretical basis for the research by establishing a link between moral and professional development and provides a framework for professionalism. This chapter justifies the need to teach and assess professionalism and the role of both faculty and clinical training centres in this regard.

Chapter 3 explains the research design, the methodology and the participants' profile. Included in the discussion were the ethical measures, techniques employed and criteria used in deciding on the sample and the methods adopted in the capturing and analysis of the data.

Chapter 4 describes and summarises the main results. The chapter identifies emerging themes and describes the main findings focusing on personal growth, accountability and responsibility, as well as a critical reflection as it links to students' experiences of professionalism. Similarities and differences in how experiences were perceived in the three rotations are noted and discussed.

Chapter 5 constitutes the concluding chapter that links the theoretical framework with the findings. Recommendations based on the findings are made to promote policy formulation to inform curriculum development as well as identify gaps and highlight suggestions for future research as informed by findings.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

Some of the established facts about professionalism are that it is expected by patients and society in general, based on the assumed primacy of patient welfare, patient autonomy and social justice as the driving forces in the delivery of health care (Mueller, 2009). One of the assumptions is that, unlike the knowledge and skills that are taught in medical school, professionalism focuses on attitudes that can be acquired by the student and need not be taught and assessed. However, it is also an established fact that teaching professionalism is not sufficient as students need to experience positive professional behaviours for them to internalise and emulate such behaviours (Harris, 2004). More importantly, it is critical for medical educators to acknowledge that there are consequences to improper conduct.

While Chapter One served to contextualize and lay the framework for the present study, the current chapter elaborates on many of the concepts and issues initially raised in the introductory chapter. This chapter is approached with a view to understanding the notion of professionalism and establishing a link between moral and professional development grounded in ethics as central to the initial construct of professionalism. The definition of professionalism is considered as an evolutionary process that was initially framed and constructed through the Hippocratic Oath. Current thinking is presented, as guided by the standards of good practice, determined by professional bodies. The need to bring honour to the profession of medicine is explored in response to calls made by professional bodies to teach professionalism. The role of faculty members and academic clinicians is critically assessed as this role informs the reflective practice of BCMP students as complete health care workers. Thereafter, the adopted approach on assessing professionalism, as reflected on by BCMP students, is critically assessed as it informs the analysis described in the methodology chapter.

2.2 The Notion of a Profession

The word profession is derived from *profess,* described in the American Physicians Charter (2002) as "proclaiming something publicly". According to Stern (2006:17), the earliest definition of a profession is accredited to Judge Louis Brandeis (1912) who defined a profession as a service that is provided to society and includes three elements. Brandeis described these elements: firstly, as an occupation that required preliminary training that is intellectual in nature and was more than just a mere skill; secondly as an occupation that is largely pursued for the benefit of others and not just self; and thirdly, as an occupation where financial gains are not the attributes by which to measure one's success. This definition was extended further in the 20th Century by Abraham Flexner (1915) who went beyond Brandeis's three elements to include excellence and self-regulation (ibid.). Traditionally, only a few professions enjoyed this noble status of belonging to the "learned professions" based on their public obligation to serve (Pellegrino, 2002). Medicine, academia, the ministry and law are some of these professions where there is an obligation for members to apply their special knowledge to society and thus have a public duty to serve their communities (Cruess, Johnston and Cruess, 2004).

Newman (1957:5; 50) posits that medicine as a profession was comprised of cultured and highly educated gentlemen, wise men who were technically competent for their time. Southwick (1997) refers to a far more comprehensive definition of profession provided by the Australian Council of Professions as part of its conference proceedings in April 1997. The delegates described and adopted the term profession to refer to "*a disciplined group of individuals who adhere to high ethical standards and uphold themselves to, and are accepted by the public as possessing special knowledge and skills in a widely recognised, organised body of learning derived from education and training at a high level, and who are prepared to exercise this knowledge and these skills in the interest of others*".

Unique to medicine is the taking of the Hippocratic Oath (Jotterand, 2005), a public declaration that has long been associated with the practice of medicine as a profession. Previously the Hippocratic tradition was considered to be an overriding doctrine, according to Irvine (2001), the basis of medical ethics and a source of traditional morality focusing on beneficence, justice, trust and clinical autonomy. This tradition affirmed the identity of doctors and presumed commitment to the profession. The current view is that the

Hippocratic Oath is at the best of times symbolic, is limited and generally perceived as unreliable as a basis for medical ethics (Beauchamp and Childress, 1994:25). This thinking is supported by Miles, cited in Jotterand (2005), who is of the view that oaths do not compel ethical behaviour but are human instruments that are crafted to sensitize the reader to moral moments and choices. Miles proposes that the practice of medicine should consider the wisdom of older physicians who have over the years connected theory with clinical practice and should be called on to bridge the inter-generational gap in medical practice by emulating the moral philosophy. This view is shared by Warner (2004) who, on the occasion of his presidential address to the Society of University Surgeons, posited that in the past professionalism was assumed as the practice of medicine and was doctor-centred, but that in the 21st Century kindness and altruism remain key desirable attributes for any practising health care professional. Sethuraman (2006), on the other hand, described the Oath as a process of transitioning from being a student to becoming a professional. Beyond the Oath-taking ceremony, the Oath is taken to affirm a relationship of trust between the patient and the physician with every patient encounter.

2.3 Theories of Morality and Professional Development

At the very core of professionalism is ethical decision-making and moral reasoning as a process of determining right from wrong. From early philosophical writings, the morality that is expected of individuals who commit to the practice of medicine requires that they possess character traits that are consistent with virtue and ethics and exhibit benevolence, truthfulness, compassion, courage, intellectual honesty and fidelity to trust guided by the principles of ethics (van Bogaert, 2008). According to Dhai, McQuoid-Mason and van Bogaert (2011:3), this process requires careful systematic reflection on, and analysis of, one's actions and behaviours. Purtillo (1999) defines ethics as an outcome of moral development. Furthermore, Purtillo describes moral education as facilitating systematic reflection by providing a specific language, an approach and guidelines for studying the components of personal, group and societal morality to create a path for self and others. It is Lefton's (2000) description that extends the boundaries as he presents morality as a system of learned attitudes that are concerned with social practices in communities, organizations and institutions. He is of the view that an exhibited behaviour is used to evaluate situations and behaviours as either good or bad, right or wrong.

Beauchamp and Childress (1994:44-111) refer to a theoretical model of a healing relationship between a doctor and a patient that is guided by the four principles of ethics, described as the prima facie principles of autonomy, beneficence, non-maleficence and justice. For this reason no discussion on morality is complete if it does not consider the moral character of the individual, as this aspect is considered a critical element in the provision of health care. According to Hoyt-O'Connor (2008:118), moral virtues are socially valued character traits, presented by Aristotle in his theory of virtue ethics as similar to habits or skills that are acquired and perfected through practice. These traits define the kind of person a physician should be, linking his or her intellectual excellence to moral excellence (Pellegrino, 2002). In line with this viewpoint, Gillon (1994) has described medicine as an essential moral enterprise that aims to do good for others. On the other hand, Pellegrino and Thomasma (1996) consider the end of medicine as the good of the patient as determined by the knowledge and skills of a health care worker. The interface provided by these authors consolidates the views of Swaner (2004), who proposes four components of moral behaviour, these being:

- An ability to recognise dilemmas;
- An ability to reason correctly;
- A personal commitment to moral action and accepting responsibility for the outcome; and,
- Possessing a moral character of persistent behaviour that is not governed by fatigue or temptation.

For health care professionals, their virtuous character is judged based on their actions and response to work-related needs and pressures of patients and colleagues as either facilitating teamwork or reducing conflict (Blackmer, 2007). Ideally the focus should be on the good of the patient as a virtuous end. Thus the corresponding defining values of a physician-patient relationship should also consider the responsibility of health care workers to support, instil and impart professional values to students (van Bogaert, 2008:31, 45). Pellegrino (2002) is of the view that the good health care provider should exhibit character traits that demonstrate commitment to fidelity, trust, benevolence, compassion, intellectual honesty, courage and truthfulness. Cohen (2006) observed that admission of students to medical school focused on a consideration of privileged cognitive traits as reflected in their academic marks instead of the student's professional behaviour and ethical reflection. Based on the complex and compounded versions of morality presented earlier in this discussion,

these do not exonerate students from assuming responsibility. As they assume responsibility, they are required to learn about professionalism. Students become central to all that is done in relation to professionalism in clinical training centres and indirectly foster a relationship between patients and health care providers as:

- Students strive to become competent professionals;
- Their supervisors endeavour to practise as competent clinicians; while,
- The patients seek restoration of normal functioning of their bodies.

Students are admitted to medical school as young adults in the process of affirming their personal identity (Branch Jr., 1998). Prior to students entering university, all moral education is the responsibility of parents, teachers and community members. Although universities have no control over the moral development of the students they admit to their institutions, the assumption is that the academic performance of these students is in part grounded in self-discipline and commitment (Cohen, 2006). Realistically, institutions aspire to graduate classes of competent professionals on an annual basis. Furthermore, it is expected that each graduate will be a morally conscious individual and a reflective practitioner who embodies the values of that particular institution and the profession of medicine. Herein lies the goal of all members of faculty, namely to prepare registered students for fulfilling careers as health care practitioners and ensure a lifetime commitment to a moral community.

The process of moral development, when viewed from Jean Piaget's theory of cognitive development (1896-1980), has relevance if it is considered from a perspective of repeated engagement with the environment for one to be able to engage in moral reasoning (Piaget, 1932). Based on this theory, the professional developmental process assumes that if the students take on the role of children as presented in Piaget's research, and their lecturers are assumed to represent their parents, then both the medical school and the clinical training centres represent an environment where they constantly construct and deconstruct their professional development. Realistically though, a shortcoming of Piaget's theory was that it focused on children aged 7-11 years whereas the student who is admitted to medical school has completed Stage 3 of moral development, according to Kohlberg's theory (1972). Such a student is in the process of acquiring professional moral excellence to match the academic excellence needed to prepare for his/her professional life.

According to Kohlberg's highest level of moral development, it is expected that students will consider elements of morality based on rights and justice with due consideration for the preservation of life and democratic participation in a "just community" at the expense of other values (ibid.). However, Kohlberg's theory can be criticised as it focuses on moral thinking and not on moral action and is based on Western methods with a Western cultural bias. Other considerations for moral development include Carol Gilligan's 1982 theory of the ethics of care that improves on and disputes Kohlberg's theory. Gilligan's work places emphasis on interconnectedness as an integral component of moral reasoning (van Bogaert, 2008:81). This interconnectedness of health care teams towards the common good of the patient is well-placed if one posits moral development as a multi-staged process with medical students operating in the moral domain defined by caring and compassion (ibid.). Similarly Gilligan's theory has its own limitations as it is criticised for limited multicultural exposure of subjects, for assuming that all women are nurturing and that it is only men who are logical in their moral reasoning (Lefton, 2000).

However, it is perhaps Dreyfus's five-staged theoretical model of skill acquisition that takes professionalism to the next level (Benner, 2004). The model displayed in Figure 2.1 assumes professionalism to be a skills development process in which participants are initially novices (Stage 1), move to the status of advanced beginners (Stage 2), to becoming competent (Stage 3), then proficient (Stage 4) and become experts (Stage 5) based on their pre-existing moral outlook. This model proposes that morality is about "seeing", "knowing why" and "knowing how" and considers morality to be a transition from detachment to emotional involvement. Based on the Dreyfus model, Huddle (2005) considers morality to be a type of skill that is founded by one acquiring a kind of knowledge that is specific and relevant to the profession and for the individual to be able to do the right thing even when no one is observing one's behaviour. Huddle's initial premise is based on the fact that health care students are not moral novices as informed by Piaget's theory. Huddle's conceptualization is only relevant provided students are guided through maxims and principles in the early stages of moral development. He proposes mentoring through the different stages of Dreyfus's model until the desired level of expertise required by the profession is attained. This requirement places the burden of learning about professionalism on faculty and clinical teachers.

Stage 1: Novice

- "rigid adherence to taught rules or plans"
- no exercise of "discretionary judgment"

Stage 2: Advanced Beginner

- limited "situational perception"
- all aspects of work treated separately with equal importance

Stage 3: Competent

- "coping with crowdedness" (multiple activities, accumulation of information)
- some perception of actions in relation to goals
- deliberate planning
- formulates routines

Stage 4: Proficient

- holistic view of situation
- prioritizes importance of aspects
- "perceives deviations from the normal pattern"
- employs maxims for guidance, with meanings that adapt to the situation at hand

Stage 5: Expert

- transcends reliance on rules, guidelines, and maxims
- "intuitive grasp of situations based on deep, tacit understanding"
- has "vision of what is possible"
- uses "analytical approaches" in new situations or in case of problems

Figure 2.1: Dreyfus's Model of Skill Acquisition (Benner, 2004)

The Dreyfus model is favoured as participants in the Benner study (2004) were nursing students who were followed over a 21-year period using narratives to observe skills development and moral development. As with Benner (2004), a process of transformation from student to mature professional is described as proto-professionalism by Hilton and Slotnick (2005), citing a range of influences where students migrate from the periphery in their first year to centrality by the sixth year. Hilton and Slotnick are of the view that students who are exposed to positive experiences are likely to attain phronesis (professionalism) at the end of the training period and continue to display positive behaviours as practitioners. In contrast, where students have negative experiences, they reach attrition and are most likely to take forward observed negative behaviours as lived experiences. Moreover, these students are likely to emulate cynicism towards those in their care and in practice (ibid.). It would appear that certain individuals struggle to balance the two skills at expert level with moral agency most likely to be compromised at the expense of the skills base.

According to Branch Jr. (1998), students are more likely to develop a strong empathic identity with their patients and demonstrate higher levels of compassion and care. He is of the view that the culture in the wards generally does not encourage reflection, and difficulties in acculturation and socialization force students to abandon their values in exchange for team cohesiveness as they work their way up the ladder. While Newman (1957:41) portrayed the physician of the 1800s as a cultured gentleman, he was of the view that the students of that time exhibited character traits of low habits when compared to the medical students of today who are considered respectable members of the community. The expectation is that the individual at this level has moved beyond the community of family, teachers and local community to embrace a broader society in the form of patients, their families and other health care workers (Crain, 1985).

Based on this proposed sequential construct one assumes and expects some health care students to have higher levels of moral excellence when compared to some of their clinical teachers who may demonstrate unprofessional behaviour (Malpas, 2011). The latter is relevant to faculty and clinical teachers who fail to understand that they have an inherent responsibility to demonstrate and emulate good behaviour for the benefit of the health care students who learn by following the model of a virtuous professional (Pellegrino, 2002; Harris, 2004). In this regard, Huddle (2005) refers to a process that requires deeper commitment over a period of time for health care students to develop the desired character.

2.4 Defining Professionalism

Stern (2006:17) posits that one refers to professionalism when a professional displays core humanistic values that are characterised by caring and compassion as a foundation upon which the practice of medicine is based. In the Physicians' Charter adopted by the American Board of Internal Medicine (2002), professionalism is described as being based on the three fundamental principles of ethics that include primacy of patient welfare, patient autonomy and social justice as well as attributes of professionalism. The Board presents these attributes as commitment to professional competence; honesty with patients; patient confidentiality; maintaining appropriate relations with patients; improving quality of care; improving access to care; justice; scientific knowledge; managing conflicts of interests and commitment to professional responsibilities. Swick (2000), on the other hand, refers to medical professionalism as when a professional is able to meet societal expectations and function as a physician to meet individual patient needs and those of the collective by exhibiting the nine aforementioned attributes of professionalism.

William, cited in McQuoid-Mason and Dhai (2011:59), elaborates on the concept of professionalism and describes it as "*an occupation that is characterized by high moral standards, including a strong commitment to the well being of others, mastery of a body of knowledge and skills, and a high level of autonomy*". Unlike other professions where the relationship is a two-way process, health care provision is multi-pronged, with the relationship extended to families, communities and society at large (Harris, 2004). Medical professionalism extends the public commitment further as health care professionals are subjected to professional codes of conduct with corresponding ethical and moral obligations (Dhai and Etheredge, 2011:16). According to Pellegrino (2001), one who attests to being a medical professional "*declares aloud that he (or she) has special knowledge and skills, that he (or she) can heal or help and that he (or she) will do so in the patient's interest, not his (or her) own".* However, Hatem's definition was considered to be far more appropriate as a working definition for students' use in the BCMP programme. This definition was considered to be most comprehensive as it describes professionalism as ''*The extended set of responsibilities that include the respectful, sensitive focus on individual patient needs that transcends the physician's self-interest, the understanding and use of the cultural dimension in clinical care, the support of colleagues, and the sustained commitment to the broader societal goals of medicine as a profession*". These preceding two definitions constitute some of the many theoretical definitions of professionalism.

Responding to the on-going challenge of the absence of a universal definition, Rogers and Ballantyne (2010) proposed, as an outcome of an empirical analysis, a practical working definition of medical professionalism. The suggested definition, according to these two authors, must not only be consistent with current literature, but also address current complaints and make provision for future complaints. As Rogers and Ballantyne (2010) are of the view that what is needed is greater improvement in the assessment of professionalism, the practical definition that they offered provides clarity on how professional behaviours are defined. They recommend five domains that should be incorporated as the basis of a formal curriculum on professionalism:

1. Responsibility (to incorporate conscientiousness and record-keeping);
2. Relationships with, and respect for, patients;
3. Probity and honesty;
4. Self-awareness and capacity for reflection; and,
5. Collaboration and working with colleagues.

Similarly, Mueller (2009) suggests a practical definition to describe professionalism that must incorporate both personal and cooperative attributes as described by the Physician's Charter on medical professionalism and designed to consider the training context. Mueller suggests a framework founded on a sound understanding of ethical and legal aspects of medicine to include clinical competence and communication skills. He suggests, as attributes of professionalism, the notions of humanism, excellence, accountability and altruism. This definition constitutes the themes found in many of the standards of good practice including the country's codes of ethics as provided by the Health Professions Council of South Africa (Dhai and Etheredge, 2011:16-34). This definition also incorporates the elements of professionalism as described by Adams *et al*. (1998) on behalf of the Society for Academic Emergency Medicine. Similarly, Fallat and Glover (2007) present the same components of professionalism in their technical report on behalf of the American Academy of Paediatrics that was extended to consider the needs of families and the community. Professionalism differs from the Oaths that guide professionals to fulfil the covenant between society and the health care agency. With professionalism, health care professionals are expected to incorporate the three principles, i.e. patient welfare, social justice and respect for patient autonomy when dealing with patients (Muller, 2009; van Bogaert, 2011: 3; Zijlstra-Shaw

et al., 2011). Moreover, professionalism is considered to be central if the public's trust in health care practitioners is to be sustained and it is also critical for meeting the standards of patient-centred care in the 21st Century (McQuoid-Mason and Dhai, 2008; 2011). According to Phaneuf (2008), professionalism consists of "two-faced" components. The two components are images presented by faculty members and academic clinicians together with a skills-based approach that encompasses knowledge, know-how, interpersonal skills and ethical values. However, there is consensus among researchers that no single definition best describes professionalism (Zijlstra-Shaw *et al.*, 2011). In a literature review of professionalism spanning 30 years, Arnold (2002) identified many empirical definitions of professionalism but there remain conflicting statements on how to define, teach and assess it effectively (Ginsburg *et al*., 2002).

2.5 Teaching Professionalism

With the evolution of medical education, formal teaching alone cannot meet all of these expectations and adequately prepare students to be competent and responsible professionals. With respect to that preparation, the different sectors of the medical community have a responsibility to partner with universities in the development of professional behaviours and socialization into the profession to complement earlier parenting. The foundations of a societal obligation are inculcated in students as part of their training when they publicly commit to serve by participating in an Oath-taking ceremony (Pellegrino, 2002). This undertaking remains a guide unless it is in internalised as a moral compass for facilitating the development of professional behaviour. Much of what has been discussed earlier places the patient at the centre of an ethical framework and constitutes the explicit form of professionalism: it is based on research conducted centuries ago. However, when students occupy centre stage in the teaching environment, teaching is student-centred. Expressed concerns about the increasing number of complaints directed against clinicians to professional bodies are attributed to unprofessional conduct rather than to lack of knowledge or inadequate technical skills. This finding motivated the American Board of Internal Medicine to institute the teaching of professionalism in the 1980s (Ginsburg *et al*., 2002). In meeting quality standards of training and service provision, professional bodies and accreditation organizations expect that students at all levels will be taught, and assessed on, professionalism (Mueller, 2009; HPCSA, 2006).

Based on a paper authored by Cruess (2006), the attainment of professionalism should not be seen as an event but rather as a process, a desired state, an expectation and a requirement. Such an undertaking obligates both the academic and the clinical environment to engage students in the attainment of a sound and professional ethic that will benefit patients and society. There is, however, consensus on the need to teach and assess professionalism grounded in theory (Cruess *et al*., 2000; Passi *et al.*, 2010). As health care students are not yet professionals, but rather professionals in training, they should be trained in the same environment in which they will practise (Asghari, Fard and Atabaki, 2011). This exposure allows students to meet the expectations of their patients and also be afforded an opportunity to simulate professional behaviour that is modelled on the conduct of their teachers and their supervisors in the clinical setting. For this reason Gaiser (2009) cautions faculty and professional bodies not to reduce professionalism to a mere checklist but to facilitate and support quiet moments at the end of the day that facilitate reflection to achieve the three goals: “I heard, I saw, I discovered”. Gaiser is of the view that faculty must inform what is prescribed and embrace what takes place in the clinical teaching areas if health care students are to achieve expected levels of professionalism. In resource-limited settings, even though students are limited in the health care that they provide to patients, they may be perceived by patients as having the appropriate knowledge (Mahood, 2011). This perception is especially relevant in the absence of a suitable qualified health care professional (Brainard and Brislen, 2007); hence students must be prepared for such occurrences and be able to acknowledge their own limitations.

As medicine is no longer considered only as a profession par excellence, the humanistic element is critical in the development of a professional identity. Mueller (2009) is of the view that if professionalism is taught but not assessed, this is tantamount to violating the interests of patients, students and practising physicians. As submitted by Szauter *et al*. (2003), there is much value in professionalism supported not only by formal classroom instruction, but also by a learning environment that reinforces internalization of concepts. The prescribed or explicit curriculum constitutes domains sometimes referred to as elements or attributes of professional behaviour. There are often notable similarities in what constitutes these domains with slight variations as they are informed by empirical studies, professional bodies (HPCSA, 2008; Mueller, 2009; Zijlstra-Shaw *et al*., 2011) and complaints regarding unprofessional behaviour (Rogers and Ballantyne, 2009). On the other hand, the hidden or implicit curriculum defined by Swick *et al*. (1999) as observed behaviours in the clinical teaching centres is easy to recognise but difficult to define and is considered to be a far

more effective form of teaching professionalism either as a positive or negative experience. Lempp and Seale (2004) describe the hidden curriculum "*as a set of influences that function at the level of organisational structure and culture"* to become a critical learning area*.* They are of the view that the influence and impact is far greater when students observe positive role modelling and valued characteristics amongst faculty and their clinical teachers. Similarly, Kovatz and Shenkman (2008) describe professionalism as an education milieu derived from both the formal and informal curriculum where a student expects to learn from the workplace and its environmental culture. This expectation places value on the implicit curriculum, often referred to as the hidden curriculum.

The provision of health care should not be limited to hospitals and clinics (Hoyt-O'Connor, 2008:117). For this reason Hoyt-O'Connor posits that medicine should never be merely about private practice but must also consider socio-political factors. This view is shared by Wearn *et al*. (2010) who describe the hidden curriculum *as a set of unwritten rules, influences and attitudes* that older students exert amongst novice students within medical school, with these being exerted further by doctors in clinical training centres. Brainard and Brislen (2007) are of the opinion that the customs, rituals, rules and other aspects often escape the attention of those in administrative echelons but take centre stage for the students who struggle to survive in that environment. Gordon (2003a) supports an approach that considers personal and professional growth as grounded in experience. Gordon places emphasis on professionalism that does not rely solely on formal teaching but rather is developed and refined over a period of time.

This idea was extended further by van Mook *et al*. (2009) as they were of the view that teaching and assessment of professionalism should be extended to speciality training. They believe that this extension will help maintain consistency between academic and moral excellence. Mahood (2011) offers a comprehensive perspective as she refers to the hidden curriculum as a form of medical education that is so much more than attainment of academic excellence. She considers the hidden curriculum to be a socialization process that is critical for district-based family physicians and the BCMP students who worked under the supervision of family physicians (Doherty *et al*., 2012). Mahood cautions that the working environment can be a breeding ground that fosters diminishing ethical standards in the face of manpower challenges and inadequate resources. In addressing the challenges presented above, Branch Jr. *et al*. (2001) suggest six strategies that enhance the teaching of professionalism. In elaborating on these six strategies, they are of the view that those who

teach professionalism must show commitment and that the curriculum must be tailored to the training context. The adopted approaches should facilitate communication among students and encourage self-reflection. Furthermore, they suggest that the hidden curriculum must be acknowledged and negative aspects addressed, including the incorporation of corrective measures for disruptive physicians.

2.6 Assessing Professionalism and Role-Modelling

The evaluation of medical student professionalism can take any one of the documented 88 different forms of assessment, according to a literature review undertaken by Lynch, Surdyk and Eiser (2004). As they identified the many forms of assessment, they grouped their findings into content area to be assessed and the type of outcome to be examined. In their recommendations, they suggested that future research should focus on improving existing forms of assessment rather than creating new forms (Lynch *et al.*, 2004). Kleshinski, Shriner and Khuder (2008) have suggested that professionalism can be acquired either through peer discussion, observation or role modelling. While there is little consensus on the process to be followed in the attainment of professionalism, reflection is considered a critical component (Ginsburg *et al.*, 2000; Howe, Barrett and Leinster, 2009). Assessing professionalism should not be viewed as a tick-box exercise but should be used as a tool to reward performance, identify lapses and be equally employed as an instrument to dismiss those who fail to achieve competency (Mueller, 2009).

A recommendation submitted by Arnold (2002) proposed that assessment of professionalism should seek to match context specificity with the basic principles of professionalism. According to Swick *et al*., 2006; Schwartz, Kotwicki and McDonald, 2009, when evaluating professionalism various methods must consider different contexts, be realistic, cost-effective and create opportunities for feedback to students (Stern, 2006). In line with Dreyfus's model, Huddle (2005) proposes a narrative and personal reflection as the most effective form of evaluation. Expressing views on role-modelling, house officers in a study conducted by Paice, Heard and Moss (2002) reported as positive findings a good role model as being a competent clinician, a good teacher who cares for patients and demonstrates professional integrity. Similar findings were reported by Curry *et al.* (2011) when they solicited the views of third-year medical students on what they considered to be exemplary behaviour in theatre. This finding was affirmed by Warner (2004) who defines the role of an academic clinician as

an opportunity to influence virtually every medical student, thereby shaping his/her future. Just as students recognised good role models in the same study by Paice *et al.* (ibid.), negative findings focused on consultants who demonstrated unethical role modelling. The house officers further classified the consultants as either being incompetent, mean or disrespectful towards junior colleagues and patients. Brainard and Brislen (2007), reflecting on their personal experiences as medical students, cited the unprofessional conduct of medical educators as being the chief barrier to learning about professionalism. They found feelings of helplessness to be an on-going challenge for students. They referred to an academic hierarchy that encouraged students to be professional and ethical chameleons, a view that is supported by Coulehan (2005) and Mahood (2011).

In a cross-sectional descriptive study undertaken by Asghari *et al.* (2011) with 150 medical interns based in a teaching hospital in Iran, the interns observed good role modelling 70% of the time. Even then, the interns expressed as beneficial the value of feedback that was given to students. They were of the view that breaches of professionalism by faculty and clinical teachers—even by a smallest margin—impact negatively on a student's academic performance and professional integrity. Locally, in a study undertaken by Vivian *et al*. (2011) at the University of Cape Town, medical students observed different forms of patient rights abuses and professionalism lapses but were not sufficiently empowered to report these to faculty. These experiences of professionalism as an outcome of a collective of observed negative behaviours may adversely influence the career choices of medical students (Baingana *et al.*, 2010). Wear and Castellani (2000) together with Huddle (2005) share the same view, proposing that as a measure of credibility of moral direction, assessors should be encouraged to submit themselves to professionalism evaluation in the same way that students do. They believe that this approach will encourage students to embrace observed exemplary behaviours. Premised on this grounded knowledge of a specific context inducing positive feelings about a sound professional ethic, Baingana *et al.* (2010) conducted focus group discussions at Makerere University in Uganda with health professions undergraduate students. They consider their study to be the first in Africa to solicit views of students on how they learn about professionalism, noting differences in attitude between first and fifth years that are similar to findings among students based in first world countries. They reported that students are more likely to report positively on professionalism if they are placed in the wards, are exposed to and are working directly with patients. In their study, students were also sensitised to cultural perceptions of acceptable standards of professionalism that differed from the Western methods that place much focus on patient autonomy. Similarly, in

a US study undertaken by van Mook *et al.* (2009), the medical students reported a positive shift in their perceptions about professionalism when transitioning from faculty to the clinical environment. Their focus changed from being student-centred to becoming more patient-centred. It would appear that the clinical training has potential benefits for learning as is the case with community-based learning, due to the guaranteed exposure to psychosocial issues of medicine (O'Sullivan, Martin and Murray, 2000; Hoyt-O'Connor, 2008:117). In a qualitative study undertaken by Bergh *et al*. (2006) at the University of Pretoria, final-year medical students were of the view that learning about professionalism is a lifelong process and one that does not begin and end with medical studies. Referring to their soft skills development, they proposed an interplay between "being" and "becoming" and the learning process as a concept of "guiding" and "growing", referring to the desired mentoring. Both metaphors resonate well with the Dreyfus model of professionalism as another form of skills development (Huddle, 2005).

As personal and professional development is a continuum grounded in experience, teaching and assessing professionalism is considered a critical step in graduating not only knowledgeable but also skilled practitioners. These students upon graduation must demonstrate a commitment to the ethical practice of medicine (Irvine, 2001). As health care provision is patient-centred, the requirement to maintain professional standards must be facilitated and modelled in the training environment to simulate a real setting, maintained and sustained in all heath care facilities for the good of the patient (Harris, 2004). For this reason, training facilities have a moral obligation to engage students in the attainment of a sound and professional ethic that will benefit patients and society (Cruess, 2006).

The preceding literature review suggests that the student is central to the process, underpinning the development of professionalism in a clinical training setting. The corresponding key features of this process that were identified and discussed are summarized in Figure 2.2.



Figure 2.2 Key features underpinning the development of professionalism

2.7 Conclusion

The literature considered the health care student as central to good patient care where professional development is guided by a principled approach in the clinical teaching environment. The Dreyfus model was considered to be the most relevant as it considers attainment of professionalism as a skill to be developed over a period of time. Professionalism was presented as an explicit and implicit offering demonstrating the relevance of context when learning about professionalism. Positive role-modelling was regarded as a critical element in emulating good behaviours. However, a limitation of this review is that available literature on professionalism is broad and varied, mostly sourced from international authors. In the next chapter the methodology underpinning the study is described.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter provides a detailed explication of the aims and objectives of the study; the research design; population and sampling procedures; method of data collection; data management and analysis; as well as ethical considerations.

3.2 Research Questions, Aim and Objectives

Research Questions

Based on expressed concerns relating to de-professionalization of the practice of medicine:

1. Do current teaching and assessment strategies as evidenced through exhibited personal attributes adequately prepare BCMP students to be reflective practitioners?
2. Are BCMP students able to meet their professional responsibilities by committing to the core values (contextual attributes) of professionalism?

Aim:

To assess the Bachelor of Clinical Medical Practice (BCMP) students' experiences and perceptions of professionalism during clinical rotations with a view to making recommendations designed to enhance congruency between the teaching of professionalism with the professionalism exhibited during their clinical rotations.

Objectives:

1. To assess BCMP students' experiences of ethical and moral standards in the clinical environment as reflected in the development of personal attributes;
2. To ascertain BCMP students' perceptions of professionalism in the clinical environment as reflected in contextual attributes; and,
3. To compare BCMP students' experiences of attainment of professionalism in paediatrics, emergency medicine and adult in-patient departments.

3.3 Research Design

The research design took the form of a retrospective, exploratory, descriptive, analytical and review-based case study. The researcher employed qualitative methodology with quantitative elements to assess BCMP students' personal reflection on ethics and moral values that sought to evaluate their experiences of professionalism during their final-year clinical rotations. The study was conducted based on a retrospective design method as data was obtained from portfolios that were initially designated as tools for the formative assessment of a block placement. The exploratory approach was chosen as it allowed for a greater understanding of the BCMP students' experiences learning about professionalism at the different training sites. According to Babbie (2013), exploratory research is an answer to the "what" of the study, is especially relevant when studying a new area of interest and is mostly achieved using a qualitative approach. Similarly the descriptive aspect of the study sought to describe the "how" and "why" of the study by considering the context, the behaviours and attitudes related to professionalism as perceived by the students (Mouton, 1996:101).

The qualitative approach is a method that seeks to elicit the participants' personal accounts of their experiences and the meaning of those experiences (Schurink, Fouche and de Vos, 2011:399; Bernard *et al*., 2011). For this research, the interpretive qualitative approach was adopted as efforts were made to understand the world of the BCMP students as they navigated the various training sites (Terre Blanche, Kelly and Durrheim, 2006). Thus the comparative experiences in the various training sites supported the collective case study approach. According to Fouché and Schurink (2011:321), a collective case study enhances the understanding of the researcher regarding a social issue or population being studied and enables comparisons between cases and so that theories can be extended and validated. The case being studied may refer to a process, activity, event, programme or individual or multiple individuals. On the other hand, the quantitative approach is considered a more exact approach, a science almost, and uses numbers to describe the relationship between variables. The value in employing a qualitative or a quantitative method or a combination of the two is often determined by the researcher based on intended outcomes of the study. However, Delport and Fouché (2011:433) posit that many authors in the human sciences are of the view that it is not unusual to employ both methods whether one does that consciously or not. The qualitative method was the most preferred method in many of the studies reviewed (Bergh *et al*., 2006; Baingana *et al*., 2010; Asghari *et al*., 2011). This method was

chosen to assess in the first instance the students' ability to reflect critically and independently on moral and ethical issues. Secondly, the idea was to assess the students' ability to reflect on the core values of professionalism as a relative and applied concept; hence there was a need to include the quantitative elements (Bernard *et al*., 2011). As the current research was a focused case study, it was necessary to undertake an analytical approach in order to understand issues of professionalism that were specific to the BCMP students and relevant to their training contexts. Content analysis is described by Strydom and Delport (2011:380) as a method of transforming the symbolic content of a document from an unsystematic qualitative form to a systematic quantitative form. Content analysis was employed to examine emerging themes, meanings and patterns from the submitted portfolios and quantify the frequency with which they were articulated. The review-based approach supported a decision to propose as an outcome of this study, a curriculum review of adopted methods in the teaching and assessment of professionalism.

3.4 Population and sampling procedures

The study focused on portfolio entries completed by final-year Bachelor of Clinical Medical Practice (BCMP III) students registered with the Faculty of Health Sciences at the University of the Witwatersrand (Wits). During the period in which the research was conducted, the students were undertaking clinical training in District Education Campuses (DECs) based at two Gauteng sites and four sites in North West Province (Figure 3.1). The sites were chosen based on condition that they met the minimum standards of training as prescribed by Wits for programmes that require health care students to engage in community-based education and training. As the entire population of 25 final-year BCMP students was targeted, no sampling procedures were adopted. BCMP students undertook a compulsory five-week rotation in each of the specified clinical disciplines, namely: paediatrics, emergency medicine, surgery, outpatients and adult in-patient departments.

3.4.1 Inclusion Criteria

All registered final-year BCMP students who voluntarily agreed to participate in the study were included in the research. The portfolio entries for each of these participants for the rotations in paediatrics, emergency medicine and adult in-patient departments formed part of the study. As part of this current study, only portfolios from three of the five rotations were included, based on their time in paediatrics, emergency medicine, and adult in-patient

departments as these sites adequately covered the BCMP scope of practice. In choosing the portfolio entries to represent the three specified clinical disciplines, the researcher was of the view that the unique experiences in paediatrics allowed the students to reflect critically on issues that were specific to children as patients (Fallat and Glover, 2007). The reflections based on the time spent in emergency medicine and the adult in-patient departments complemented the experiences in the surgery and outpatient departments, which were the other two departments where students were required to take their clinical placements. For this reason, the latter two departments were excluded from the research. The researcher was also satisfied that reflecting on their experiences in paediatrics, emergency medicine and adult in-patient departments adequately represented the maximum spectrum of a clinical training environment described by Kaldjian *et al*. (2012).

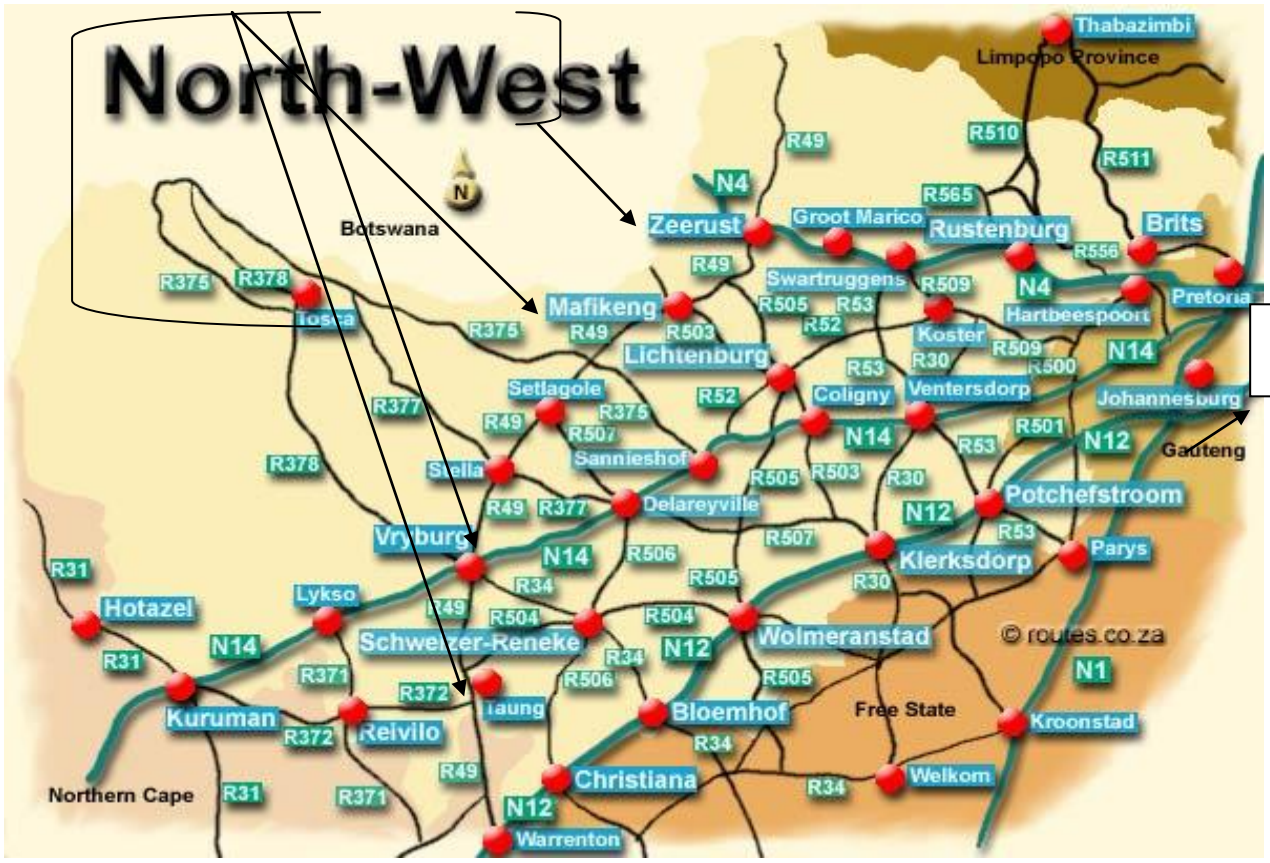

Figure 3.1: **Map of Student Placements**

Key: Eleven of the BCMP students were based at sites in North West Province identified by arrows. The remaining fourteen students were based in Gauteng indicated in the rectangle along the periphery of the map.

3.4.2 Exclusion Criteria

Students who did not wish to participate in the study were excluded as the principle of voluntary participation was upheld (Dhai, 2008). Portfolios undertaken in surgery and outpatient departments were excluded from the study for the reasons described in the inclusion criteria.

3.4.3 Description of the Sample

A total of 71 portfolios were received for analysis instead of the 75 that were expected: this constituted a limitation of the study. The return rate for the portfolios was 100% (n=25) Emergency Medicine (EM), 92% (n=23) Adult in-Patient Ward (AIPW) and 92% (n=23) Paediatrics (Paeds). The reason for the shortfall was that even though all the students' portfolios were submitted for assessment, the theft of the clinical coordinator's bag with her personal computer meant that the four portfolios that were submitted electronically (two each from AIPW and Paeds) were not available for analysis. All 25 final-year BCMP students spent five weeks for each rotation in a Level 1 District hospital designated as a clinical training site. The closest site in Gauteng Province was a mere 10km from medical school, while the most distant site was in North West Province some 450km away. Eleven of the 25 students rotated in training sites in their home province, the North West Province, which is classified as a rural province (Couper, de Villiers and Sondzaba, 2005:126) while the remaining 14 students were based in Gauteng Province.

All the portfolios were analysed and no attempt was made to only continue analysing the narratives until saturation was reached and no new themes were forthcoming. Instead, it was felt that all data deserved to be analysed as the portfolios provided rich, qualitative insights into the experiences of the BCMP students. The portfolios were all written in English and submitted as hard copies ranging from one to five pages dependant on whether the document was typed or handwritten. There was no limitation to the word count, unlike in other studies conducted at other institutions. One such study undertaken by a US medical school on Case Observation and Assessments required students to submit a four-page, typed and double-spaced document (Kaldjian *et al*., 2012). In this study, no other socio-demographic data was available for any of the students as part of this analysis as the portfolios were anonymized to protect the identities of the students (Howe *et al*., 2009).

Consequently, it was not possible to formulate a profile of the student participants or paint a definitive picture of the sample.

3.5 Research Instrumentation

Portfolios were considered to be an ideal form of assessing students' perceptions of professionalism based on the fact that they allowed for students' voices to be heard. The benefits of the researcher's choice of instrument and adopted analysis in undertaking this research are well documented in the literature (Branch Jr., 1998; Bernard *et al*., 2011; Zijlstra-Shaw *et al*., 2011). Lynch *et al*. (2004) identified portfolios as one of the 88 instruments for assessing professionalism. They further described a suitable instrument as one that is informed by the content area to be addressed and type of outcome that is desired. Similarly, the use of portfolios is considered a personal and narrative form of reflection with value for both the students and the educators as it creates opportunities to give feedback (Harris, 2004; Huddle, 2005; Malpas, 2011). According to Branch Jr. (1998), independent reporting by students allows for critical reflection and honest discussion.

Driessen *et al*. (2005) refer to the evidence of competence and progression that were considered when portfolios were selected as a tool to assess students' experiences of professionalism. Driessen *et al*. (2007) reported, as an outcome of a systematic review, the value of portfolios as effective and efficient tools of assessment in primary care. This view is also shared by Mathers *et al*. (1999). This finding was critical to the current study as it supported the context; in this case study the primary health care settings were the District Education Campuses. The fact that written reflections facilitate a process whereby students link their clinical experiences with the development of professionalism was of particular interest in this study as the reflection process constituted a summation of a three-year integration of theory and clinical work (Coulehan, 2005; Howe *et al*., 2009; Bernard *et al*., 2011). Reading the portfolios was an exhaustive process, as it required the researcher to be attentive and capture the story as narrated by the student. The fact that students were not guided in the process relative to the research process, contributed to the data analysis process being an extended and consuming experience. The negative experiences of the researcher and the perception of the use of portfolios as a tedious process have been noted and reported by Driessen *et al*. (2005) and Driessen *et al*. (2007).

3.6 Data Collection

As part of their formative assessment at the end of the block, the BCMP students were asked to reflect on their experiences of professionalism as a one-page activity in their portfolios by responding to the instruction below, set out in italics.

Reflect on the nature of the relationship between Health Care Professionals and Society as it is observed in the workplace. Your reflection should be based on your daily interactions with patients and other members of the health care team taking into account the rights and responsibilities of patients as described in the Patients' Rights Charter and the Batho Pele principles. Refer to Hatem's definition below of Professionalism as a founding principle on which to base your reflections: "The extended set of responsibilities that include the respectful, sensitive focus on individual patient needs that transcends the physician's self-interest, the understanding and use of the cultural dimension in clinical care, the support of colleagues, and the sustained commitment to the broader societal goals of medicine as a profession".

This exercise was considered to be critical in that it could be used to evaluate both moral and academic functioning as a measure of professional integrity as the students personally decided on the content of their discussions (Kaldjian *et al*. 2012). In a similar study undertaken by Bernard *et al*. (2011) in the US, medical students were asked to observe and record observations demonstrating professional or unprofessional behaviours during an Emergency Medicine clerkship.

3.7 Data Analysis

Data was captured from the rotation portfolios completed by the BCMP students in which they critically reflected on the activities in that particular rotation in terms of their interaction with Health Care Workers (HCWs) and patients. The BCMP students were also required to reflect on their experiences of professionalism as informed by Hatem's (2003) definition of professionalism that students had discussed extensively in their first year. The researcher sought to find meaning in each of the stories narrated by the students and to also consider cultural and social artefacts as determined by the context (Schurink *et al*., 2011:402-3). For this reason the qualitative approach was a method of choice to analyse the open-ended

reflections (Dey, 1993:11-13). Themes were categorized as personal attributes with sub-themes comprising accountability and responsibility, critical reflection linked to professional development, as well as personal growth as described by Malpas (2011). The open-ended responses to these three sub-themes were subjected to simple frequency analysis as a descriptive tool using Excel (Bernard *et al*., 2011). Similarly, students' responses on their reflections as informed by Hatem's definition were open-ended and not grouped into categories. However, for the purpose of the analysis, the core values were distilled according to the HPCSA guidelines that direct the practice of health care professionals in South Africa (HPCSA Booklet 1, 2008; Dhai and Etheredge*,* 2011:31-32). The identified contextual attributes were analysed by grouping them into sub-themes and computed using simple descriptive statistics methods captured on Excel as depicted in Table 3.1 (page 43). Students' experiences of professionalism were compared across disciplines for similarities and subjected to an ethical analysis that informs the discussion in the following chapter. According to Mogalakwe (2006), there is value in adopting a method of study that is relevant to the phenomenon you wish to study and is considered to be cost-effective.

As part of the data analysis process, the researcher read through each of the portfolios (Paeds; EM and AIPW) to get a sense of the students' writing styles. The process of immersion was repeated by reading through additional portfolios from the same discipline to ascertain if students followed and responded to the instruction in a similar manner. The researcher highlighted key words from the students' portfolios in response to the instructions. This process was followed by identification of major topics, which were clustered together. Each portfolio was paraphrased and direct quotes were transferred to a new document that became the working document representing the dataset for Paeds, EM and AIPW. A one-page summary was generated and major findings highlighted in accordance with the objectives. In accordance with recommendations by Schurink *et al*. (2011:408), the process was revisited. The portfolios were read again to validate earlier findings and this was repeated until common themes were identified from the portfolios for each of the three disciplines. The focus was very much on authenticating the results in the three datasets. The data analysis process is depicted in Figure 3.2 (page 44).

Furthermore, to quantify the data the themes that were crystallized as part of the second objective, attributes that matched the core elements of professionalism, i.e. the contextual attributes, were captured in an Excel spreadsheet each time they were reflected on by students (Bernard *et al*., 2011) and formatted as presented in Table 3.1 (page 43).

3.8 Procedures Adopted to Enhance the Trustworthiness of Data

According to Lincoln and Guba (1985:20) the aim of trustworthiness when undertaking this qualitative analysis was to reassure the readers that findings of the research were "worth paying attention to". To achieve this goal, the four criteria needed to be fulfilled. These were credibility, transferability, dependability and confirmability.

Credibility

This construct is a measure of the extent of the truth or believability of the data as drawn from the original sources, and determines whether this data is adequate for the drawing of inferences. Efforts were made to enhance credibility of the study by providing a detailed description of the theoretical framework, the setting for the study and the methods of collecting and analysing the data as recommended by Lincoln and Guba (1985). Credibility was further enhanced through triangulation of data sources (Raines, 2011:497) whereby portfolios were collected from different training sites to represent the three departments, i.e. paediatrics, emergency medicine and adult in-patient wards.

Transferability

This construct refers to the extent to which the findings can be applied in a different context with a similar background and a different set of respondents. In order to achieve this goal, the researcher included verbatim descriptions of the data to allow readers to make inferences from presented information. As the students formed the first cohort to be trained, a detailed description of the context was provided not only as a reference point but also for the purpose of training future middle-level health care workers in District Education Campuses (Lincoln and Guba, 1985:319-320; Schurink *et al*., 2011:420). However, it is acknowledged that the study was based on one cohort of BCMP students, which precludes generalization or transferability of findings to other groups of BCMP students trained at other universities.

Dependability

This construct refers to the reassurance that if the study were to be repeated the same findings would be reported for a different group of BCMP students based at the same sites. Due consideration of external factors that might occur over a period of time, such as changes arising from a review of the training curriculum or retraining of supervisors, needs to be taken into account to close identified gaps. Dependability of data was enhanced through the provision of the same set of instructions for all students. Moreover, all portfolios were analysed by the same researcher using the same method of data analysis (Lincoln and Guba, 1985:319-320; Schurink *et al*., 2011:420-421).

Confirmability

This construct refers to the measure of the extent to which the different sets of data facilitate independent interpretations of findings relative to the final report. It is assumed that the process of immersion and repeated readings of the portfolios enhanced neutrality (Lincoln and Guba, 1985:319-320; Schurink *et al*., 2011:421). Data analysis in this study was confirmed by Prof. Eleanor Ross, a research consultant at the Steve Biko Centre for Bioethics.

3.9 Ethical Issues

In conducting the study, the following ethical principles were considered:

Obtaining permission and safeguarding the interests of students

Ethical clearance was obtained from the Human Research Ethics Committee (HREC-Medical) of the Faculty of Health Sciences at the University of the Witwatersrand. Ethics Clearance Certificate Number M110740 is displayed in Appendix E. Defining the role of research ethics committees (RECs), Dhai and McQuoid-Mason (2010) have placed emphasis on a fair and just approach to the selection of research participants by ensuring that selection, recruitment, inclusion and exclusion criteria are based on sound scientific and ethical principles.

Vulnerability of Research Participants

The vulnerability of the students was considered based on the asymmetrical relationship that exists between students and their lecturers as suggested in Guideline 13 of the International Guidelines for Biomedical Research involving Human Subjects on hierarchical structures (CIOMS, 2002:65). The researcher had no teaching responsibilities in relation to the students in their final year of study. All teaching responsibilities of the researcher were limited to their first and second years. The data was only made available to the researcher following marking and grading of portfolios by the relevant lecturers. Marks were blanked out before the portfolios were made available to the researcher. On condition that the students' academic performance was not going be compromised by the research, the researcher was granted permission to proceed with the research by the Acting Head of the Department of Family Medicine (Appendix F). As the study was based on academic records intended primarily for a different purpose and based on the asymmetrical relationship between students and the researcher, permission to proceed with the research was sought and obtained from the Dean of Students. In line with the recommendations of the Human Research Ethics Committee (Medical), the BCMP students were approached by a neutral third party for informed consent to include their portfolios in the study.

Informed Consent

In this current study, all four components of the consent process, namely: disclosure of information, understanding of what the research entails, capacity of the participants to engage with the information and voluntariness that constitute the ethical and legal elements of a valid consent process as described by McQuoid-Mason cited in Dada and McQuoid-Mason (2001:5) and Dhai (2008) were considered. The researcher provided the students with information in the same language as that used for academic purposes. The information provided was such that each student was able to understand what was included and their interests were considered as the information sheet addressed the "what", the "how", the "when" and the "so what" of the research (Appendices G and H). A departmental office administrator facilitated the consent process as it involved students. The process of obtaining individual informed consent is considered a universal requirement in all research, although according to research undertaken by Tsotsi (2009), there is variation in how this process is implemented in developed countries compared to developing countries. In South

Africa as per provisions of the Constitution (1996) as described in Section 12(2) (c) which are borne out in the National Health Act (2003) and Booklet 10 of the Health Professions Council (2008), all research participants have a right to bodily and psychological integrity which includes a right not to be subjected to medical or scientific experiments without the participants' informed consent. Furthermore, responding to concerns that were raised about the quality of ethical reviews in developing countries, Cleaton-Jones and Wassenaar (2010) published detailed guidelines on what is plausible within the South African context regarding the protection of human participants in health research. While they have made recommendations to strengthen the role of Research Ethics Committee in response to cited deficiencies, their findings suggested that South Africa's legal and policy provisions were applicable even to the most vulnerable research participants.

Voluntary Participation

The students were provided with an information sheet detailing the intention of the research and the approach to be adopted in analysing the data. All 25 students agreed to participate in the study and submitted written informed consent. In submitting the signed consent forms, students confirmed their willingness and interest in having their portfolios included in the research (Dhai, 2008). Students had the right to consult the research supervisors should they wish, and full contact details were made available to the students. Students were also encouraged to contact the Chair of the Health Research Committee at Wits if they had any queries related to the research.

Right to Decline

Students were given explicit assurance that should they not wish to participate they would not be victimised in any way. They were also assured that their academic profile would not be compromised in the event that they declined to participate. This guarantee was structured in line with the recommendations provided in the CIOMS, Guideline 13: 65.

Confidentiality

Copies of data pertaining to the research question were made after which the original portfolios were returned to the coordinator of the programme. All data from the portfolios was anonymised and all information pertaining to students was replaced by unique numbers (Table 3.1) in such a way that only the researcher could link each entry to a particular portfolio (Howe *et al*., 2009). Details of the sites where students were based were excluded from the analysis to protect the identity of students (Dhai, 2005). No other personnel were identified by name in either the analysis or the final report. Students were informed of the intention of the researcher to include, where it was deemed necessary, direct quotes from their portfolios.

Feedback to Participants

As all the data that was used in this study was anonymised, it was not possible for the researcher to share the preliminary findings of the study with the graduates. However, two aspects of the research process, i.e. acknowledgement of the input made by the class, and the fact this group is the first cohort of the Clinical Associates programme, mandate the researcher to assume ethical responsibility and make the results available to the graduates as soon as the university processes are finalised (Dhai, 2005). Referring to due processes with regards to respect for potential and enrolled participants, Dhai (2005) makes the following recommendations:

- Show due respect to the research participant by managing all information in accordance with confidentiality rules;
- Permit participants to change their minds and withdraw from the trial without being penalised;
- Provide participants with new information gained during the trial;
- Monitor their welfare throughout their participation; and,
- Inform participants of what was learned from the research.

The value of the ethical process described above cannot be overlooked if the research is to be considered as scientific and ethical; it must meet all seven ethical requirements before approval is obtained from the relevant Research Ethics Committee (ibid.).

Table 3.1 Professionalism Data Analysis Sheet					
Rotation	**Entry ID**	**Clinical Dept**	**Province (Gauteng/North West)**		
1	**P 1 - P25**	Paeds			
2	**EM 1 - EM 25**	Emergency Medicine			
3	**AIPW 1 - AIPW 25**	Adult In Patient Ward			
BCMP Students' Experiences, Reflections and Perceptions					
Personal Attributes (Individual) - Qualitative Analysis (Themes)			**n =**		
1. Accountability and Responsibility					
2. Critical Reflection					
3. Personal Growth					
Contextual Attributes (Others) - Quantitative Elements (Themes)			**Frequency /Percentage**	**Comparative Analysis**	
Core Values			**Paeds**	**Emergency Medicine**	**Adult In- Patient Ward**
1. Respect for Persons					
2. Beneficence					
3. Non Maleficence					
4. Human Rights					
5. Autonomy					
6. Integrity					
7. Truthfulness					
8. Confidentiality					
9. Compassion					
10. Tolerance					
11. Justice					
12. Professional competence and self Improvement					
13. Community					

Definitions of Core Values (HPCSA Booklet 1, 2008)

Respect for persons: Health care practitioners should respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value.

Beneficence: Health care practitioners should act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest.

Non-maleficence: Health care practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.

Human rights: Health care practitioners should recognise the human rights of all individuals.

Autonomy: Health care practitioners should honour the right of patients to self determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.

Integrity: Health care practitioners should incorporate these core ethical values and standards as the foundation for their character and practice as responsible health care professionals.

Truthfulness: Health care practitioners should regard the truth and truthfulness as the basis of trust in their professional relationships with patients.

Confidentiality: Health care practitioners should treat personal or private information as confidential in professional relationships with patients - unless overriding reasons confer a moral or legal right to disclosure.

Compassion: Health care practitioners should be sensitive to, and empathise with, the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.

Tolerance: Health care practitioners should respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions.

Justice: Health care practitioners should treat all individuals and groups in an impartial, fair and just manner.

Professional competence and self-improvement: Health care practitioners should continually endeavour to attain the highest level of knowledge and skills required within their area of practice.

Community: Health care practitioners should strive to contribute to the betterment of society in accordance with their professional abilities and standing in the community.

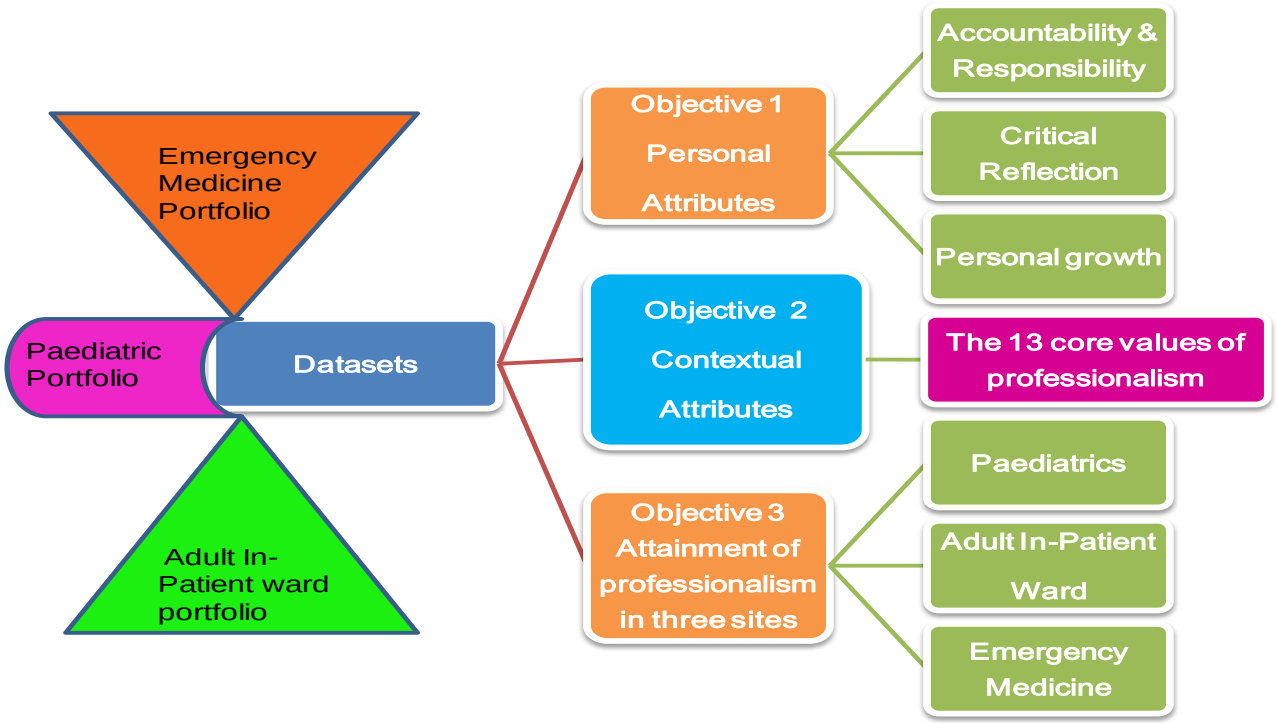

Figure 3.2 The Data Analysis Process

3.10 Conclusion

In this chapter the researcher sought to justify the research design as guided by the aims and objectives of the research. A thematic analysis of personal and contextual attributes of professionalism was described and justified. Ethical issues were considered in relation to the asymmetrical relationship between the researcher and the students. The procedures adopted for data management and analysis were also discussed. In the following chapter, discussion on personal and professionalism attributes is informed by the outcome of the analysis.

CHAPTER FOUR: PRESENTATION AND DISCUSSION OF RESULTS

4.1 Introduction

In the previous chapter, the research design and methodology were discussed. In this chapter, the main results are presented as personal and contextual attributes to assess if objectives 1 and 2 were met. In terms of objective 3, the BCMP students' experiences in the attainment of professionalism in the three departments are evaluated. The major themes are identified and classified with their corresponding sub-themes. Themes are depicted in the form of figures and illustrated with verbatim quotations that allow the voices of the students to be heard. A summary of the key findings is presented at the end of each theme followed by an integrated discussion for the two major themes, i.e. personal and contextual attributes.

4.2 Presentation and discussion of results

The BCMP students' perceptions of professionalism in terms of the two major themes represented in this study, namely: personal attributes (objective 1) and contextual attributes (objective 2) are reflected in Table 4.1. The students' views on attainment of professionalism (objective 3) are presented as informed by the students' comparative experiences in paediatrics, emergency medicine and adult in-patient wards.

The reflections included in this study ranged from brief comments to detailed, elaborate descriptions as determined by the student concerned. The researcher consolidated the feedback into a narrative for each theme. The quotes are presented verbatim and have not been edited in any way.

Table 4.1 Presentation of overall results

<table>
<tr><td>Major Themes</td><td colspan="2">Objective 1: Three sub-themes were identified as indicators of ethical behaviour and reflective practice.</td></tr>
<tr><td rowspan="3">Personal attributes</td><td colspan="2">1. Accountability and responsibility to consider the relationship between health care professionals and society</td></tr>
<tr><td colspan="2">2. Critical reflection linked to professional development</td></tr>
<tr><td colspan="2">3. Personal growth</td></tr>
<tr><td rowspan="8">Contextual attributes</td><td colspan="2">Objective 2: Thirteen sub-themes were identified based on the core values of professionalism as determined by the Health Professions Council of South Africa (Booklet 1, 2008)</td></tr>
<tr><td>1. Respect for persons</td><td>7. Truthfulness</td></tr>
<tr><td>2. Beneficence</td><td>8. Confidentiality</td></tr>
<tr><td>3. Non Maleficence</td><td>9. Compassion</td></tr>
<tr><td>4. Human Rights</td><td>10. Tolerance</td></tr>
<tr><td>5. Autonomy</td><td>11. Justice</td></tr>
<tr><td>6. Integrity</td><td>12. Community</td></tr>
<tr><td colspan="2">13. Professional competence and self-improvement</td></tr>
<tr><td rowspan="4">Attainment of professionalism</td><td colspan="2">Objective 3: Comparative experiences of professionalism based on BCMP students' experiences in EM, Paeds and AIPW.</td></tr>
<tr><td colspan="2">1. Paediatrics (Paeds)</td></tr>
<tr><td colspan="2">2. Emergency Medicine (EM)</td></tr>
<tr><td colspan="2">3. Adult in-patient wards (AIPW)</td></tr>
</table>

4.3 THEME 1: Personal attributes of professionalism

Students reflected on their personal moral development as ethical, accountable and reflective practitioners in accordance with the first objective of the study. They also reflected on the nature of the relationship between health care professionals and society. As future health care professionals considering their personal development, the BCMP students critically reflected on their role in promoting patient autonomy and social justice. The results of each theme are presented below.

Table 4.2 Personal attributes of professionalism

Personal attributes	**BCMP students' reflections/per department**			**Frequency of reflections in portfolios**	
Attributes of reflective practice	**Paeds n=23**	**AIPW n=23**	**EM n=25**	**Total N=71**	**Percentage**
1.1 Accountability and	18	21	15	54	76.1%
Nature of relationship	8	8	6	22	30.9%
between HCPs and society					
1.2. Critical reflection	17	17	17	51	71.8%
1.3. Personal growth	7	12	6	25	35.2%

Key: Paeds = Paediatrics

AIPW = Adult In-Patient Ward

EM = Emergency Medicine

HCP = Health Care Professional

4.3 *Sub-theme 1.1: Accountability and responsibility to consider the relationship between health care professionals and society*

As part of this theme, students made reference to the Oath linked to professional commitment as a basic requirement in meeting patient needs. As one student reflected:

> *"When I started the BCMP we were all asked to take an Oath; this Oath meant that patients will always come first and everything else later."*

Students described as a norm the expectation for all HCPs to be knowledgeable regarding their duties and responsibilities:

> *"The moment you start talking it means you know your duties, your rights and your responsibilities. Therefore you should be able to discuss patient's rights and responsibilities."*

> "*Being a health care provider is one thing but being a professional health care provider is something else because you need to know ethical standards very well and understand their meaning*."

The ideal HCP was perceived to be someone capable of incorporating core ethical values and standards of good practice as part of their daily interactions with patients:

> "*One should bear in mind that these standards are not set just to fill an Act booklet, but they are there for us HCP to practice them..."*

The expectation was that this knowledge would automatically transfer to patient care, with the emphasis on the need to treat all patients in a fair and just manner:

> "*The Oath has no significance if HCP mistreats patients...We take the Oath not because we are doctors but because sooner or later we are all patients."*

Students extended the commitment to the Oaths to include Batho Pele principles, which provided a framework through which HCPs committed themselves to public duty, extending from a promise on the wall to the actions of HCPs. A copy of the Batho Pele principles is set out in Appendix D.

> *"A good HCP is one who takes Batho Pele Principles into account whenever consulting a patient...If you have eyes you will notice that every hospital has Batho Pele posters on the walls. These posters state the patient's right and our responsibilities as health workers..."*

The commitment to the profession as a public duty was not lost to the BCMP students. In their reflections, the patient was considered a priority in all that was done. Some students highlighted the

fact that at the point of consultation patients are vulnerable but that HCPs have a corresponding responsibility as determined by their public duty to treat patients as people:

> "*Until HCW realise that they are public servants, they will not fulfil their duties. Being a public servant means rendering good standard service with passion and effectiveness...*"

Some of the criteria for unethical conduct referred to by students, besides the attitudes of HCPs, included the failure of HCPs to respond to emergencies or failure to follow protocol as reflected in the following question posed by one of the students:

> "*Who owns a paediatric emergency? Is it casualty or the labour ward*?"

Even when patients were treated with respect, in line with the Batho Pele principles and the Patients' Rights Charter (set out in Appendix C and D), students observed systemic challenges that resulted in lack or shortage of equipment. From the perspective of the BCMP students, lack of equipment often led to patients receiving sub-optimal care with adverse outcomes. While the students considered the impact of the systemic challenges not to be in the best interests of the patients, they valued the attitudes displayed by the HCWs:

> *"I feel like being in a District Hospital is very depressing because most of the time you will watch patients dying in front of you... We get used to working in an environment with less equipment that actually works. Patients die due to lack of equipment such as arterial blood gas machines and central lines - not because doctors and nurses do not care.*"

Students also expressed concerns about their personal safety and about exposing themselves to infectious diseases and materials. They felt that their safety was compromised when protocols were not followed. Furthermore, this experience also contributed to patient welfare being compromised:

> *"My secret fear is that we work in environments that are not ideal, that are not safe and sometimes I feel like our lives are put at risk...Most students and junior doctors are not willing to expose themselves to infectious diseases..."*

> "*Fear of contagion compromises patient care...When sterility is not practiced it compromises patient care."*

However, this issue was not the only concern. Students felt compromised when they had to deal with violent patients such as those presenting with acute episodes of psychosis, mental patients and patients who were brought in by police following a pub brawl or gang violence. The students felt that they did not have the required skills to handle such patients.

The nature of the relationship between health care professionals and the patients demonstrated a commitment to the calling of the HCPs. Students were of the view that this relationship was founded on trust and required every interaction between HCPs and patients to reflect this trust, as encapsulated in the following response:

> *"Credit must be given to the minority of HCW who are still committed to their jobs such as Sr S. What I like and applaud her for is the fact that she took her own initiative and walked an extra mile to make the patient feel much better."*

The students commented explicitly on the nature of the relationship between HCPs and their patients and its rewards by pointing out the benefits of this mutual trust, as depicted in the following response.

> *"Amazingly I found It is easier to work with children as what you see is what you get...As heartbreaking as it is when the children are sick, there is a sense of relief and accomplishment... Once they are well, they are the most grateful patients."*

The perception was of HCPs assuming a responsibility founded on trust, thereby calling for HCPs to go the extra mile to meet their professional obligations to patients and society:

> "*To be regarded as a good HCP requires a long-life commitment and an overriding dedication to one's fellow human beings and society."*

The link between the profession and society was highlighted by a student who referred to patients as having multiple roles in society and thus deserving of the respect that was due to them:

> "*A patient is not just a patient she is a mother, a wife or a friend. As HCWs we serve, we care and save lives... Our job as HCW has to be done to perfection - there's no room for lousy mistakes because when we make mistakes, people die and that defeats our purpose in the health system."*

Patient education was considered by many to be a critical tool in closing the knowledge gap between the professional HCP and the patient, as this factor would limit non-compliance and unnecessary hospitalisation:

> "*The 12 year old's right to refuse treatment is not informed if he is RVD reactive, defaults on treatment and refuses transfusion for fear of contamination by infected blood.*"

The relationship between health care professionals and their patients was perceived as complex when HCPs failed in their duties to inform the patient regarding reasons for admission. The most frequent question the patients tended to ask of the BCMP student following consultation with a consultant validates these concerns: *"So what do they say I have?"* As some of the students could speak the local languages they felt that they were forced to make up for the shortcomings of the

other HCWs who had failed to meet their professional responsibility to provide patients with appropriate information:

> "*HCPs seem to be forgetting that patients have a right to be told about their illness and given an explanation as to why we take bloods or put up drips."*

The death of patients, particularly in the wards, was perceived as the necessary end when students felt that the patient had been attended to and had reached the end stage of the disease. Students understood that they could not "play God" and that it was not possible to save all the patients. However, there were instances when the students spoke of a wrongful death when patients had died due to lack of equipment. The following response captured this concern:

> *"Shortage of beds is not only an inconvenience to doctors but also increases the mortality...and the transmission of illness to other patients and to staff."*

The high mortality rates were depressing to some of the students but they learned from the HCWs to move on and continue to render the required health care to patients:

> *"Having to continue to working like nothing happened was one of the difficult parts...but seeing everyone else continue made it easier...We cannot play God we can't save all the lives. Death is a part of us... We also need to come to terms with the fact that we are going to lose some."*

The students decried the lack of debriefing sessions as they struggled to deal with their own emotions:

> "*When death is no stranger to your setting where should one find refuge especially when everyone has accepted this as a norm?*"

For one student, death presented an opportunity for the student to learn an important skill, namely, that of breaking bad news to families:

> *"I feel like being in a District Hospital is very depressing because most of the time you will watch patients dying in front of you...I witnessed death every week of the rotation about two people per week most of them were from Stage 4 HIV. I also had a chance to break bad news to the family of the deceased."*

Students also expressed concerns about patients who did not observe referral protocols. Instances where patients logged a call to emergency medical services and were brought in by ambulances when they could walk unaided, were considered a burden. Students labelled these patients as abusive to a health service meant for critical patients. Similarly, family members who failed to observe hospital protocol such as the stipulated visiting hours caused much strain to the service and

showed no respect to other patients as they demanded the attention of attending HCPs, straining the relationship between health care professionals and society.

In the context of this theme, the majority of BCMP students (n=54) reflected on the determinants of accountable and responsible practice and sought to define ethical and unethical behaviour based on their experiences. The principles of good practice were referenced in relation to patient care with a distinction drawn between health care providers and professional health care providers. Professional HCWs were described as those HCWs whose behaviour was exemplary. On analysing their responses, it seemed that most (n=21) were informed by their experiences in the adult in patients ward (Table 4.2). The general trend was of students reflecting on what they considered to be the responsibilities of HCWs. As the students encountered a range of ethical issues/challenges, they continued to refer to the requirements of standards of good practice as determined by the Oath, the guidelines of ethical conduct of HCWs, Batho Pele and the Patients' Rights Charter.

In summary, only about a third of the students (n=22) reflected on the relationship between health care professionals, their patients and society (Table 4.2). Even with the limited numbers, strong views were expressed that provided much detail on the nature of the relationship. The benefit of this relationship was compromised when patients were not informed regarding their care in instances where the disease was not explained to the level of understanding of the patient and how the treatment was going to benefit them. This was a common finding that was context-specific for patients admitted in Paeds and AIPW. It would appear that rural patients bore the brunt of these experiences. Death was an experience that was recognised as the necessary end but at times raised ethical dilemmas presenting either as a challenge or an opportunity. At times lack of resources was blamed for mortality in EM and AIPW. There were also instances where the families of sick patients violated hospital protocol and abused state resources (AIPW and EM). A recurring observation was a reference to a minority of HCPs who still had a conscience and showed commitment to patient care. These findings need to be viewed against the backdrop of the current state of health care in South Africa. For example, Dhai (2012) refers to the current state of health care in this country and subsequent ills that patients are subjected to as being similar to the apartheid era where patients were denied access to health care due to prevailing policies. Furthermore, Dhai blames the state for system deficiencies, lack of accountability and declining standards of care as a result of late or non-payments of suppliers, incompetent managers and non-delivery of services.

4.3 *Sub-theme 1.2: Critical reflection linked to professional development*

This theme allowed students to reflect on their professional development as they rotated through the different departments. Many of the students (n=51) were motivated to exhibit model behaviours, and recognised the value of constantly reflecting as a skill that develops over a period of time (Table 4.2). They recognised the need to conform to the theoretical guidelines as one student acknowledged being influenced to short-circuit the accepted process of clerking patients. According to the student, this process tended to compromise patient care and led to the wrong conclusion, forcing the student to go back to the correct management approach.

Context-specific approaches in obtaining sensitive patient information such as the patient's HIV status were reflected on as positive and negative experiences. One student was fortunate in that it was one of the parents who recognised the student's naivety and proceeded to show the student the correct way to elicit confidential information:

> *"I remember in the first week I asked one of the mothers if she was HIV positive and she said no. She then called me to speak privately with her and it was only then when she disclosed that she was HIV positive. I then realised my mistake immediately and never did it again."*

The negative experiences included cases where in one facility patients were asked to divulge sensitive information within earshot of all in a busy out-patients department. Some of the reflections were based on experiences that had a profound impact on their learning experiences, from assumptions they made as students to a realisation that to err is human:

> "*In medicine you should never say never and never say always as not every malnourished patient is HIV infected*...a*s a Clinical Associate student I have learnt that patients either die because of late medical intervention, natural causes... – as HCPs we are subject to mistakes, patients can die on account of our errors. We are human beings - educated and trained does not exempt us from infallibility.*"

The general perception was that there was no limit to learning and sharing information in the clinical training environment. The benefits were not limited to the BCMP students as the registered learners:

> *"Being a Teachable Learner made my interactions with my colleagues a lot better. I also taught some nurses some things that they needed to know which made work easier and more fun"*.

The attitudes of HCPs were highly regarded and linked to outcomes of the consultation process. Students were of the view that raging tempers and shouting at patients were all attributes that

compromised patient care. One student recalled a verbal dispute witnessed between an HCP and a patient's mother. The exchange had a far-reaching impact on the student. The effects of this exchange were not only perceived as causing harm to the patient but also the student as a trainee HCP. As an outcome of this negative experience, the student reflected on the impact of this experience towards his/her approach to patients as follows:

> *"I resolved to learn to control my temper, my daily frustrations and be wary of the control that my mood might have on the outcome of the patient consultation."*

The concept of "*pushing the line"* (i.e. consulting as many patients as possible to address the long queues), was expressed as a concern as it compromised ethical patient care.

> *"Pushing the line at the expense of the patient compromises privacy and confidentiality."*

Students also expressed reservations about their standing in view of the current crisis where there was an on-going shortage of HCWs. One of the students vocalised an underlying fear that this crisis might challenge their commitment to professionalism.

> "*...I feel the medical crisis which South Africa is facing with the lack of doctors, professionalism is affected and slightly reshaped and warped as ultimately the fashionable trend is '**push the lines**'. Instilling genuine professionalism is going to be a struggle and we stand to watch and see how Clin Assoc will impact the health field and how long it will take for them to be engulfed by the ways of the health care system or if they'll stand firm and hold their own new ground.*"

Students considered the harm that may come to patients when they are forced to "push the line" and work beyond their scope of practice.

> "*How far out of my scope may I work knowing the care I can provide to a patient may be harmful*?"

Students reflected on the value of prioritising patients by demonstrating compassion and putting the patient first, as encapsulated in the following response:

> "*We spend a lot of time worrying about how many patients are waiting. You forget the one in front of you...we need to adopt a way of focusing on the patient, so the moment he walks in we should tell ourselves my patient is the one in front of me.*"

Mayosi *et al*. (2009) refer to the rising burden of non-communicable disease in rural areas and among poor people residing in urban communities due to rapid industrialisation. These factors call for the strengthening of district health services. The concerns expressed by Mayosi *et al*. regarding the increasing demand for health services were reflected in the experiences of the BCMP students as they undertook their training in District Education Campuses. The fact that the majority of the

students were able to reflect on their experiences was considered a major achievement as it provided evidence of their learning experiences both from and with patients.

4.3 *Sub-theme 1.3: Personal growth*

As part of this theme, just over a third of the students (n =25) reflected on their role on being the first group to be admitted to the programme as Clinical Associates (Table 4.2). They focused on their concerns and referred to a period of uncertainty but attributed much value to their learning experience.

> "*It all started with 25 Guinea pigs and hopeful personnel...initially we used to be very unsettled...it was not easy to infiltrate the hospitals people were confused...eventually it became enjoyable and it was a marvellous learning experience."*

There was the struggle to fit in but a definite sense of pride in establishing an identity. The corresponding responsibility to earn the trust and respect of patients was considered a critical undertaking:

> "*After introducing yourself as a Clin A student the follow up question in most cases is if you are going to be a doctor...in most cases patients' trust depreciates once you tell them you are not going to be a doctor. Now you have to prove yourself then later on that's when you get the compliments."*

They expressed the benefits of working together as partners, responding to patients as individuals and human beings with unique needs and recognising the complexity of diseases as social ills. They also acknowledged their own strengths and their contribution to the welfare of a patient with one student reflecting following a successful attempt to resuscitate a patient with asthma:

> "*...by the time the doctor came back the patient was not in distress and all the vitals were normal and all he had to do was countersign all that I did and prescribe medication for the patient. After all this I gained respect from the sisters and they started calling me Doctor...I correct them...I am Clinical Associate not a Doctor."*

Commenting on the value of interpersonal relationships, BCMP students allowed themselves to transition from student to health care professional in a training capacity while acknowledging the bonds that were necessary to sustain their personal development:

> *"Making a relationship not only with colleagues but your patients as well, we are beginning to understand that health is defined by the health of our relationships."*

The ultimate reflection was in regard to the clinical training environment preparing and providing insight for future practice:

> "*It is amazing that we are able to write journals and we are not short of ethical issues. It is not good for patients to notice them but for us students it is a good thing to observe so we don't make the same mistakes and these things shape us to be better professionals."*

There was a perception of safety networks provided by the training environment, an opportunity to learn from one's mistakes to get to the level where they needed to be:

> "*I didn't know the chest compressions were so tiring and the human chest is softer than the manikin we practise on in medical school. Two minutes into chest compression you are exhausted and I guess you need to do it more often to get better*."

However, these experiences were not always positive. Students expressed concerns about being resented by nurses for doing a doctor's job and knowing a lot more than nurses. This once again created the need for the students to prove their worth and clarify roles. Students acknowledged the responsibility of carrying the programme, bridging the gap between public duty while meeting societal expectations and educating patients about the new profession:

> "*As a carrier of the title, we have to understand the name so we may portray the name...If we as Clinical Assoc go out there next year living out our name and behaving in a manner that which is expected of Clinical Assoc then the public will certainly notice the difference and start questioning...with that the patients will see the difference."*

In summarizing their reflections on personal growth, just over a third of the entire class reported on aspects of personal growth such as migrating from being guinea pigs to becoming health care professionals with a defined role and functioning as part of a team. The majority of these experiences of professional growth were borne out of their experiences with admitted patients in Paeds (n=7) and the Adult in-patients ward (n=12). The view was that patients admitted to the children's and adult wards presented with the same conditions. As one student put it, one just needed to adjust the doses of medication to suit the patient. Their capacity to reflect on their personal growth, acknowledge professional gaps in their knowledge and attain desirable behaviours for practice came from their experiences in EM (n=6). Students also reflected on their frustrations and the role of the clinical training context in preparing them for future practice. At times they exhibited exponential growth and a level of readiness to enter the world of work. There were instances where they were limited in their skills set and reflected openly on being students with limited capacity. They appreciated the value of healthy relationships for the functioning of the team.

4.4 Integrated Discussion on Personal Attributes

The BCMP students reflected on a range of ethical issues they had observed and experienced during their clinical rotations in the three departments. In a study undertaken by senior medical students in Australia and by fifth-year medical students in a university in the US, similar findings on ethical issues were observed as reported by Malpas (2011) and Kaldjian *et al*. (2011) respectively. Reporting on fostering students' personal and professional development in medicine in a study conducted in Australia by Gordon (2003b), 96% of the students found the reflection process to be a useful exercise. In the present study, the most critical finding was the internalization of the Oath being directly linked to BCMP students showing empathy to their patients. They achieved this by motivating for standards-guided, patient-centred care being considered central to the public's trust in the health care profession (McQuoid-Mason and Dhai, 2008; 2011). According to Pellegrino (2002), each patient encounter is an opportunity for every HCW to demonstrate commitment to the profession by using attained competence to demonstrate an altruistic approach towards patients. This value that students assigned to the Oath is supported by Harris (2004) who refers to the role of the Hippocratic Oath as an undertaking that drives the health care worker's call to be a physician and a guide for whatever intervention is provided to patients. Branch Jr. (1998) reported similar findings on critical incidents reports submitted by third-year medical students who developed an empathic relationship with their patients.

Hafferty (2002) offers a different view to current findings as the results of his US study present medical students as being unreceptive to the notion of Oaths as they were not able to integrate values and duty for future practice. This view is shared by Jotterand (2005) as he cautions that medical professionalism lies not in the Oath tradition or the ethos of the member but in the philosophy of medicine that explores the values internal to medicine. Beauchamp and Childress (1994:25) have stated that they hold no strong views of the Oaths compelling commitment beyond the symbolic ritual. Stern and Papadakis (2006) blame this weakness on the structure of the curriculum where ethics teaching is introduced early on, with positive reinforcement only implemented in the latter part of the training period. Kaldjian (2011) on the other hand, supports opportunities that expose students to reflection about ethics and the values of professionalism in clinical practice. The factor that compels one to believe that the BCMP students had internalised the Oath has been their ability to link the Oath to ethical standards of good practice and the expected commitment for HCWs to provide the same care they would expect if they were admitted as patients. The second reason perceived to fulfil Stern and Papadakis's aspirations was facilitated

through early exposure to the clinical environment and reinforced learning that was provided by an integrated curriculum. Furthermore, the BCMP students linked the Oaths to public duty through Batho Pele, a public service standard that extends societal commitment and the respect that is afforded patients informed by the Patients' Rights Charter. In this way, their commitment to the Oaths or expected commitment of other HCWs provided a direct link to professionalism through the three ethical principles of patient welfare, social justice and respect for patient autonomy (Mueller, 2009; van Bogaert, 2011: 3; Zijlstra-Shaw *et al*., 2011). The views expressed by students in this study in regard to the relationship between the profession and society are supported by Irvine (2001) who addressed this very topic as president of the British General Medical Council. He called for doctors to respond to patients as knowledgeable, skilled, ethical and committed HCWs. Furthermore, he called for an improved relationship that responded to patients and their families, thereby ensuring that they have sufficient information, sufficient choice and sufficient autonomy.

Students referred to a few HCWs who met the professional criteria and who demonstrated the life-long commitment referred to by Irvine and reported by Bergh *et al*. (2006). In the present study, the student-patient interaction was reported in the form of both positive and negative experiences. One of the students referred to the rewards of caring for paediatric patients whom the student considered to be the most grateful patients. Another student reflected on being taught by the mother of a patient the proper approach to soliciting sensitive patient information. The personalised reference to patients as "*my patient*" was evidence of a period of growth from students feeling like "*guinea pigs"* to "*teachable learners"* who accept the responsibility that embodies the profession (Green-Thompson *et al*., 2012). This reflection is supported by Baingana *et al*. (2010) who report on senior students' perceptions on learning about professionalism at Makerere University in Uganda as the times when you are alone and doing the right thing, guided by the standards of good practice. Final-year medical students at the University of Pretoria (SA) also reported on positive experiences whilst interacting with patients (Bergh *et al*., 2006).

The precarious nature of the relationship between society and the profession has been cited by Pepper and Slabbert (2011) who suggested that South Africa might be on the verge of a malpractice storm. Some of the reasons for this storm were provided by the BCMP students. These included complaints of having to work beyond their scope of practice, and not having an opportunity to debrief, observing substandard care that is provided to patients due to lack of resources, shortage of personnel and sometimes inappropriate attitudes of HCWs. Similarly Vivian *et al*. (2011) reported on professional lapses where students at the University of Cape Town (UCT) observed deviations in

the care that was provided to patients. Such incidents undermined the perception of the practice of medicine as a noble profession. Pepper and Slabbert (2011) are of the view that when the relationship between the patient and the doctor is undermined, these experiences may compel knowledgeable patients to litigate even for minor medical transgressions. Irvine (2001) makes reference to the good doctors who must be supported to remain good and given opportunities to become even better. He is of the view that bad doctors must be managed for the better good of society. Further to this, he calls for evolving professionalism that responds to societal needs and doctors (HCWs) who are not only knowledgeable and skilled, but are ethical and committed.

It is perhaps the quadruple burden of disease—described by Mayosi *et al*. (2009) as including communicable, non-communicable, injury-related and perinatal and maternal disorders—that has culminated in what has been dubbed a medical crisis in South Africa by the BCMP students as they refer to the notion of "*pushing the line*". This negative experience was reflected on as instances where student learning and patient care were compromised due to the shortage of health care workers. When such situations were experienced, students were forced to make decisions beyond their scope of practice as they took over the professional relationship. Whilst this experience may be viewed as negative, unintended benefits for the students were reported as instances where a negative experience reinforced their skills development. Death presented one such opportunity for the students to learn valuable skills.

Mueller (2009) supports activities that engage students in improving their communication skills, referring to opportunities that allow students to learn about breaking bad/sad or unexpected news to patients. Bergh *et al*. (2006) also reported on opportunistic learning following the death of a patient when the students had to break bad news to the family. The burden that comes with the high number of patients seeking treatment in a training hospital was observed by fifth-year medical students in Uganda. However, no reference in that study undertaken by Baingana *et al*. (2010) was made to the high patient load being a burden on the students except in regard to the impact it had on resources and attitudes of staff. The researcher is not aware of any other study where students found themselves obligated to take on a professional responsibility to meet an institutional need. Mahood (2011) refers to primary health care/community practice as the sector most vulnerable to staffing challenges and lack of resources where students are most likely to be turned into ethical chameleons. Mahood calls for vigilance in these settings in order to safeguard the interests of students as trainees.

This discussion on the three themes that constituted personal attributes was a reflection of how the BCMP students perceived their formal curriculum. Data demonstrated that students developed a principled approach to how they dealt with their patients and recognised the limits of what was permissible at their level. The students acknowledged HCWs who demonstrated commitment to the core values of good practice. As the students made ethical judgments by demonstrating the development of their moral integrity and reasoning—a finding that was also reported by Howe *et al*. (2009) in a study conducted in the UK—it was evident that their decisions were guided by their professional education (Hilton and Slotnick, 2005). Irvine (2001), places greater emphasis on the role of medical schools "…*becoming the major foci for development of professionalism and demonstration of excellence...not just in education but in the models of good practice that underlie it*". According to the Lancet Editorial (March, 2009), all efforts should be made to explore the full potential of students, as they are pliable when they start their medical education and are considered to be medicine's greatest asset.

4.5 THEME 2: Contextual Attributes of Professionalism

In accordance with the second objective, the core elements of professionalism were analysed as provided for in the HPCSA guidelines (Booklet 3 Standards of Good Practice, 2008). These are presented below based on frequency of reflections during each of the three clinical rotations placements and expressed by the students as either positive or negative statements. Each of the core elements or attributes of professionalism are referred to as themes for the purpose of this study. The results are presented in Table 4.3, followed by a brief discussion on each of the core elements of professionalism (Figure 4.1**).** The third component of this discussion focuses on presentation of the evidence on attainment of professionalism as the third theme. The subsequent discussion serves to integrate the personal and contextual attributes to complete the cycle of professionalism.

Table 4.3 Contextual attributes of professionalism

Core Elements as described in Appendix H	Paediatrics (PAEDS)		Adult in-Patients Ward (AIPW)		Emergency Medicine (EM)	
	n=23	Percentage	n=23	Percentage	n=25	Percentage
Respect	**18**	(78.2)	**12**	(52.2)	**10**	(40.0)
Beneficence	**9**	(39.1)	**5**	(21.7)	**2**	(8.0)
Non-Maleficence	**6**	(26.1)	**3**	(13.0)	**2**	(8.0)
Human rights	**5**	(21.7)	**6**	(26.1)	**8**	(32.0)
Autonomy	**11**	(47.8)	**6**	(26.1	**8**	(32.0)
Integrity	**14**	(60.9)	**12**	(52.2)	**7**	(28.0)
Truthfulness (communication)	**9**	(39.1)	**9**	(39.1)	**7**	(28.0)
Confidentiality	**8**	(34.7)	**14**	(60.9)	**10**	(40.0)
Compassion	**14**	(60.9)	**6**	(26.1)	**8**	(32.0)
Tolerance	**13**	(56.5)	**7**	(30.4)	**5**	(20.0)
Justice	**8**	(34.8)	**7**	(30.4)	**10**	(40.0)
Professional competence (teamwork)/self-improvement	**18**	(78.2)	**14**	(60.9)	**30**	(120.0)
Community	**9**	(39.1)	**9**	(39.1)	**6**	(24.0)

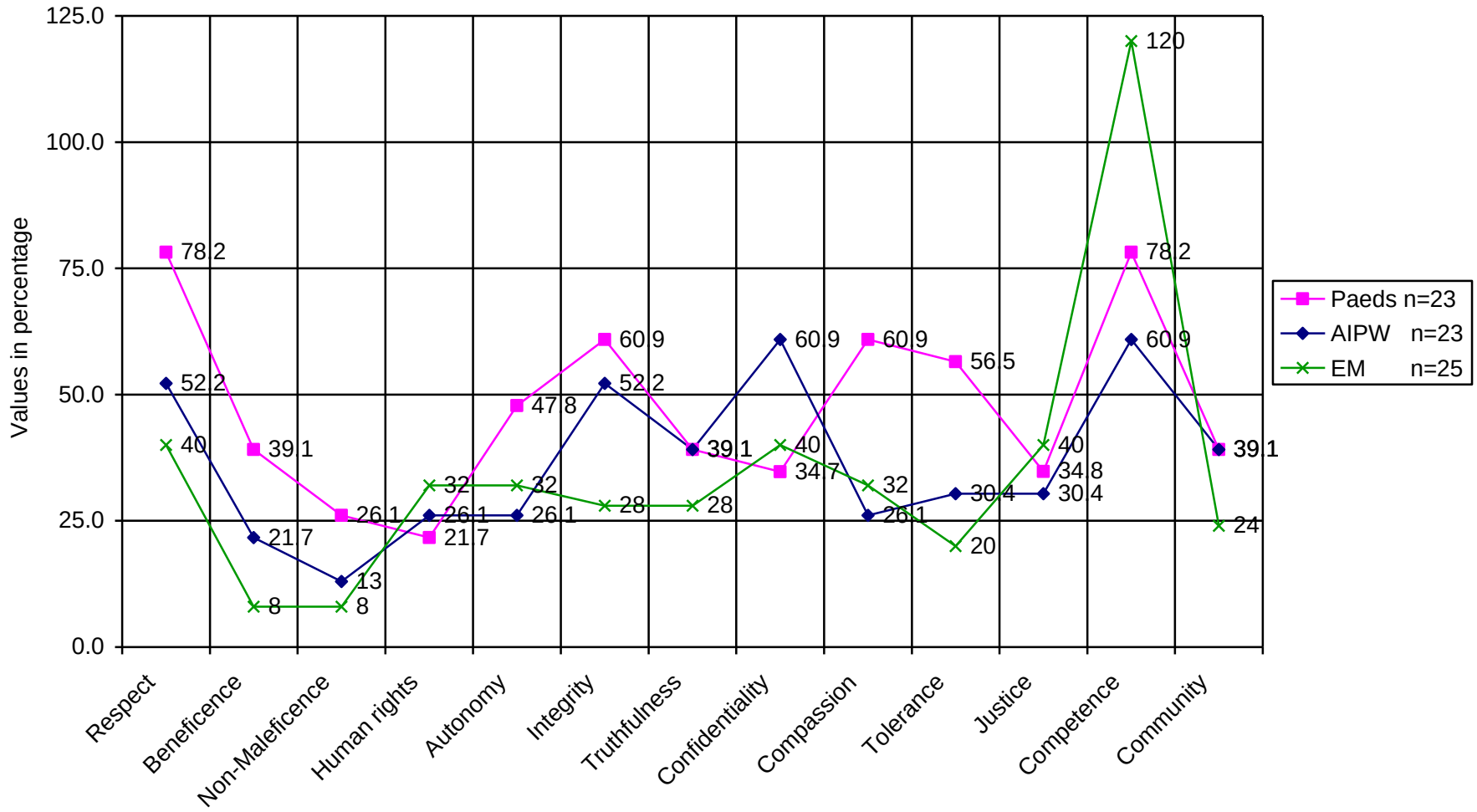

Figure 4.1 Analysis of the contextual attributes of professionalism

4.5 *Sub-theme 2.1: Respect for persons*

Many of the BCMP students' experiences of respect shown to patients were in the Paeds department, calculated at 78.2% compared to the 52.2% in AIPW and 40% in EM (Figure 4.1). The respect was not limited to patients but was extended to parents and was also used to meet standards of good practice:

> *"...show respect to the patient and document what you do to avoid the patient's mother denying that such a service was offered."*

In a US study by Bernard *et al*. (2011), respect was recorded as the most important theme in a professionalism narrative undertaken by medical students doing an EM clerkship. Curry *et al*. (2011) also reported on observed behaviours where patients were treated with respect (52%) but also observed respect shown towards team members. In the present study, students reflected on the value that comes with showing respect to the patients and the impact thereof. For example:

> *"I have realised that the more respect I have towards my patient and taking into concern their opinions, the more easier it is to fully manage the patient because they become comfortable and give out as much information. Time spent on consultation becomes minimal yet effective."*

4.5 *Sub-theme 2.2: Beneficence*

The most positive experiences were in Paeds at 39.1% and 21.7% in AIPW. In EM at 8%, students reflected on their negative experiences (Figure 4.1):

> "*Every patient expects to be treated well and deserves quality care from HCPs. It first starts with me introducing myself to the patient and most HCPs don't do that. Most patients do not know who is treating them.*"

The interests of the patients were best served if they were prioritised by the individual HCW to facilitate a relationship between the health care worker and the patient:

> *"Health service is based on patient versus clinician attitude. The more polite and honest you are, the better the relationship you develop with your patient."*

The BCMP students reflected on the same issues reported by Bernard (ibid.) when they considered the limits of their practice, the need for on-going learning and being the best you can be for your patients. In AIPW it was the plight of admitted patients to which students were sensitised.

4.5 *Sub-theme 2.3: Non-Maleficence*

A few students reflected on harms they had directly observed as reflected in 26.1% of portfolios in Paeds; 13% in AIPW and 8% in EM (Figure 4.1). Students reported on these examples either as physical or psychological incidents intentionally inflicted or as an outcome of negative behaviours that served as learning experiences for their own professional development:

> *"Impatience can lead to a lot of unsuccessful punctures and resulting haematomas and physical and psychological harm to the patient…I learnt that Paeds patients are more sensitive and delicate creatures which means that extra care and precision was required to have the best outcome from their illness."*

One student cited arguments over the management plan of a patient as a cause of potential harms to patients. Once again students demonstrated a conscientization to the well-being of patients. The language of health care does not necessarily fit in with the categories designated as official languages. It is a language of compassion that transcends all boundaries as it attempts to respond to the patient in consultation. It is the conduct of HCPs that limits harm to patients. In the current study, students observed patients being hurt by a HCW who did not observe the language of health care. In line with these findings, Szauter *et al*. (2003) reported on a few incidents where their students, in a study conducted in the US, observed as patients were subjected to psychological harms. Similarly, Vivian *et al*. (2011) reported on verbal abuse of patients in their study conducted at UCT (SA). In another study conducted in the US, Feudtner, Christakis and Christakis (1994) reported on their students observing as many as 80% of incidences that violated patients' rights.

4.5 *Sub-theme 2.4: Human Rights*

The students were able to reflect on health as a Constitutional right with many of the violations either compromising the dignity of the patient or denying them access to health care. The majority of these negative experiences were observed during their time in the EM department, this constituting 32.0% of the responses, followed by 26.1% in AIPW and 21.7% in Paeds (Figure 4.1). The following responses encapsulated expressed concerns:

> *"No matter how ill the patient is or how impaired their cognitive function is, patience and privacy are virtues that make the health sector a better place."*

*"Most HCPs are professional when they interact with patients but there are HCW who **shout at patients** and **do not want to help** certain patients because they smell in a certain way or behave in a certain way."*

Students highlighted the plight of psychiatric and homeless patients, who were often the victims when these transgressions were observed. Mathiti (2006:227) draws attention to the reluctance of health care professionals to treat homeless people. He suggests that "the construction of the homeless body as dirty, smelly and infectious leads to exclusion and, where this is not possible, to hostile reception". Elsewhere he states, "the panoply of stigmatisation by some sections of the medical fraternity limits their access to health care" (p. 220).

4.5 *Sub-theme 2.5: Justice*

Students reflected on cases where they felt that the observed conduct did not reflect a fair and just treatment of the individual patients. The cases were in EM (40.0%), Paeds (34.8%) and in AIPW (30.4%). In essence students were commenting on lapses in professionalism as their focus was on linking morality to professionalism (Figure 4.1). Students lamented the discrimination that they observed at three levels, the first one being different standards of care for different patients depending on who they were and their social standing in society:

"Patients as human beings are entitled to the same care whether a patient is a hot shot business man or a homeless man. The right to life and respect should be given to both persons."

"*It is not justified, neither is it acceptable to treat patients in a discriminating manner just because they are of a certain level in their financial stand, sexual orientation or racial group.*"

Secondly, they referred to the treatment meted out to patients who were classified as non-South Africans when they failed to present an identity document on admission. This type of treatment they considered to be a violation of Kant's imperative for rational choices:

"*Surely we understand that people should have files before they get proper treatment but if the patient's life is at stake, the file will follow after the patient has been treated. Our fellow nurses were judging those patients and they made them sit on a cold floor.*"

The third violation was cited as instances where patients were compromised by their presenting illness. One student referred to an incident in theatre where the attending doctor made fun of a patient who presented with an inguinal hernia:

"*...I found disturbing because this patient was pouring all his concerns to a doctor and she was busy laughing at him. She went on to make fun of this situation until he [patient] was really offended, unfortunately he couldn't really argue as he was undergoing an operation.*"

In a study conducted in Israel, Kovatz and Shenkman (2008) reported on similar findings where patients were discriminated against based on their racial profiles and their background. Similarly, Kaldjian *et al*. (2011) reported on instances where students in the US were witnesses to communication that humiliated and undermined the dignity of the patient. Students have reported in the study at UCT (SA) by Vivian *et al*. (2011) that they felt hopeless and paralysed by the asymmetrical relationship. Supporting these experiences, Brainard and Brislen (2007) referred to an organizational hierarchy that discouraged students from reporting unprofessional conduct. While the findings in this present study were not as prominent, just over a third of the students reported on such violations and they were still high when compared to just over 1% of similar violations noted by students in a study undertaken in the US by Szauter *et al*. (2003). London *et al*. cited in Vivian *et al*. (2011) noted that health professional students in South Africa demonstrated limited knowledge of their responsibility to act as patient advocates when they observed human rights violations. Furthermore, Vivian *et al*. (2011) are of the view that there is a disjuncture between what students are taught and what they get to experience in practice. As a recommendation they suggest an alignment in the teaching and practice of medicine that supports students when reporting observed violations.

4.5 *Sub-theme 2.6: Autonomy*

Students engaged with the complexity of the consent process referring to the "*dynamics of the consent process that are unique to South Africa"*. The students' reflections highlighted instances where there were challenges with the process of obtaining consent. In some cases students reflected on cases where the patient's belief system was taken into account. Many of these were observations occurred in Paeds (47.8%), with EM at 32.0% and AIPW at 26.1% (Figure 4.1). The feeling was that the process of obtaining informed consent was sometimes not taken seriously. In such instances it was perceived to be merely a paper exercise. The following verbatim comment captures this theme:

"*The consent should be considered as a process and not merely an affirmation ritual or signature on a piece of paper at a particular point in time."*

One student deliberated on this issue, expressing views as to the purpose and the intentions of the consent process as honouring the rights of the patients to be active participants:

> *"Informed consent must be related to values of autonomy and honesty even when performing an IC Drain...The patient always has the last word when it comes to consent."*

In this respect, Kaldjian *et al*. (2011) reported on some challenges observed by students in the US with obtaining informed consent during a clinical rotation in Paeds and Internal Medicine. In this study, the complexity of the consent process was highlighted by a student who presented a unique experience in Paeds that the student linked to the health-seeking behaviour of the parents associated with a traditional belief system:

> *"As much as I thought I have learnt about the ethos surrounding patient consent, little did I know there would be more to learn. Working in paediatric ward has taught me that one has to go the extra mile when trying to obtain IV access in young children. I was surprised by the seriousness of the African beliefs regarding the shaving of hair ...it is to be safely discarded (by throwing it in the toilet or burning it) to avoid possible bewitchment."*

In dealing with children, informed consent presented many challenges. Students were of the view that while the interests of the parents needed to be taken into account, the fairness of the process was evidenced when the final decision was to the benefit of the child:

> *"Sufficient information is subjective and consistency is a challenge. Voluntary decision making is important so long as it is beneficial to the child."*

Students were not clear as to who had the final say in terms of what interventions were administered to the child. They referred to the concept of dealing with "difficult parents" who argue over the care of the child. It was also not clear to the students about who they should consider to be the primary care giver and who had the final say in what procedures were carried out with the child:

> "*Who has the upper hand? Is it the mother or the father?"*

Deliberating on these challenges, one student was of the view that while one is required to show respect to the parents, the benefits must accrue to the child. This belief was articulated as follows:

> "*The patients are too young to comprehend their diagnosis/prognosis and autonomy is not expressed independently...As a HCW you must not argue with the parent but do your best for your patient [the child]."*

The view was that HCWs should engage patients in getting them to understand the material risks associated with procedures they undertake. Tsotsi (2009) in her research described the process of attaining informed consent when conducting research in developing countries as a complex process

and a contentious issue that is context-specific. In addressing the challenges raised by Tsotsi, research conducted by Penn and Evans (2009) suggested as one of their recommendations certain cultural and linguistic modifications to the informed consent process to protect vulnerable participants. Their recommendations facilitate an opportunity for participants to be conversant with the research process. At community level the dynamics of family relationships, the vulnerability of the patients as determined by the illness and their age were some of the challenges raised by the students in the present study that were consistent with findings from the Uganda study conducted by Baingana *et al*. (2010).

4.5 *Sub-theme 2.7: Integrity*

The required professional integrity was reflected on as a process that called for application of standards of good clinical practice and ethical conduct. It was an observed attribute for many of the admitted patients as reflected in portfolios in Paeds at 60.9% and in AIPW at 52.2% but not so much in EM at 28.0% (Figure 4.1). The expressed view was that core ethical values and standards should be incorporated as the foundation to demonstrate the character and practice of responsible health care professionals.

> *"Patients are not difficult often, only because they want to be, because we never elucidate our intentions we forget that their bodies are theirs, so they have a right to know our intentions…we should consider patients' opinions, their expectations and perhaps see them as people not so much as patients*"

Fostering a relationship of trust and respect as an observed practice with the parents of paediatric patients was considered to be a critical component in demonstrating professional integrity:

> "*...the doctors in the paediatric ward have a good relationship with their patients. They are well known and trusted by parents.*"

Similar findings were reported in a study by Curry *et al*. (2011) where the cooperation of staff members and the corresponding respect shown to the parents led to the successful management of paediatric emergencies. Chenenack and McCullogh (2009) provided support for these findings as they reported on professional integrity as a virtue that requires both moral and intellectual excellence. Their view was that not only does this protect and promote the interest of patients, but that embedded in this approach are measures limiting violations to the profession. According to Lindeke and Block (1998), the value associated with self-determination, advocacy for the disenfranchised and at-risk populations, as well as an obligation to demonstrate compassion and

care for the patient and their family, is considered an ideal opportunity to present professional integrity.

4.5 Sub-theme 2.8: Truthfulness

Students reflected on the norm of what informs the relationship between patients and HCWs and the potential benefits thereof.

> "*Once you start consulting patient you should reassure your patient that your conversation will remain in the room...and there is no way the patient's relatives are going to find out things you discussed. In this way you will gain a patient trust hence a doctor-patient relationship is build.*"

Whilst trust and truthfulness are central to any relationship with patients, the basis of the students' reflections was borne out by their frustrations as negative reflections in 39.1% of cases (Paeds & AIPW) and 28.0% in EM (Figure 4.1). Students observed that for many of the patients, poor communication between the HCW and the patients was not in the best interest of the patients, as one student reflected:

> *"During my 5 weeks in the medical wards I found that the HCW do not really communicate well with their patients. As a result the patients walk out of the hospital not knowing what condition they were treated for. This results in patients coming back with a similar condition...Patient-Clinician Bonds are very important bonds...in treating the patient adequately. Patient-clinician relationships consist of trust, respect, honesty and communication. All four elements are vital."*

The dilemma around the issue of trust that students faced was based on the fact that there was no consensus as to when it was the right time to tell a child that he or she was HIV-infected or the reason why the parents died.

> *"Children are not informed about their status a challenge especially with orphans who are cared for by grandmothers or care givers."*

Vangu (2008), in his research on truth-telling, referred to a public view where the impression was of doctors concealing information as he interviewed cancer patients at a tertiary hospital in Johannesburg, SA. In Vangu's study the majority of patients (86%) expected to be told the truth about their condition. While truth-telling is not always encouraged, students felt it was unfair for patients to be expected to take chronic medication for life if they did not understand the associated value. In the present study, this issue was considered particularly relevant to patients in Paeds and AIPW. Although it mostly applied to patients who were HIV-positive, it was not limited to them. To

address truth-telling, particularly for teenagers, one student suggested a progressive approach based on the level of understanding of the patient concerned:

> "*In the same way that mathematics is being taught to children, so can the education of HIV be delivered to the infected children. Therefore the information on HIV should be progressive and make the child understand."*

Kovatz and Shenkman (2008) considered withholding or giving false information to patients and their families to be unethical conduct.

4.5 *Sub-theme 2.9: Confidentiality*

The privacy of patient information was seen as a contentious issue that led to many violations of confidentiality due to systemic issues, noted in 60.9% of portfolios in AIPW and in EM at 40.0%. Students were of the view that this violated the rights, privacy and dignity of patients.

> "*It is difficult to maintain HIV confidentiality in a hospital environment when you are separated by a curtain and where 80% of patients in the ward are on ARVs.*"

> "*Economic setup of cubicles makes it very difficult for HCW to do certain procedures like putting a catheter because everybody will be looking and the person this is done to is very uncomfortable, when nurses bath them and when counsellors talk to them about their HIV status...what you do ethically is you are violating patient confidentiality aspect of things*..."

Many of the preceding statements confirm findings reported by Baingana *et al*. (2010) suggesting that this experience might be a common finding in developing countries. One of the students suggested a solution to a concern raised by many in the group:

> "*In my head I have thought of a way to resolve the problem...there should be a consultation area in the wards. In this way, nobody else will know about other people's sickness...*"

In contrast, students had a positive experience in Paeds (34.7%) with one reflecting on respect that was extended to a third party, in this case a parent of the patient (Figure 4.1):

> "*Paeds was good, priority was given to the patient [child]...parent education was important."*

Students also reflected on instances where the family demanded to know what was wrong with the patient thereby creating a dilemma for the HCW who could not disclose without violating the rights of the patient.

"*There is the challenge of maintaining confidential and privacy of patient information when patient is confused and a family member is interviewed to gather information*..."

This entitlement to patient information is often associated with a particular setting as Baingana *et al*. (2010) reported similar findings in Uganda and elsewhere in Africa. The standard community practice demands that certain members of the family and sometimes the extended family members are assigned the responsibility of looking after the loved one and are expected to report their findings to the family. In such cases, depending on the gender of the one afflicted by the illness, the person who requests personal information may fall outside of the realm of Western structures (Baingana *et al*., 2010). One student deliberated on this aspect on the basis of acquired insight into cultural practice as it applied in the context where involvement of family in treatment decisions is believed to benefit the patient, as elucidated by Ndebele *et al*., cited in Baingana *et al*., 2010. The student was concerned about a critically ill patient living with HIV who was in denial and not in a position to determine what would be in her best interest. Based on this experience, the student proposed that the conditions of disclosure should be reviewed to consider what would benefit the patient.

"*... if the patient is unable to accept his/her condition they are unlikely to make it...if the patient is not in a state of making decisions for herself, we as HCW have a responsibility of disclosing the patient's status to the closest family member so we could have a chance to save her life*.**"**

This belief is aligned with the practice of communitarianism, which is a common practice in many of the developing countries in Africa (Dhai *et al*., 2011:11).

4.5 *Sub-theme 2.10: Compassion*

Students reflected on the value of demonstrating compassion and care in the clinical setting mainly in Paeds (60.9%) and in EM (32.0%); to a lesser degree in AIPW (26.1%). This attribute was directly linked to positive professional behaviours displayed by HCWs and observed by students who then emulated what they observed (Figure 4.1):

"...I learnt that a warm room, warm heart and warm stethoscope leads to a calm child and bonding with the child."

Students made reference to the concept of implementing a bio-psychosocial approach and "owning patients" and assuming responsibility for their patients as beneficial strategies. In a study by Curry *et al*. (2011), students observed the value of demonstrating compassion and communicating well

with 70% of the patients who were about to go to theatre. Communicating in a caring and compassionate way was also reflected on positively in a study by Bernard *et al*. (2011). Whilst compassion and care were demonstrated as being lacking in the beginning of the 20th Century right up to the 1950s (Newman, 1950:50) and subsequently restored, the threat to professionalism as driven by external factors has brought back the references to medicine as being an uncaring profession (Haug, 1976; Warner, 2004; Dhai and McQuoid-Mason, 2010; Pepper and Slabbert, 2011). The positive reflections that BCMP students experienced in Paeds were consistent and met the recommendations of the Ethical Guidelines for Good Practice (HPCSA, 2008). These guidelines require health care professionals to always show regard and respect for their patients as their primary professional duty. Similar requirements are recommended by the American Academy of Paediatrics (Fallat and Glover, 2007).

4.5 *Sub-theme 2.11: Tolerance*

The expectation for HCWs to respect religious, cultural or traditional practice is a moral requirement that informs the professional conduct of HCWs. The view of one student was that as the Bachelor of Clinical Medical Practice functions under the umbrella of Rural Health, culture is something they should understand and implement in practice without being judgemental. However, a few students expressed concerns about competing interests, citing the value of life when considered in relation to cultural practice. One student presented this issue as something that needed to be considered as a national concern:

> *"We are not supposed to see our culture [medicine] as superior to others or judge other cultures by the standards of our own. But what is important, culture or life? There are a lot of questions arising about some cultural beliefs...I'm not saying science is superior than culture but honestly, what is important to us as a nation?"*

In many instances it was the parents' health-seeking behaviour that was a source of conflict for patients in Paeds (56.5%) and relatives in AIPW (30.4%) and in EM (20.0%). Students reflected on their experiences of observing parents demanding that their critically ill children be released so that they could consult traditional healers. Similarly, students observed families of patients admitted in AIPW making the same requests (Figure 4.1). In certain instances, patients refused to accept healthcare if it was not culturally or religiously acceptable, for example, therapeutic amputation of a limb. In cases where parents were Jehovah's Witnesses, they refused to authorise blood transfusions for their children. These were not the only limits to which HCWs were pushed; there were also systemic failures as reflected on by a student working as part of a team:

"We could have managed and treated the patient appropriately if we knew earlier that the patient had a tumour and that was the cause of the seizures. Transport delayed, wrong stretcher, referral delayed ...lack of resources compromised patient care."

Based on these experiences, students observed this as pressure on the tolerance of the HCP, who even in these circumstances were obligated act in the best interests of the patient.

"There were repeated admissions for herbal intoxication...most mothers were not aware that children need lipids and proteins as much as they do carbohydrates. Children are medically neglected when medication is withheld."

With this behaviour, one of the students was prompted to question the value of cultural practices. While culture and religion were conflated, the principles underlying the questions were the same.

"...Personally I cannot help but question some of the cultural practices out there and this is coming from a medical point of view: Polygamy and the fight against HIV/AIDS; Culture when it is forbidden to receive blood from another person...are you willing to die or lose your child just because your culture forbids certain practices? People refuse to be amputated because it is culturally forbidden."

Findings from the present study in regard to cultural practices were once again supported by findings from the Ugandan study reported by Baingana *et al*. (2010). The only difference was that the BCMP students urged the establishment of a committee that would pursue this topic with a view to considering national interests. Similarly, Ross (2008) interrogated the dilemmas inherent in respecting cultural practices that impinge on the rights of others, and raised implications for South African health care professionals.

4.5 *Sub-theme 2.12: Professional competence and self-improvement*

In this theme, students reflected on their professional development as a process acquired either through observed role modelling or their experiences of being mentored. Students enjoyed exceptional positive experiences in EM at 120%, in Paeds at 78.2% and in AIPW at 60.9% (Figure 4.1). The perception was that where HCWs worked together, benefits accrued to patients and students were able to emulate observed behaviour and also elicit positive feedback from patients:

"What kept me going were those patients that become better, went home and came back being well for the reviews and the comments they would write about the care they got when they were discharged."

Teamwork was also a critical area of development that was noted by students as contributing to their learning and improvement of skills. Students were of the view that their own competence was determined by the extent to which the team cooperated and pulled together for the benefit of the patient and the student as a trainee HCW. One student described the role of professional HCPs as reflective of the grounded theory described by Pellegrino (2000) as follows:

> "*HCPs are there to decrease the gap between scientific medical health information and society. With professionalism comes compassion, responsibility, autonomy and competency. Once all these features are acquired then one has the features of professionalism.*"

The present data supports the assertion by Swick (2000) when the value of professionalism is considered from two levels, namely the individual and the collective. This approach allowed students to make informed choices about their preferences related to areas in which they wished to work:

> "*I work best behind closed doors in an office than I do in open space like casualty. I find it difficult to take a focused history...*"

> *"We were attached to him and we had hoped he would live...my colleague and I had an emotional breakdown...it had not been easy...but we had to be strong ...it's one of the reasons why I don't want to work amongst children.*"

Students were motivated to do more when they were in teams:

> **"***Clinical Assoc should adapt to being a good team player mainly because health is complex and nobody knows everything or how to relate to different patients and their unique needs.***"**

Similarly where the experience was negative, students perceived their inexperience as denying them an opportunity to attain desired and professionally required skills:

> "*...if there was anything to be done or learned the consultant would call the intern doctors first and it would seem as if they forgot about the Clin Assoc student...during ward round I was not allowed to see patient on my own...the head of department would move me around the department everyday...I was very confused and tired and did not learn much.*"

Hatem (2003) refers to complementary teaching where the resident consultant mirrors the faculty teaching model. He is of the view that taking the time to meet the team and enquiring about the student's educational needs validates the learner and sets a tone of caring. His model encourages engagement, discussion and demonstrates many of the attributes that represent professionalism. It enhances the needs of the patients and the learners, promoting respect for both while encouraging a commitment to excellence in practice. Similarly, Doherty *et al*. (2012) are of the view that the

presence of a doctor is integral to the functioning of a clinical associate and that the new cadre must function as part of a team. Rogers and Ballantyne (2010) in their empirical study back the call made by the BCMP students to be supported in the clinical environment: they identified—as one of the responsibilities of HCWs—the need to collaborate and work with colleagues. The fact that students were able to recognise these deficiencies in the system calls for sensitisation of all categories of staff to teaching responsibilities in clinical training centres. Lindeke and Block (1998) are of the view that the process of interdisciplinary education must be deliberative, inclusive, and respectful of all key players. This finding underlines the need to obtain "buy in" from all health care professionals to support the Clinical Associate programme (Doherty *et al*., 2012).

4.5 *Sub-theme 2.13: Community*

Many of the reflections that informed and motivated students to contribute to the betterment of society were borne out of frustration and should be read along with the discussion on tolerance and justice. Students reflected not only on their experiences but also on what they felt should be taken into account to improve the plight of the community as mentioned in 39.1% of portfolios in both Paeds and in AIPW and to a lesser degree in EM at 24.0% (Figure 4.1). A specific issue that was raised as a cause for concern was the number of patients who refused hospital treatment (RHT). One student was of the view that this issue needed to be pursued as a community discussion as it created conflict between HCWs and society:

> *"The RHT conflict arises when the doctor refuses to sign RHT because the child is too sick to be discharged and parents who sign RHT when a child is too sick often to take the child to a traditional healer."*

There was also a concern that traditional practice in rural communities was the most likely reason underpinning the request for RHT:

> "*In rural areas we tend to face more challenges of diseases because of people's ignorance and cultural belief. People sign RHT to go and perform rituals...and refuse to take prescribed medication for the patients.*"

Patients have a right to refuse treatment provided the decision is rational and fully informed (HPCSA Booklet 10, 2007). Results from the present study were consistent with views expressed by Crain (1985) as he considered morality and rights-based health care to be informed by the propensity of the health care community to preserve the value of life. Exposing students to community issues and

to service learning is considered to be a valuable approach to teaching professionalism as students are able to relate to patients in their context (O'Sullivan *et al*., 2000; Coulehan, 2005). What was achieved by the students in the current study was the complete immersion in a community where they became sensitised to cultural issues, a similar experience to that reported by Baingana *et al*. (2010). Cruess, Cruess and Steinert (2010) suggest that when teaching professionalism, due consideration should be given to respect for local customs and values and teaching should be related to the different cultures within that context.

In keeping with this theme, the BCMP students reported on all the attributes or domains or elements of professionalism described as core values by the Health Professions Council of South Africa (Booklet 1, 2008). There was a positive association between frequency of reflections and the positive nature of the experiences of professionalism for the majority (53.8%) of the attributes including: respect for persons, beneficence, integrity, truthfulness, compassion, tolerance, and professional competence and self-improvement. For some (23.1%) of the attributes (confidentiality, autonomy, community) students had a range of experiences leading to on-going debate and internal conflict as they had to navigate parents' or family interests; as well as traditional and cultural practices. For the remaining attributes (justice, human rights and non-maleficence), also at 23.1%, the reflections were guided by negative experiences.

4.6 THEME 3: Attainment of Professionalism in the Departments of Paediatrics, Emergency Medicine and Adult In-Patients

The attainment of professionalism was perceived as a process linked to the acquisition of knowledge and ethical understanding with one student placing emphasis on the need to act according Kant's maxim principles. Dhai *et al.* (2011:9-10) define Kant's moral law as a categorical imperative that is unconditional, supreme and must be applied universally. According to the BCMP student, it is these attributes that inform conduct of HCPs:

> *"Immanuel Kant talks about these issues- people should not act of instinct or pure emotion but should rather make rational choices. If we act according to Kant's 3 maxim principles then we will act in ethical manner."*

Individual experiences in Paeds, AIPW and EM are presented, followed by an integrated discussion that reflects on similarities and differences in how professionalism was perceived in the three departments.

4.6 *Sub-theme 3.1: BCMP students' experiences of professionalism in Paediatrics*

The vulnerability of the paediatric patient was not lost on the students and where patients were treated with respect, students could emulate such behaviours as illustrated in the following comment:

> "*I have never, not once seen any of the doctors in Paeds dept late or not showing up...I have never seen such dedicated medical officers who enjoy what they do and do it with love without complaining about anything."*

The perception was of a relationship founded on trust and a personal relationship that existed between the doctors and their patients (parents). Professionalism was considered to be the cornerstone of a functional environment and bound the team together, as one student reflected:

> *"Effective working environment totally depends on the professionalism of colleagues and effectiveness of teamwork you learn good working ethics."*

The observed respect for patient confidentiality, as related to HIV, was also reflected on:

> "*I really like to commend the doctors in the paediatric ward...for caring so much...especially when it comes to HIV confidentiality... All the time there is the part of the history taking where they have to ask about HIV status of the mother. They always leave this part to ask last and would always ask the mother to step outside the cubicle to be asked the question.*"

The positive influences were considered to be critical learning points as students were likely to pick up good habits and would be motivated to emulate their leaders:

> "...*I wish one day I would be like them...always being able to put my patients' needs before mine*."

The view was articulated that this competence is lost along the way partly through the process of burnout, and there was a consciousness that when this process happens, patients pay the price. The feeling was of the burden of responsibility that was prematurely transferred to students. For some, observing unprofessional conduct by HCPs prompted students to do the right thing:

> "*Some HCPs disappeared because we were there to do the work ...this situation has motivated me to demonstrate professional behaviour...in a clinical setting.*"

The clinical training centres were perceived as areas where students were influenced by what they experienced and observed. Similarly, clinical training centres were areas where they were most likely to be negatively influenced if they observed unprofessional conduct, as the students perceived themselves to be:

"*...unborn health care practitioners...*"

4.6 *Sub-theme 3.2: BCMP Students' Experiences of Professionalism in Emergency Medicine*

Emergency medicine offered unique opportunities to the students. It was perceived as a place where everything starts. Consequently, there was an expectation that processes should be properly aligned:

"*...it is like a station where everyone comes and waits for their lift to go to the place they should be.*"

Positive experiences of teamwork were context-specific and affirming to the students as the roles were clearly defined. The perception was of benefits that accrue to the patient:

"*It was good to work with an efficient team. You were not left trying to find where you fit in. The triage system worked because it was used consistently...When HCW do triage very well it allows HCWs to provide services to patients who need help urgently."*

BCMP students reported having highly positive experiences of role modelling. The perception was of clarity of roles as the students were there to learn from, and be influenced by, doctors:

"*They were more than doctors, they cared, their eyes were full of passion and enthusiasm. Everything that they taught us was everything they did. I had the deepest desire to be just like them."*

They were inspired by their experiences of opportunistic mentoring:

"*... Dr D would give us on the spur of the moment lectures on different conditions seen in ER and inspired me to further my studies, he was always available to teach, answer any questions and clarify any uncertainties we may have.*"

The range of experiences enabled one student to reflect on future practice and making an informed choice as an engaged student:

"*My first time I was so confused...I didn't know where all the equipment was...eventually I sat in the corner feeling really useless and demotivated. After all the fuss Dr D sat me down...encouraged me and explained that we shouldn't feel that way. We gonna get used to the madness...*"

There was no shortage of role models as one student was supervised by two doctors, each with a different approach. The one would teach and encourage the student to read further, while the other encouraged the student to read on the subject matter and approach the doctor for a discussion. These experiences helped the students to make informed choices about future practice:

"I thought I would like to see myself in EM but all that has changed...I have a greater understanding and evolved perception on EM."

Based on these positive experiences, students were able to identify unprofessional behaviours:

"The most unprofessional behaviour is when HCW come in late to work and disappear during working hours."

4.6 *Sub-theme 3.3: BCMP Students' Experiences of Professionalism in the Adult in-Patient Wards*

The role of professionalism was presented comparatively as positive and negative experiences, as either context-specific or individually motivated behaviours. One student reflected on being assisted, and granted an opportunity to practise a skill until the mentor was satisfied that the student had attained the desired level of competency.

"*The more confident and comfortable I was...he would just observe...and would come and check on me and continue with what he was busy with.*"

The observations and experiences coupled with positive health outcomes and feedback from the patients compelled one student to motivate for a particular training site to be considered as an ideal clinical training environment:

"*Personally I think that (...) hospital should be a permanent practising site for the Clinical Associate students...I learned a lot and I think others also learnt as much.*"

In the same setting the unprofessional conduct of a clinical supervisor denied a student an opportunity to learn:

"*I was supposed to do ward rounds with the other doctor, however this new doctor wouldn't pitch on time on several occasions and that meant that I had no one to supervise me, because sometimes he would only come at 12h00 or not at all.*"

The extent of observed unprofessional behaviours in one setting prompted one student to suggest that perhaps legal recourse might be the only way to get some HCWs to do the right thing. However, instances where patients were respected and students were included as part of the team allowed students to understand their role very positively.

The following discussion endeavours to integrate the experiences in Paeds, EM and AIPW and highlight similarities and differences.

4.7 Integrated Discussion on Attainment of Professionalism in the Departments of Paediatrics, Emergency Medicine and Adult In-Patients

Whilst this section focuses on the attainment of professionalism, this phenomenon should not be considered in isolation as much of what is presented by the researcher is informed by the formal curriculum (socialization in terms of personal attributes) framed from an ethical perspective, i.e. an ability to recognise right from wrong and good from bad (van Bogaert, 2008; Dhai *et al*., 2011: 3). In regard to this section, two scenarios are presented for consideration, underpinned by the assumption that attaining professionalism is achieved through a formal curriculum which can be a structured or a non-structured informal activity/event often referred to as the hidden curriculum (Hafferty, 1998; Paice *et al*., 2002; Lempp and Seale, 2004; Brainard and Brislen, 2007; van Mook *et al*., 2009; Baingana *et al*., 2010; Mahood, 2011).

The first scenario assumes that the clinical environment resembles a swimming pool. In this scenario, the students have theoretical knowledge on how to swim to the other end of the pool, understanding that there is a shallow end and a deep end. The presumption is that all the HCWs in the facility are able to swim in the shallow end and constitute a team. There are the designated clinical teachers who take on the role of coaches as they take students not only through the basics but guide them through to the deep end to get them to the level where they have the confidence to swim on their own. This responsibility is the role of the clinical teachers who should be available to students in clinical training centres. Many of the BCMP students responded to their professional calling and demonstrated a passion for their work and a commitment through reinforced positive experiences either via mentoring, role modelling and/or constructive feedback. This experience could be seen as testimony that there were such HCWs who met the criteria of experts and facilitated teamwork in Paeds as the students referred to an "*effective working environment*" and doctors who were always there on time. In EM, students referred to a "*triage system that worked because it was used consistently"*. The concept of the pool resonated well with what students witnessed in the settings in which they were based, as there was consistency in practice (Paice *et al*., 2002; Wagner, 2004; Stern and Papadakis, 2006; Cruess *et al*., 2004; Baingana *et al*., 2010; Asghari *et al*., 2011; Bernard *et al*., 2011). A US study undertaken by Curry *et al*. (2011) supports current data as their students observed very positive and exemplary behaviour by all the HCWs who worked together in theatre to deliver health care for the benefit of the patients.

A number of researchers report on students who are drawn to senior clinicians such as “Dr D” and “Sr S” who embody a good work ethic and responsibility, as was observed in the present study by students in all three departments (Paice *et al*., 2002; Baingana *et al*., 2010; Vivian *et al*., 2011; Green-Thompson *et al*., 2012). These findings were similar to those that emerged from a study undertaken by Bergh *et al.* (2006) where students at the University of Pretoria (SA) expressed views on attainment of soft skills (professionalism) as an interplay between what was covered in class and in practice. In the current study, the process of “guiding” and “growing” as described by students in the research by Bergh *et al*. was attained by the student in AIPW who was coached until a level of confidence was attained in performing circumcisions. Warner (2004) is of the view that it should be the aspiration of every consultant to influence and model for each and every student with whom they come into contact. Based on these experiences there were many examples of students who wished to emulate observed behaviours: “*I wish one day I would be like them”; “I have a greatest desire to be like them”,* particularly in EM and in Paeds (Adams *et al*, 1998; Paice *et al*., 2002; Fallat and Glover, 2007; Gaiser, 2009). Current data supported the attainment of professionalism as an outcome of observed behaviours where the attainment of professionalism was considered by Bergh *et al.* (2006) as interplay between “being and becoming”. BCMP students migrated through the different stages of Dreyfus’s Model of Skill Acquisition as described by Benner (2004), as they migrated from the novice stage when they were challenged in handling sensitive patient information in Paeds to demonstrating practical wisdom in resuscitating a patient with asthma in AIPW. Their confidence levels improved as they learned important skills under proper guidance of an expert consultant as described by Ashgari *et al*. (2011). The BCMP students made reference to Kantianism as a maxim principle that directs one in making rational choices, demonstrating proficiency to expert level according to the Dreyfus model. The understanding of attainment of professionalism as a form of learning, either as positive or negative experiences, exposed those students who dangled their feet along the edge of the pool, as they did not learn much.

In contrast, those who immersed themselves completely, such as the BCMP student who had two mentors in EM, were the ones most likely to attain a full and complete experience. The pool as a metaphor demonstrated this process very well. The value of this scenario was in the contextualisation of the moral development process as described in Piaget’s theory on cognitive development (1896-1980). When this development was realised, the student in AIPW was sufficiently empowered to question the suitability of the context for meeting the course objectives. The BCMP student not only considered the site in terms of how well the students were trained, but also in relation to how the site functioned to meet the needs of the patients and the team. Kaldjian *et al*. (2011) refer to the value of patients in helping students attain skills and knowledge and urge all

HCWs to prioritize and consider the welfare and interests of patients. The BCMP students' view of what was possible in that site was informed by repeated positive engagement in that particular facility for the student to make this declaration: "*Personally I think (...) hospital should be a permanent practising site for the Clinical Associate students."* These findings are supported by Green-Thompson *et al*. (2012) as one of the students in their research reflected positively on confidence levels attributed to good clinical exposure. The present data demonstrated the value of a partnership between faculty and the clinical environment in establishing congruency in the attainment of professionalism (Harris, 2004). According to Ginsburg *et al*. (2000), when students are asked to reflect on observed behaviours that depict positive and negative attributes of professionalism it is considered to be a non-threatening approach when compared to methods that require students to reflect on behavioural descriptors.

In the second scenario, the researcher asserts that students are like a sponge that is a build-up to the first scenario. For the BCMP students, many of their experiences were informed by positive behaviours. These experiences helped minimise the impact of the negative experiences in Paeds and EM but also highlighted the conflicting issues such as the dynamics of informed consent in South Africa and the issue of RHT. In the present study, even though the students were exposed to negative experiences they engaged with the issues at hand in such a way that they had a positive outcome for the majority of the encounters. One student reported being influenced to take short cuts when clerking patients until the student realised that this approach interfered with the clinical reasoning perspective that was taught in class and decided to revert back to the latter. A student who observed an HCW shouting at patients and refusing to provide health care to others decided to demonstrate a higher level of commitment by drawing on his/her character traits and knowledge to escape the social constraints of that particular setting. In line with this finding, Branch Jr. (1998) refers to challenges in acculturation and socialization of students in the wards. He is of the view that clashes between personal values and what they experience in the wards may lead to the erosion of their characters if, they lack a strong work ethic and empathy towards patients.

Many of the students demonstrated a heightened sensitivity to violations of patient rights. Students reported incidents where patients' dignity, privacy, confidentiality and rights to exercise their autonomy and self-determination were ignored. These findings were consistent with those reported by Vivian *et al*. (2011) and Baingana *et al*. (2010). Despite the positive experiences cited earlier that constituted what the BCMP students considered to be good behaviours, students reported on a few HCWs who came in late or disappeared during working hours. Of concern is the experience of one

student in AIPW who reflected on the repeated absence, or the late arrival at 12h00, of the supervising doctor. According to Hilton and Slotnick (2005), idealistic students who suffer repeated negative experiences are unlikely to attain practical wisdom or phronesis (the term used to refer to professionalism). Asghari *et al*. (2011) reported similar findings where the interns observed good role modelling 70% of the time but were of the view that deviation in the behaviour of clinical teachers was a breach of contract that could adversely affect their academic and professional integrity. The interns were of the view that breaches of professionalism by faculty and clinical teachers, even by a smallest margin, impact negatively on a student's academic performance and professional integrity, if overlooked, and that no feedback is provided to the students. Brainard and Brislen (2007) had similar experiences. As students, they reflected on the unprofessional conduct of their clinical teachers as an impediment to them learning about professionalism. Vivian *et al*. (2011) contend that students feel disempowered and will not report even the most blatant transgressions if they are committed by either their faculty or clinical teachers as they are concerned that they may be victimised. One ponders the plight of the student who initially had plans to specialise in critical care but talks of "*a greater understanding and evolved perception on EM*". This statement highlights the one weakness in this programme, namely, "lack of safety zones and debriefing platforms". There is a concern that such experiences may adversely influence students' future career choices (Baingana *et al*., 2010).

As lecturers solicit feedback when teaching the theory of ethics and professionalism, Gaiser (2009) is of the view that professionalism should not be reduced to a mere tick list. Gaiser motivates for daily reflection to encourage students to achieve the three goals: "I heard, I saw, I discovered." Stern and Papadakins (2006) are also of the opinion that it is the responsibility of the clinical teachers to design programmes that facilitate learning about professionalism and also allow students to identify strategies that will assist them in dealing with dilemmas through mentoring and role modelling. Gofton and Regehr (2006) make a case for the power of the hidden curriculum as they refer to socialization of students in the clinical context where they absorb every word/gesture/action that is performed or omitted. They caution that every silence or irritation may communicate unintended values. An alternative approach is offered by Shwartz *et al*. (2009) as they encourage clinical teachers to use negative experiences as teaching moments or critical incidents to allow students to be realistic about the practice of medicine and help develop their characters. Rogers and Ballantyne (2010) in their empirical study adopted a similar approach as they analysed medical professionalism complaints reported to the Medical Board of Australia to identify attributes that would safeguard the profession against future disciplinary actions.

The two scenarios affirmed the fact that training of all BCMP students in professionalism can no longer be considered as an event that happens in isolation: the reason for this is that current findings were similar to studies undertaken by international and local medical schools (Green-Thompson *et al*., 2012; Vivian *et al*., 2011; Asghari *et al*., 2011; Baingana *et al*., 2010; Paice *et al*., 2002). A major achievement in the present study is that the BCMP students moved beyond their experiences to offer possible solutions to organisational challenges. The majority of the studies referenced in this research are based on a curriculum of four or five years with a previous undergraduate degree or work experience, or a seven- or six-year degree programme. More importantly, in all the programmes trainees have role models going back many decades. Despite this curriculum differential, early exposure to the clinical training environment and the integrated curriculum could possibly be credited for the maturity of the BCMP students.

4.8 BCMP Students' Commitment to Ethical Practice

As ethical decision-making and moral reasoning are considered to be central to the attainment of professionalism, this study sought to establish if students have demonstrated a commitment to ethical practice. Professional development of the students and attainment of the desired state was guided by a principled approach in the clinical training environment (Beauchamp and Childress, 1994:45; Gillon, 1994). An analysis of BCMP students' reflections was considered from the literature review framework. The health care student was central to the good of the patient. The Oath became a critical undertaking for the students as they learned to treat the patients as ends in themselves (Pellegrino and Thomasma, 1998). Guided by moral virtues as socially valued characters acquired and perfected through practice (Hoyt-O'Connor, 2008:118), the BCMP students reflected on their learning process as a period of migration from being "*guinea pigs to becoming teachable learners"*. The professional obligation and the relationship with society as a contractual obligation founded on trust was observed in all three departments (Paeds, EM and AIPW) as the students modelled their positive behaviours to emulate their supervisors (Asghari *et al*., 2011), to reflect the trust that defines this relationship and the contractual obligation (Dhai and McQuoid, 2011). These observations satisfied the multi-pronged relationships in health care that extend from families to communities and to society (Harris, 2004). Similarly, displays of cultural sensitivity where, for example, a baby's hair had to be disposed of in a certain way, extended understanding of the contractual obligation between the profession and society. The demonstrated attribute helped students to observe the extent to which HCWs are morally obligated to meet the needs of patients. Not only did this satisfy the right of patients to be respected, but it also highlighted the perceived

complexity of the process of obtaining informed consent as the students made reference to the "*dynamics of informed consent within the South African context*". Propelled by positive experiences of an extended commitment to patients in the facilities in which they rotated, students changed their attitudes as they personalised their approaches and made reference to "my patient" (Lefton, 2000). As they made reference to "Dr D" or "Sr S", it would appear that these were the ideal supervisors who modelled the desired and effective strategies for teaching professionalism (Swick *et al*., 1999). As they considered themselves to be "*unborn health care professionals"*, the demonstrated attributes encouraged students to prioritise patient care (Mueller, 2009; McQuoid-Mason and Dhai, 2011) as they observed HCWs demonstrate a selfless approach (Warner, 2004). There was a consciousness of what was beneficial or harmful conduct as this was considered to be the responsibility of HCWs. As they reflected on their positive experiences, they also reflected on observed behaviours that they perceived to constitute physical and psychological harms to patients. The BCMP students' reflections were looked at from a justice perspective to consider fairness, which seeks to reduce personal bias, and a rights-based perspective to consider what is determined in the social contract between professionals and society (Rawls 1958:178-179). The students reflected on observed discrimination against patients and the patient violations they witnessed that were in violation of the principle of justice and ignored the vulnerability of patients. Students were of the view that the cognitive function of the patient should not have been the primary determinant of what was done to patients. In arguing for a fair and just approach, they presented Kant's categorical imperatives as a moral law that guides what is done, not the absolute pleasure that is derived by the individual to whom care is provided (Dhai *et al.*, 2011:9).

The focus was on the virtuous conduct of the HCWs who facilitated teamwork or reduced conflict (Blackmer, 2007). Similarly, those HCWs who supported and imparted professional values to students (van Bogaert, 2008:31-45) were referred to as "*professional health care workers"*. The culture in the clinical training centre that assisted students to understand professionalism as a process developed and refined over time (Gordon, 2003a; Warner, 2004) helped the students to consider their role as future HCWs. Through these positive experiences and the principled approach of beneficence, students offered suggestions to address the confidentiality and privacy of admitted patients (Dhai *et al*., 2011:14). Similarly, students were of the view that the progressive realization of rights to health information could be presented in a mathematical formula for the "12-year-old" to understand the implications of an HIV diagnosis.

In reflecting on their experiences and observations, while it was obvious that students were able to make conscious and moral choices related to how patients should be treated, this should be considered in their capacity as students. As they rotated through the different departments the role of their clinical teachers became critical (Lempp and Seale, 2004) in reinforcing positive behaviours. Through these reflections, it is possible that the moral consciousness of the majority of BCMP students was raised to the level where they were proficient in working towards becoming experts (Benner, 2004) or even attained phronesis (Hilton and Slotnik, 2005). However, there were instances where they operated as novices. They were traumatized when patients in their care died as the result of a lack of resources. At the same time they were mature enough to appreciate that this presented an opportunity for them to learn how to break bad news to families to complete the cycle of patient care; this agreed with findings reported by Bergh *et al*. (2006). Unsafe environments, either as a result of shortage of resources or perceived occupational hazards, were an area where the students were morally challenged. Perhaps the vulnerability of the students should be considered in the context of a climate of vulnerability as posited by Dhai (2012). The BCMP students' ethical commitment remains a personal undertaking, partially influenced by earlier experiences and the clinical training environment. Whether this commitment is sustainable or not will to a certain extent be determined by the immediate professional environment (Malpas, 2011; Mahood, 2011). As this was a blinded study, it has not been possible to provide a true identity of those who demonstrated the desired attributes of professionalism. It is expected that with time they will mature to become future role models for this cadre of health care workers.

4.9 Conclusion

This chapter presented a detailed discussion of the findings that emerged from this study. Thematic analysis was undertaken in relation to the first objective (personal attributes). Further analysis using simple descriptive statistics was undertaken to respond to the second objective (contextual attributes). In relation to the third objective, students' personal experiences and perceptions of professionalism that were thematically analysed guided the process of attainment of professionalism in the three departments. In the following chapter, findings are summarized and recommendations are put forward emanating from these findings.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In Chapter Four, data on personal and contextual attributes was presented and analysed. The experiences of the BCMP students informed the discussion on the attainment of professionalism in response to the two research questions. In this chapter, the key results are summarised and conclusions are drawn from these findings. Recommendations to address some of the challenges are offered together with ideas that will be presented to faculty for curriculum review/policy framework.

5.2 Summary of key research findings

The BCMP students reflected on a range of ethical issues. The most critical finding was the internalization of the Oath directly linked to BCMP students showing empathy to their patients, which could possibly be attributed to an integrated curriculum and early exposure to the clinical training environment. The students migrated from feeling like "*guinea pigs"* to becoming "*teachable learners*" who accepted their responsibility to become future role models as members of their profession. Deaths of patients created an opportunity for students to learn valuable communication skills. With the shortage of health care workers and an increasing burden of disease, the BCMP students felt pressured into "*pushing the line"*. The relationship between health care professionals and society was perceived as a complex one; nevertheless, students were able to recognise the qualities of an ethical, professional health care worker.

BCMP students demonstrated an understanding of the core values of professionalism and acknowledged the attainment of professionalism as being a process. In paediatrics, BCMP students experienced the most positive behaviours. Teamwork and role-modelling encouraged the students to demonstrate compassion and care for their patients. In emergency medicine, they observed teamwork and role-modelling and were exposed to many positive experiences when being mentored. Discrimination against patients was an issue as well as the negative attitudes of some of the health care workers. In the adult in-patient wards, students were mentored and realised the value of being patient-centred. They also observed compromised privacy and confidentiality,

especially for patients with HIV/AIDS, resulting from the physical arrangement of the cubicles. Lack of resources was perceived as leading to substandard care. Cultural and traditional practices presented challenges for staff caring for admitted paediatric and adult patients. These practices tended to compromise patient rights and patient autonomy.

5.3 Conclusions

While this study had a number of limitations it proved valuable in identifying both opportunities and challenges presented by the context in relation to the attainment of professionalism.

5.3.1 Portfolios as research instruments

Despite the limitations of this study, a narrative reflection— influenced and informed by the students' personal experiences—was possible. As early as 2005, Huddle compelled the caring professions to consider a narrative and personal reflection as a methodology with which to assess professionalism. In the present study, portfolios proved to be ideal instruments to facilitate student reflections as they provided a medium through which BCMP students' voices could be heard. The portfolios demonstrated the students' ability to engage as moral practitioners as all the candidates were able to share their personal experiences of professionalism during clinical rotations in each of the three departments.

5.3.2 Objective 1: BCMP students demonstrating personal attributes as ethical and reflective practitioners

The teaching approach where professionalism was incorporated in the BCMP curriculum, following a method described by Stern and Papadakis (2006), was found to be satisfactory for the following reasons:

- *Setting expectations*: The Oath-taking ceremony followed by early exposure to the clinical training environment facilitated internalization of the Oath. The intended purposes, i.e. promotion of patient primacy and social justice, were achieved. Students showed high levels of compassion and care towards their patients. They prioritised respect for patients, guided

by the standards of good practice and the code of conduct as provided by the HPCSA. They cited the importance of treating all patients in the same manner, including the value of showing respect to paediatric patients, and being non-judgemental to the homeless and to non-South Africans.

- *Providing experience of ethics, morality and professionalism*: through their reflections the BCMP students were able to establish the link between ethics, morality and professionalism based on a teaching approach that was driven by an integrated curriculum. Reference to patients' interests was reflected on as guided by the Oath, the Batho Pele principles and the Patients' Rights Charter. The students considered themselves to be "*teachable learners"*.
- *Teaching and evaluation*: the clinical training centres were perceived as areas where students were influenced by what they observed and what they saw. They accepted the responsibility to promote their profession and be role models for others.

In addition to the factors mentioned by Stern and Papadakis, students reflected on the following additional factors:

- *Exposure to different cultural and belief systems*: Cultural awareness was enhanced. Cultural and traditional belief practices as well as the health-seeking behaviour of parents and families of admitted patients in rural communities were perceived to compromise patient autonomy. Patient education was found to be lacking, compromising health outcomes, especially for patients with chronic conditions such as HIV.
- *Confrontation with the death of patients*: Students experienced death as a loss of life, sometimes a necessary end, but also acknowledged that death presented a learning opportunity in terms of how to break bad news to the family.
- *Awareness of the need for safety and security*: Safety and security from biological materials as well as dangerous behaviour on the part of violent and mentally ill patients were repeatedly expressed as concerns for future practice.

5.3.3 Objective 2: BCMP students' experiences of contextual attributes as embodied in the core values of professionalism

- *Positive experiences*: BCMP students described specific elements to define positive experiences where they were mentored in EM, observed role modelling in Paeds, were supervised in AIPW and were embraced as part of the team.

- *Negative experiences*: these were informed by individuals whose behaviour resulted in access to health care being compromised, inadequate or, in extreme cases, denied. The attitudes of some of the health care professionals, the lack of resources and the patients' belief models were perceived to contribute to increased mortality rates in the wards.

5.3.4 Objective 3: Attainment of professionalism in paediatrics, emergency medicine and adult in-patient departments

- Professionalism was acknowledged as a process rather an event, in keeping with Dreyfus's model on the different levels of the attainment of professionalism as a skill.
- While acknowledging that the BCMP students were novices in some instances, the majority of their reflections placed them at higher levels.
- Although this research started off as an academic activity, it demonstrated that by teaching and assessing professionalism students were able to achieve moral and intellectual excellence.
- The departments of paediatrics, emergency medicine and adult in-patients in the designated DECs proved to be important settings for the teaching and learning of professionalism as they supplemented and complemented each other.

5.3.5 Contribution of the study

The study demonstrated the following:

- There were tangible benefits associated with early exposure to the clinical setting, as the BCMP students appeared to have internalised the Oath.
- Teaching professionalism encouraged reflective practice that was patient-centred.
- The important role of the clinical training centres was highlighted when students considered themselves to be "*unborn health care professionals"*.
- The concept of "*pushing the line"* was perceived as being a South African concept borne out of a shortage of HCWs.
- BCMP students described an HCW who has attained professionalism as follows:

> "*HCP are there to decrease the gap between scientific medical health information and society. With professionalism comes compassion, responsibility, autonomy and competency. Once all these features are acquired then one has the features of professionalism*."

The researcher is satisfied that the framework of the curriculum, as it is structured, adequately prepared the BCMP students to be critically reflective HCPs who were able to identify the features of a professional health care worker. Moreover, this research has demonstrated congruency between adopted teaching methods and the experiences of professionalism in the clinical training centres. However, there are structural curriculum issues that require Faculty input.

5.4 Recommendations

5.4.1 BCMP students' recommendations

In line with the suggested outputs of professionalism by Gaiser (2009), namely: "I heard, I saw, I observed", the BCMP students offered various recommendations from their collective experience. The BCMP students reflected on their future role as Clinical Associates with the responsibility of carrying on the programme by bridging the gap between public duty while meeting societal expectations. As future professional HCPs, they engaged and reflected on their role as part of the health care team, citing corresponding responsibilities. Through their clinical rotations either in North West or Gauteng provinces, they developed insight into some of the challenges in the different training centres and offered the following as recommendations:

- Establishment of a consultation area in the ward for patients to be afforded privacy and respect;
- Creation of a counselling room for admitted patients to address HIV confidentiality;
- Hanging of curtains in the cubicles to deal with the physical design of cubicles and address the privacy and dignity of admitted patients;
- Attention to parent education to promote the best interests of children and also to patient education to encourage compliance in cases of patients diagnosed with chronic conditions;
- Provision for disclosure of confidential patient information for critically ill HIV patients to enlist family support, specifically for rural patients;

- Facilitation of a nationwide discussion to consider the role of cultural/traditional practices in the interests of public health; and
- Introduction of lectures on cultural issues in health practice to promote the interests of rural patients, as the programme is part of the Centre for Rural Health.

5.4.2 Discussion points for curriculum review / Faculty policy framework

The points presented below are guided by the reflections of final-year BCMP students borne out of their experiences in the different training centres. The researcher is of the view that these discussion points can potentially influence how the faculty defines its role and responsibility to extended clinical training platforms. In this regard, it is recommended that the faculty initiate discussion forums on the following topics:

1. Establishing the role of faculty in facilitating the attainment of professionalism and the role of teaching hospitals in facilitating the attainment of professionalism during clinical rotations;
2. Establishing safe zones for students during clinical rotations such that students are supported throughout the period of training to limit harms that may impact negatively their experiences as an outcome of patient behaviours;
3. Initiating debriefing sessions and formal feedback sessions as part of clinical training with the aim of enhancing insight and preventing burnout;
4. Promoting professional development to address breaches of professionalism for all staff in clinical training centres;
5. Addressing the dynamics of informed consent in rural communities;
6. Highlighting the dilemma of culture versus the right to life and access to health care as well as traditional practices and their impact on health outcomes.

5.4.3 Further research

There is an on-going challenge in assessing a process by which professionalism is attained and sustained by HCWs to benefit health care students. Fruitful areas of future research include:

- Development of effective tools to evaluate and measure professionalism;
- Design of training materials that address lapses in professionalism for all HCWs in the training facilities that have partnered with the university in preparing students to be accountable and responsible health care professionals;
- Replication of the present study with future cohorts of BCMP students;
- Comparative evaluation of BCMP students' experiences of professionalism in urban-based District Education Campuses and rural-based District Education Campuses; and
- Monitoring of the conduct of Clinical Associate graduates so as evaluate the effects of context on the sustainable practice of professionalism.

5.5 Concluding Comments

The experiences of professionalism presented in this research are validated by Coulehan (2005) who is of the view that becoming a physician (Clinical Associate) is more than just a matter of behaving. It is about repeated engagement with the context, witnessing or emulating what students see in practice and making learning about professionalism a required practice (Harris, 2004; Mahood, 2011). The role of clinical teachers is critical in graduating a morally competent, ethically reflective and professional health care worker especially if one takes into account the fact that BCMP students consider themselves to be "*unborn health care professionals*". This being the first cohort of students in the Bachelor of Clinical Medical Practice course, these students have shown a willingness to immerse themselves in practice to achieve moral and academic excellence. Through their portfolio narratives, they showed a willingness to shape their evolving journeys of moral growth and personal development. They also exhibited an extended commitment to their profession and a commitment to take on the role of future coaches (role models). Faculty owes it to the students to standardise training, identify effective sites that promote learning and find as many as possible of the doctors who are willing to take on the role of "swimming coaches", based on the assumption that a student is like a sponge.

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APPENDICES

Appendix A: BCMP Year 1, 2 & 3 Curriculum Overview: Theory and Clinical Areas

YEAR 1	Block 1	Block 2	Block 3	Block 4
Weeks	7 weeks	10 weeks	7 weeks	8 weeks
Theory	Medical Biology, Microbiology & Biochemistry	Respiratory System	Gastrointestinal System	Renal System
	Systems Overview -Anatomy & Physiology	Cardiovascular System	Musculoskeletal System	Reproductive System
	Defenses: Immune System	(Integrated approach)	(Integrated approach)	Neurologic System
	Homeostasis: Endocrine System			Special Senses
	Pharmacology			(Integrated approach)
Skills Lab	½ day per week	½ day per week	½ day per week	½ day per week
Anatomy Lab	½ day per month	½ day per month	½ day per month	½ day per month
Clinical Areas	Wards (1 full day/wk)	Wards (1 full day/wk)	Wards (1 full day/wk)	Wards (1 full day/wk)
		OPD (1/2 day/wk)	OPD (1/2 day/wk)	OPD (1/2 day/wk)

YEAR 2 Weeks	Block 1- TBL: Adult Health, 9 weeks	Block 2- Clinical Experience: Adult Health, 12 weeks	Block 3-TBL: Women, Child, Adoles Health	Block 4- Clinical Experience: Women, Child Health, 9 wks
	Blood: Anaemia & Malaria		6 weeks	
	Liver Disease (Pharm Rev)	OPD (Daily for 4 wks)	Women's Health	Antenatal
	HIV & TB (Immune Rev)	HIV (Daily for 4 wks)	Gynecological & OB	Maternity
	Emergency Trauma	Wards (Daily for 4 wks)	Embryology	Postnatal
	Neurologic Conditions	After hrs (Casualty15hrs/wk)	Neonatal Health	Family Planning
	Opthalmologic Conditions	TBL (1 time wkly)	Child Health	Paeds (3 wks)
	ENT Conditions	PBL (1 time wkly)	IMCI	Casualty (3 wks)
	Respiratory Conditions	CME (1 time wkly)	Adolescent Health	Afterhrs (Casualty 15hrs/wk)
	CVS Conditions			TBL (1 time wkly)
	Endocrine Conditions			PBL (1 time wkly)
	Renal Conditions			CME (1 time wkly)
	GI Conditions			
	Muscu-skeletal Conditions			
	Dermatologic Conditions			
	Men's Health			
	Occupational Health			
	Geriatric Health			
Skills Lab	½ day week			
Anatomy Lab	TBA			
Clinic Area	OPD ½ day per wk			

Block 1		Block 2		Block 3	
TBL #1	Rotation 1 & 2	TBL #2	Rotation 3 & 4	Rotation 5	Rotation 6
3 weeks	5 weeks each	3 weeks	5 weeks each	5 weeks	5 weeks
Emergency Medicine Workshop	Emergency Rotation	Research Project-Protocol writing	Emergency Rotation	Emergency Rotation	Elective
Research Project-Intro to Protocol	Surgical Rotation	Emergency Med, ACLS Review	Surgical Rotation	Surgical Rotation	*(OB/GYN, Orthopedics,*
Surgery Overview	Paediatric Rotation		Paediatric Rotation	Paediatric Rotation	*Trauma,*
In-Pt, Out-Pt & Paediatrics Review	In-Pt Wards & Out-Pt Clinic Rotation		In-Pt Wards & Out-Pt Clinic Rotation	In-Pt Wards & Out-Pt Clinic Rotation	*Paeds, HIV, etc)*
Mental Health	Mental Health/HIV Rotation		Mental Health/HIV Rotation	Mental Health/HIV Rotation	
OPD (1/2 day/wk)	Afterhours (15hrs/wk)	OPD (1/2 day/wk)	Afterhours (15hrs/wk)	Afterhours (15hrs/wk)	Afterhours (15hrs/wk)

Appendix B: Modified Hippocratic Oath

Modified Hippocratic Oath

As a student in the Faculty of Health Sciences of the University of the Witwatersrand I solemnly declare:

That I will not improperly divulge anything I may learn in my capacity as a student of health science

That in my relations with patients and colleagues I will conduct myself with dignity as becomes a student of an honourable profession

And I further declare that I will be loyal to my University and endeavour to promote its welfare and maintain its reputation

Appendix C: The Patients' Rights Charter

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No. 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this **Patients' Rights Charter** as a common standard for achieving the realisation of this right. This Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country.

According to the national patients' rights charter every patient has the right to:

- A healthy and safe environment
- Participation in decision-making
- Access to health care services which include:
  - Receiving timely emergency care
  - Treatment and rehabilitation
  - Provision for special needs
  - Counselling
  - Palliative care
  - A positive disposition
  - Health information
- Knowledge of ones own health insurance / medical aid scheme
- Choice of health services
- Be treated by a named health care provider
- Confidentiality and privacy
- Informed consent
- Refusal of treatment
- Be referred for a second opinion
- Continuity of care
- Complain about health services

Every patient or client has the following responsibilities:

- To take care of his or her health.
- To care for and protect the environment.
- To respect the rights of other patients and health providers.
- To utilise the health care system properly and not abuse it.
- To know his or her local health service and what they offer.
- To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.
- To advise the health care providers on his or her wishes with regard to his or her death.
- To comply with the prescribed treatment or rehabilitation procedures.
- To enquire about the related costs of the treatment and / or rehabilitation and arrange for payment.
- To take care of health records in his or her possession.

Appendix D: Batho Pele Principles

The Eight Batho Pele principles were developed to serve as acceptable policy and legislative framework regarding service delivery in the public service. These principles are aligned with the Constitutional ideals of:

- Promoting and maintaining high standards of professional ethics;
- Providing service impartially, fairly, equitably and without bias;
- Utilising resources efficiently and effectively;
- Responding to people's needs; the citizens are encouraged to participate in policy-making; and
- Rendering an accountable, transparent, and development-oriented public administration

The Batho Pele principles are described as follows:

1. **Consultation**

   There are many ways to consult users of services including conducting customer surveys, interviews with individual users, consultation with groups, and holding meetings with consumer representative bodies, NGOs and CBOs. Often, more than one method of consultation will be necessary to ensure comprehensiveness and representativeness. Consultation is a powerful tool that enriches and shapes government policies such as the Integrated Development Plans (IDPs) and its implementation in Local Government sphere.

2. **Setting service standards**

   This principle reinforces the need for benchmarks to constantly measure the extent to which citizens are satisfied with the service or products they receive from departments. It also plays a critical role in the development of service delivery improvement plans to ensure a better life for all South Africans. Citizens should be involved in the development of service standards. Required are standards that are precise and measurable so that users can judge for themselves whether or not they are receiving what was promised. Some standards will cover processes, such as the length of time taken to authorise a housing claim, to issue a passport or identity document, or even to respond to letters. To achieve the goal of making South Africa globally competitive, standards should be benchmarked (where applicable) against those used

internationally, taking into account South Africa's current level of development.

3. Increasing access

One of the prime aims of Batho Pele is to provide a framework for making decisions about delivering public services to the many South Africans who do not have access to them. Batho Pele also aims to rectify the inequalities in the distribution of existing services. Examples of initiatives by government to improve access to services include such platforms as the Gateway, Multi-Purpose Community Centres and Call Centres. Access to information and services empowers citizens and creates value for money, quality services. It reduces unnecessary expenditure for the citizens.

4. Ensuring courtesy

This goes beyond a polite smile, "please" and "thank you". It requires service providers to empathize with the citizens and treat them with as much consideration and respect, as they would like for themselves. The public service is committed to continuous, honest and transparent communication with the citizens. This involves communication of services, products, information and problems, which may hamper or delay the efficient delivery of services to promised standards. If applied properly, the principle will help demystify the negative perceptions that the citizens in general have about the attitude of the public servants.

5. Providing information

As a requirement, available information about services should be at the point of delivery, but for users who are far from the point of delivery, other arrangements will be needed. In line with the definition of customer in this document, managers and employees should regularly seek to make information about the organisation, and all other service delivery-related matters available to fellow staff members.

6. Openness and transparency

A key aspect of openness and transparency is that the public should know more about the way national, provincial and local government institutions operate, how well they utilise the resources they consume, and who is in charge. It is anticipated that the public will take advantage of this principle and make suggestions for improvement of service delivery mechanisms, and to even

make government employees accountable and responsible by raising queries with them.

7. Redress

This principle emphasises a need to identify quickly and accurately when services are falling below the promised standard and to have procedures in place to remedy the situation. This should be done at the individual transactional level with the public, as well as at the organisational level, in relation to the entire service delivery programme. Public servants are encouraged to welcome complaints as an opportunity to improve service, and to deal with complaints so that weaknesses can be remedied quickly for the good of the citizen.

8. Value for money

Many improvements that the public would like to see often require no additional resources and can sometimes even reduce costs. Failure to give a member of the public a simple, satisfactory explanation to an enquiry may for example, result in an incorrectly completed application form, which will cost time to rectify.

Appendix E: Ethical Clearance Approval Human Research Ethics Committee (Medical) of the University of the Witwatersrand

.UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Ms Nontsikelelo O Sondzaba

CLEARANCE CERTIFICATE	M110740
PROJECT	Reflecting on Professionalism: An Analysis of Bachelor of Clinical Medical Practice (BCMP) Students' Portfolios during Clinical Rotations
INVESTIGATORS	Ms Nontsikelelo O Sondzaba
DEPARTMENT	Steve Biko Centre for Bioethics
DATE CONSIDERED	29/07/2011
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 15/08/2011 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Prof A Dhai

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix F: Letter of Approval from Acting Head of the Department of Family Medicine

DEPARTMENT OF FAMILY MEDICINE
UNIVERSITY OF THE WITWATERSRAND

10 July 2011

The Chairperson
HREC (Medical)
University of the Witwatersrand

Re: Application by Nontsikelelo O. Sondzaba

This is to confirm that Ms NO Sondzaba is a lecturer in the division of rural health, department of family medicine. She has discussed her research proposal with me, and in particular her request to review BCMP student portfolio reports to ascertain their understanding of and reflections on professionalism.

I think this is important information which will assist further development of the BCMP programme.

I thus support her review of these portfolios on the understanding that she will maintain strict confidentiality and will anonymise her findings in any report so that individual students or institutions cannot be identified.

It should be noted that Ms Sondzaba is not involved in assessment of the BCMP students.

Yours faithfully

Professor ID Couper
Acting HOD: Family Medicine
Head: Division of Rural Health

Faculty of Health Sciences, 10th Floor, Medical School York Rd, Parktown, 2193, South Africa
☎ +27-(0)11-717.2041, 🖷 +27-(0)11-717.2558

Appendix G: **Information Letter for Participants**

Reflecting on Professionalism: An Analysis of Bachelor of Clinical Medical Practice (BCMP) Students' Portfolios during Clinical Rotations

PARTICIPANT INFORMATION SHEET

Dear Student,

Participation in a research study:

Thank you for taking the time to read this information sheet.

Nontsikelelo Sondzaba is a post-graduate student at the Steve Biko Centre for Bioethics, University of the Witwatersrand in Johannesburg, South Africa. She is studying towards a Master of Science degree in Bioethics and Health Law. In meeting the requirements of this degree, she will be conducting an analysis on your portfolios for three of the five clinical rotations reflecting on your experiences on professionalism in paediatrics, emergency medicine and in the adult in-patient departments. She invites you to participate in this project.

The Bachelor of Clinical Medical Practice as a newly launched programme obligates staff to closely monitor classroom and contextual experiences in part to meet the requirements of an integrated curriculum. The purpose of the study is to analyse your personal reflections of professionalism in the workplace to complement the academic learning process. Both qualitative and quantitative methods will be used to analyse data from an ethical perspective. It is the intention of the researcher to use information gathered as a knowledge tool for future groups.

The study will not interfere with normal academic processes as the researcher has no academic responsibilities to you as a student in your final year of study and will only gain access to the portfolios after they have been marked by your respective lecturers. The data gathered from the portfolios will therefore be treated as secondary data. Personal information will be omitted from the research report and future publications however as your group **is the first cohort of this programme group identity cannot be strictly protected**. **All information gathered from this research will be kept strictly confidential**. Nontsikelelo will only include data from your portfolio provided you have given explicit consent by completing attached consent form. Should you not wish

for your portfolio to be included in the analysis you will not be victimised in any way, and your academic profile will not be compromised.

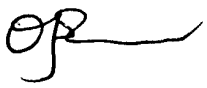
If you agree to participate, this research will not benefit you directly but will benefit future students as the results will inform an appropriate curriculum design and development in meeting the learning needs of the programme. Once the analysis is completed, you will have access to the results and you will also be informed of any future publication(s) that will be an outcome of this research.

This protocol has been submitted to the Human Research Ethics Committee (Medical) of the University of the Witwatersrand. Permission to conduct this study has been granted and approved by the Post-Graduate Research Committee and the Human Research Ethics Committee. This research is supervised by Prof. Ames Dhai and Dr. Norma Tsotsi both based at the Steve Biko Centre for Bioethics. If, for any reason, you wish to contact them, they can be reached at +27 11 717 2635, or at Amaboo.Dhai@wits.ac.za or Norma.Tsotsi@wits.ac.za. Please do not hesitate to ask any questions. The full protocol is available on request. If you are unhappy about anything that takes place or would like more information please do not hesitate to contact any one of the supervisors.

If you have any concerns or questions related to this project, you can contact Nontsikelelo Sondzaba on 011 7172091 or Nontsikelelo.Sondzaba@wits.ac.za

If you have any concerns about your rights as a research participant you can contact Ms Anisa Keshav, Wits Research Office, at +27 11 717 1234 or anisa.keshav@wits.ac.za . Ms Keshav will put you in contact with Prof. Peter Cleaton-Jones (Chair), Health Research Ethics Committee.

Yours sincerely,



Nontsikelelo Sondzaba

Appendix H: **Consent Forms**

Reflecting on Professionalism: An Analysis of Bachelor of Clinical Medical Practice (BCMP) Students' Portfolios during Clinical Rotations

Consent to Student's Portfolio Analysis

I, _____, have been approached and informed about the inclusion of my portfolio in the analysis of my personal reflections on professionalism during my BCMP final year clinical rotations. I have received a copy of the Participant Information Sheet from Ms Nontsikelelo Sondzaba. I have read the sheet and understand the purpose of this research project.

I understand that the data will only be used for the purposes of the research study and all information will be kept strictly confidential and cannot be shared with any other person unless I give my express permission.

Nontsikelelo may use quotations that do not identify me in any way. Before the research report is finalized, Nontsikelelo will show me where she has used quotations so that I can confirm that I am not identified as the source of the quote unless I specifically agree.

I understand that the inclusion of my portfolio is completely voluntary and that should I wish for my portfolio to be excluded, I will not be victimised in any way and my academic profile will not be compromised.

I also understand that if I have any questions or concerns about the process or Nontsikelelo's conduct, I can raise them directly with the supervisors of the research or I can contact the Chair of the Health Research Ethics Committee. I have noted that the contact details for these individuals are contained in the participant information sheet.

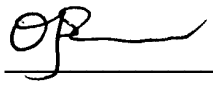
Having read this consent form and the participant information sheet, I consent to the inclusion of my portfolio and analysis of the data to be included in the research report as part of the study.

_____

Signature of participant

Place: …… Date: ……/……/2011

Witness: …… (Block/Project administrator)


_____ Date: ……/……/2011

Signature of researcher: Nontsikelelo Sondzaba

Please sign **TWO** *copies. One is for you, the participant, the other is for the researcher.*