EDUCATOR CONCEPTUALIZATIONS OF DEVELOPMENT OF PROFESSIONALISM AS A COMPETENCY IN ORAL HEALTH SCIENCE STUDENTS

Shehnaaz Kolia

9102421E

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Student Declaration

I Shehnaaz Kolia declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Master of Health Sciences Education at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University. _____ (Signature of candidate)

__23_____day of__June_____20_25_____in__Parktown_____

Abstract

This study examines educators' conceptualizations of professionalism at the School of Oral Health Sciences, Wits, using semi-structured interviews conducted with participants representing a diverse range of experiences, demographics, educational backgrounds, and academic/clinical exposure, enabling capturing of a comprehensive view of professionalism at this point in time using interdisciplinary perspectives and roles. Thematic analysis using Bernstein's theory about how knowledge is structured and communicated, appears to favour a restricted code, that is, assumes that educators have shared knowledge and understanding of professionalism. Educators primarily focus on superficial, procedural norms rather than engaging with a deeper, universalistic framework of professionalism that includes ethics and societal responsibility. This reliance on implicit assumptions and unspoken values perpetuates ambiguity in teaching and assessing professionalism, reinforcing rigid power structures and inhibiting critical dialogue. The study highlights the need for explicit curriculum integration of professionalism, supported by specific objectives and measurable outcomes, to address systemic inequalities in education and promote a collaborative approach to professional development.

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ABBREVIATIONS

AfriMEDS: African Medical Education Directives for Specialists.

CanMEDS: Canadian Medical Education Directives for Specialists

CMJAH: Charlotte Maxeke Johannesburg Academic Hospital

FHS: Faculty of Health Sciences

HCP: Healthcare Practitioner

HPCSA: Health Professionals council of South Africa

MER's: Medical Education Registrars

ORF: Official Recontextualization Field

PRF: Pedagogic Recontextualization field

RCPSC: Royal College of Physicians and Surgeons of Canada

SA: South Africa

SOHS: School of Oral Health Sciences

Wits: University of the Witwatersrand

WOHS: Wits Oral Health Centre

CHAPTER ONE

1 INTRODUCTION

The teaching of undergraduate dental students integrates cognitive, psychomotor, and affective domains, each playing a crucial role in developing competent healthcare professionals. While the cognitive and psychomotor domains have well-established frameworks for development and assessment, the affective domain lacks a similarly robust coding system, leading to ambiguity in its evaluation. This complexity necessitates that educators not only master the cognitive and psychomotor areas but also develop a nuanced understanding of the affective domain, which encompasses students' emotions, values, and attitudes towards patient care (Bertram., 2012).

The commitment to patient service is emphasized as a core responsibility of faculty, aligning with the philosophy that ‘Every skill, every decision, every morsel of scientific knowledge — [are all] to be used to better serve patients’ (Collier, 2012) Faculty competence in the affective domain is pivotal as it influences how professionalism is framed within educational programs, directly affecting student engagement and learning outcomes.

The debate on development and assessment of affective skills or professionalism is not new and has necessitated the interrogation of what professionalism is, in this day and age, so that one is able to first identify it in order to assess it (Collier., 2012).

Exploring the educational practices of developing professionalism in dental education, Zijlstra-Shaw et al posit that ‘An understanding of the various dimensions of professionalism is essential in education for both learning and assessment as it is this understanding which guides the selection of the educational material and provides the criteria for any assessment system.’, additionally, ‘For professionalism to be seen as important by students, they need to perceive that it is valued by Faculty.’ The authors conclude that assessment is essential because ‘[it] should help students focus their learning, identify individual strengths and weaknesses, provide an opportunity for improvement, highlight deficiencies in the content or delivery of the course, and in the case of health sciences education, protect the public against incompetent graduates …[and] that more research is needed, particularly with regard to a concrete definition of the concept.’ (Zijlstra-Shaw et al., 2011).

Supporting these views, Hanks et al, share their narrative overview of professionalism practices in their search to reach ‘a set of ideas and concepts that stakeholders within dental education can use to facilitate discussion and future work.’ as essential because ‘this shared understanding may help ground and inform numerous ongoing conversations, so that as a profession, we can live up to the expectations of the societal contract and trust that we are privileged to enjoy.’(Hanks., 2022).

A systematic review by Nguyen et al exploring clinical education approaches to professionalism, focussing on the areas of ‘Curriculum Design, Teaching and Learning Methods, and Assessment.’ found that much of the literature reviewed were either inconclusive or ambiguous when exploring educational outcomes. These authors concluded that ‘A working definition of dental professionalism still needs to be developed’ and that ‘The findings [are] consistent with the evidence across other health professions internationally. There is [thus] an opportunity for an inter-professional approach to develop and assess professionalism.’ (Nguyen., 2017).

Miller’s timeless refrain that ‘assessment drives learning’ has been unfailingly proven, a study by Wormald et al., affirms that medical students' self-reported drive to study a subject is directly influenced by the weighting of the subject in the overall scheme of assessment.’ A deficit in explicit pedagogical goals in positioning this domain inevitably results in questionable achievement of educational goals of a program and thus questions the credibility of the essential attributes of the graduating student (Miller., 1990; Wormald., 2009). Additional influences on learning outcomes include role modelling that is recognised as a vital part of clinical teaching as students learn professional behaviour and character by observing clinical educators in practice. Having role models who are typically respected faculty members that exemplify high standards in both teaching and clinical practice offers immense value to the teaching (Mohammedi et al., 2020). Role modelling is, however, not overtly defined in the formalised curriculum and thus not given sufficient attention resulting in a lack of professionalism training for educators in dental curricula, meaning that clinical teachers may not realize their role model impact (Sebastian et al., 2022).

Insufficient attention to the influences of social interactions, role models, and assessments means that much of the practical knowledge that is gained through students’ clinical experiences, relies on the unspoken or implicit lessons, values, and social norms that is beyond the formal, academic

curriculum. These ‘unwritten rules’ then form the hidden curriculum that can have significant negative impact on learning outcomes (Brown et al., 2020).

The School of Oral Health Sciences (SOHS), at the University of the Witwatersrand (Wits), trains undergraduate dental and oral hygiene students, and the competencies assessed during clinical teaching and learning include that of professionalism. Notwithstanding, educators at the SOHS appear unclear on the criteria for assessing professionalism due to reliance on a restricted code related to professionalism due to exiguous information on the topic of professionalism in the current curriculum. Anecdotal evidence exists of recurrent disputes between students and staff over the parameters being assessed or the level of expectation in this assessment. This is largely due to the deficiency of a well-articulated set of criteria and indeed, learning outcomes supporting the professionalism section of the clinical assessment tool. Additionally, there is little known of the induction of new educators to the SOHS on this topic in particular. The lack of elaborative coding in the current practice has a domino effect on the teaching, learning and evaluation of this important affective domain. For some time now the disconnect in discourse between student professionalism and the ‘results’ we get from the clinical assessment process, the only area where professionalism is adjudicated at the SOHS, presented a conundrum. How is it that we bemoan student behaviour, attitude and practice yet students do not seem to ‘fail’ this when assessed?

CHAPTER TWO:

LITERATURE REVIEW

2.1 HISTORY AND BACKGROUND

The dental profession has evolved significantly since the 15th century, transitioning from barbers who merely pulled teeth to respected healers (British Dental Association). This evolution has established an implicit social contract where society grants dentists respect, trust, and professional autonomy in exchange for their commitment to healing and upholding high standards of competence, ethics, and integrity (Lynch et al., 2023; Bughra., 2014).

Professionalism is the linchpin of expertise that separates the professional from the charlatan. It represents a 'code of practice' that members of a profession must adhere to in addition to having specialised knowledge and accredited skill to perform their profession (Beaton., 2022).

Professionalism in healthcare, encompassing doctors, dentists, and other health professionals, remains a complex and debated topic into the 21st century. The ongoing discourse emphasizes the need for a shared understanding of professionalism, particularly within medical teaching institutions preparing future healthcare providers (Dunn., 2016; Creuss et al., 2014; Smith., 2012).

Professionalism has garnered attention from scholars in philosophy and social sciences due to its enduring traditions that have persisted through historical shifts from medieval guilds to modern professional organizations, despite challenges from capitalism and consumerism.

Sociology has examined how external factors—political, social, and economic—have influenced the medical profession's resilience against commercialism and other ideologies. Philosophers argue that professions are living traditions that evolve with each generation while maintaining respect for their heritage (Yeo., 2009; Mook et al., 2008; Martimianakis., 2009; Salloch., 2016).

However, the latter half of the 20th century saw a decline in public trust towards medical professionals, as qualities like altruism were overshadowed by self-interest and power abuse. Factors such as corporate medicine, managed healthcare, rising costs, pharmaceutical industry ties, and medical misconduct contributed to public disillusionment. This decline illustrates the

idea that a physician's societal position is shaped by the prevailing social context rather than solely by their actions (Mook., 2009; Smith., 2006; Martimianakis., 2009; Collier., 2012).

The historical context of healthcare has led to a deeper understanding of what it means to be a health practitioner today. The values established in earlier times remain relevant, but they are insufficient to fully meet modern societal expectations of the medical profession (Dunn., 2016; Desai et al., 2022; Creuss., 2014; Holden., 2017).

Teaching institutions must adapt their curricula to reflect the evolving landscape of healthcare, ensuring that educators emphasize the responsibilities and expectations associated with being a healer, professional, and ethical practitioner. This involves instilling internalized moral values that motivate healthcare professionals to uphold high standards without external pressure. (Dunn., 2016; Desai et al., 2022; Creuss., 2014).

The 21st century is marked by rapid advancements in biotechnology and access to medical information, creating a complex environment where healthcare is effective but also potentially dangerous. This accessibility empowers patients to question medical expertise and professionalism, further complicating the role of health practitioners. ‘Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective, and potentially dangerous’, coupled with an astounding ingress and universal access to medical information by society enabling and perhaps encouraging patients to challenge medical expertise and by extension medical professionalism’ (Mook., 2009; Tallis., 2012).

To ask the question- why does it matter? The bottom line is that ‘Professionalism has more to do with the art than the science of medicine’ (Yeo., 2009). Therewithal, the deeper the exploration of this relationship, the more layers one finds in the interpretation of this ‘ideal’, yet at any one time, some authors believe that medical professionals themselves cannot explain this concept of professionalism (Creuss., 2016; Trathen et al).

2.2 SHARED MEANING OF A CONTINUALLY EVOLVING CONSTRUCT

Hanks et al. assert that professionalism is the most valuable asset in medicine, significantly shaped by societal expectations for healthcare professionals to act ethically. However, the concept of ‘doing the right thing’ is subjective and subject to a wide range of interpretations.

There appears to be consistency in the literature with regards to the following, ‘A medical professional is someone with esoteric competencies in and knowledge of medicine who commits to putting these to work primarily for the benefit of patients and communities, in keeping with the moral norms of the medical profession.’ (Hanks., 2022).

Efforts to establish a centralized understanding of professionalism and competencies for medical professionals have been initiated by governing bodies worldwide. The Royal College of Physicians in London published a report in 2005 aimed at defining professionalism. Central to their framework is a ‘new, strengthened form of medical professionalism’ designed to uphold trust and confidence in doctors within the healthcare system, focusing on six key themes: leadership, teamwork, education, career pathways, appraisal, and research (RCP., 2005).

In 2012, the Global Forum on Innovation in Health Professional Education held its first workshop focused on ‘Understanding Professionalism’ to promote transdisciplinary professionalism aimed at improving health outcomes. In 2014, the forum published a book discussing professionalism in transdisciplinary practice. A key definition provided by the task team describes medical professionalism as a belief system that organizes and delivers healthcare, emphasizing shared competency standards and ethical values among professionals. The team summarized their goals as enhancing communication and collaboration among health professionals to improve care quality and safety, enabling public participation in health decisions, mitigating political interference in healthcare, and fostering a collaborative environment among learners, practitioners, patients, families, and communities to achieve the Triple Aim of healthcare (Cuff., 2014).

The Royal College of Physicians and Surgeons of Canada (RCPSC) has developed the CanMEDS framework, which was first adopted in 1996 and subsequently updated in 2005 and 2015. This framework is designed to ensure that medical education remains relevant to the evolving healthcare landscape, with a current revision set for publication in 2025. The updates are influenced by recent critical shifts in healthcare, particularly in light of the COVID-19 pandemic and issues such as colonialism, systemic discrimination, climate change, and emerging technologies (Thoma et al., 2023; Frank 2004).

The CanMEDS framework has had a significant impact globally, serving as the foundation for competency frameworks in various countries, including South Africa. The Health Professionals

Council of South Africa (HPCSA) is adapting CanMEDS competencies into the African Medical Education Directions for Specialists (AfriMEDS) framework. This adaptation emphasizes critical thinking, social responsibility, and transformative action while specifically addressing healthcare inequalities within the African context. The goal is to produce skilled and service-oriented practitioners (Thoma et al., 2023; RCPSC., 2025; Mnguni., 2024).

The CanMEDS framework consists of seven key roles: Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional. These roles collectively aim to enhance patient care and adapt to the needs of modern healthcare systems. The HPCSA's adoption of this framework is expected to standardize teaching for health professionals in South Africa, thereby fostering public confidence in the healthcare system (HPCSA.,2014)

For coherence and to demonstrate relevance and significance to the discourse and context, it is important to add that these competencies are considered to be 'The knowledge, skills and attitudes that a learner should have obtained or mastered on completion of a qualification and against which the learner is assessed for competence.' (NQF., 2014). Be that as it may, the competencies outlined in the document are not distinctly codified for knowledge, or skill, or attitude individually but rather present a framework of integration of the ternary of competencies, that represent the harmonious blend of these three domains of learning that contribute to the development of the clinical associate, medical and dental undergraduate programs. While the focus here will be the HPCSA framework, it is necessary to be mindful of the enormous amount of supplementary work done internationally that provides us with distinct renderings of professionalism in the 21st Century that will be called on to support the views presented here.

The discussion emphasizes the need for a holistic understanding of professionalism to enhance pedagogy in health science, particularly in dental undergraduate programs. A study examining the ideologies underpinning the AfriMED core competencies framework indicates that its focus on technical skills and service-oriented care may limit its effectiveness in developing well-rounded medical professionals. This limitation arises from a lack of alignment with curriculum reform priorities that address the challenges posed by Eurocentric pedagogy and the sociocultural contexts of South African students.

Given the framework's emphasis on professionalism and affective skills, it is crucial to contextualize future discussions within the pedagogical context of dental teaching and learning.

The findings suggest that while the AfriMEDS framework identifies expectations related to professionalism, it may not adequately reflect the comprehensive educational needs necessary for effective student teaching in South Africa. This is by virtue of the focus on technical skill and service-centric care, and not on the curriculum reform priorities that conjointly maps the development of undergraduate teaching and learning that of necessity must address the paradoxes presented by Eurocentric pedagogy and the sociocultural contexts of students in SA (Mnguni., 2024).

The HPCSA core competencies (2014) outline seven essential roles for healthcare professionals, each defined by key competencies and enabling competencies that emphasize affective skills and professionalism.

Healthcare Practitioner (HCP): This role focuses on integrating knowledge and skills to provide empathetic, patient-centred care while adhering to ethical guidelines. HCPs must critically reflect on their abilities to identify personal learning needs.

Communicator: Effective communication is crucial, emphasizing understanding, trust, respect, and empathy. This role requires active listening and sensitivity to diverse backgrounds, ensuring that healthcare decisions consider patients' holistic experiences.

Collaborator: This role highlights teamwork within interprofessional settings, promoting respect for diversity among team members. Competencies include conflict management and improving collaboration.

Leader/Manager: Healthcare professionals must develop leadership skills to enhance organizational practices and community health, focusing on resource management and community needs.

Health Advocate: This role empowers practitioners to advocate for marginalized individuals and communities, promoting social justice and ethical integrity in healthcare.

Scholar: Lifelong learning is emphasized in this role, requiring professionals to critically assess their knowledge and skills continually to keep pace with advancements in healthcare.

Professional: The final role underscores the importance of integrity, respect, altruism, and adherence to ethical standards while balancing self-care with professional responsibilities (Health Professions Council of South Africa, 2014)

These roles collectively aim to foster a comprehensive understanding of professionalism in healthcare education and practice.

Tallis et al add the value concept of 'Professionalism also reflects something that is central to the practice of medicine: the need to employ judgement and to cope with uncertainty. Good medical practice can never consist of automated journeys down algorithms and standardised care pathways… the term signifies a set of values, behaviours and relationships that underpins the trust the public has in doctors' (Tallis et al., 2012). Knowledge, clinical skills, and judgement have to be combined with values such as integrity and the commitment to continuous improvement of one's practice. Central to the new professionalism is the notion of a partnership between patient and doctor and the share responsibility of respect and accountability.

In teaching dental students, it is crucial to provide a thorough introduction to the core values of the profession. While some critics argue that medical education imposes excessive political correctness, the integration of professionalism into the curriculum is essential for adequately preparing students for the complexities of 21st-century healthcare, workplace demands, and patient expectations (Birden et al., 2013). A solid foundation in professional practice equips students with the necessary skills to navigate a diverse healthcare environment effectively. This approach emphasizes the dynamic nature of professionalism and its relevance in fostering well-rounded practitioners capable of meeting contemporary challenges in healthcare (Goddard et al., 2022; Lim., 2007; Hayashi et al., 2014; Bhopal., 2015).

2.3 EDUCATIONAL BARRIERS

Having established that there is a set of well-defined values attached to healthcare professionalism, the question that then arises is, what lies at the heart of the confusion in our practices?

Discourse surrounding who should be teaching it, and the importance of classification and framing are echoed in the literature on teaching and development of professionalism.

Buyx et al, explored the role of medical ethicists as the primary point of call for teaching professionalism. These authors recognise the value of the theoretical underpinnings provided by the ethicists but add that professional socialisation is indispensable to student development as the student's professional identity is shaped by the uniqueness provided by social context and this is immeasurably facilitated by clinical practice and patient interaction. They add that developing the virtues linked to professionalism like honesty, compassion and truthfulness is not a process started in higher education but developed across the lifespan of the student. This coupled with the students and educators' unique mundane knowledge and literacy lenses may render disparate conceptions of just these simple terms.

Cunningham et al, support the view that socio-cultural contexts are essential to the equation of developing professionalism, as is the uniqueness of the individual student and educator lived experiences. The authors recommend that educators recognise the shift from the nostalgic view of professionalism, as evidenced by the background and introduction shared previously, to a more complex view that reflects on the intensity of teaching and learning that the dental student is exposed to, the diverse values, beliefs and attitudes of the contemporary student who now has greater agency in higher education settings that have shifted to the 'student as a customer' philosophy, and of necessity, now also shifted the power dynamics between teacher and student. This paper concludes with the counsel that the dental professions need to recognise that the archetypical Western/Eurocentric worldview that currently dominates the discourse on professionalism may not resonate with contemporary students and steps to diversify this approach are essential (Cunningham et al., 2024).

Pedagogic practice has also been highlighted as central to developing professionalism. Goddard et al, found that educators that rely on past experiences to guide their practice often find themselves in a state of 'pedagogic inertia' as compared to those with stronger educational foundations. The authors reiterate that reproducing past sociocultural educational practices and practicing in steep hierarchical bureaucracy institutions results in loss of educator agency and often creativity in their educational approaches (Goddard et al., 2022).

Educators may hesitate to fail underperforming students due to multifactorial reasons. This may include lack of confidence in their teaching, fear of subjectivity, unclear guidelines on curriculum and poor institutional support (Mak-van der Vossen., 2019).

The default of the traditional approaches to dental education is to focus on skill development by focussing on a ‘quota’ system to check off the number of procedures undertaken within disciplinary skill sets, this focus then encroaches on the person-centred approach to patient care wherein lies an understanding the patient's perspective, values, and preferences, and integrating them into patient management- a skill set that must have interdisciplinary consensus, support and emphasis (Kristensen., 2023).

The problem with developing professionalism lies not at its conceptualisation alone but in the people, processes and spaces in which this process is meant to occur. Acknowledging the nuanced interplay inherent in the process, is the first step toward creating space to reform the educational approach, improve and broaden the discourse on the role dental educators play in developing professionalism.

While the concept of professionalism is comprehensively defined and discussed in academic literature, a significant gap persists in its practical transmission: many educators lack the depth of understanding or training necessary to effectively teach professionalism to their students. This disconnects between theoretical clarity and pedagogical practice raises concerns about the adequacy of professional development in educational settings.

2.4 PROBLEM STATEMENT & AIM

It is apparent that medical education, including dental education, has great responsibility, both to students and society, to develop specific skills that will enable students every opportunity for success in independent practice, whilst maintaining deference to the expectation, commitment and great authority that the role embraces. As a prerequisite for educators to be able to determine consistent pedagogical practices with authentic educational outcomes, it is essential to determine the existing baseline perceptions of educators involved in developing undergraduate students. Recognising this baseline understanding will enable the setting of realistic goals for improvement on current practices. Identifying the commonly shared perceptions and origins of

ideas can aid in the point of departure from a restricted to elaborated coded approach (Moen et al., 2024).

With little evidence on what individual educators understand professionalism to be or what they perceive their individual roles are and how they develop these skills in their students, this study aimed to explore the perceptions of educators at the School of Oral Health Sciences (SOHS), Wits, on professionalism. The objectives of the study were,

1. To explore an interpretation of professionalism from clinical educators at the SOHS, Wits.
2. To determine the educators' views of their role in developing professionalism in students.
3. To establish current practices that educators use in developing professionalism in students.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

Professionalism is the term commonly used at the SOHS, to encompass all characteristics that are outside of the required knowledge and clinical skills included in the current dental curriculum. The SOHS commits to all domains as derived from Blooms domains of learning, namely, developing cognitive, psychomotor and affective skills in the undergraduate program- professionalism is established within the domain of affective skill, and the foci of assessment of this domain occurs within the clinical space when students treat patients through various procedures under the supervision of a clinical teacher. (Bloom's., 2025). There seems to be limited exploration and little information on the specific conceptualization regarding professionalism that is held within the school and as a vital contributor to the adjudication of clinical competence that is part of the competence-based approach used at the SOHS, there is pressing need to develop a shared conceptualisation of professionalism that is accessible to students and educators. This conceptualisation can assist with developing structures, processes and practices for both educators and students to improve the validity and reliability of the assessment and in the development of a professional identity for students, as well as the teaching and learning approaches to professionalism (Desai et al., 2022).) In this context, teaching refers to the sharing of knowledge to facilitate learning by providing tools that support critical thinking, learning is the dynamic process of gaining knowledge both formally and informally, and training is the focus on the development of specific skills and abilities (Jay, S. Learning vs Training: What's the Difference and Why Do You Need to Know? AIHR., 2024).

3.2 RESEARCHER REFLEXIVITY AND POSITIONALITY

As an educator at the SOHS, Wits University, my roles include lecturer; facilitator for tutorials, case-based discussions; and clinical supervision of undergraduate dental students in the clinical teaching and learning space. I am full time staff and a designated joint appointee for the Gauteng Department of Health and Wits university. I am a general dental practitioner with more years of exposure to the rigors of private practice, both locally and internationally, than my 10 years in the academic space. I am involved in teaching, particularly of the clinical years of study in the dental program, namely 3rd, 4th and 5th years with a primary focus on the 5th or final year students. I have been challenged to learn and grow in the educational space having started naive to the due diligence or great responsibility associated with teaching and learning. '...effective

teaching is somewhere in the mixture of art and science. Science provides a knowledge base of ideas that are helpful, perhaps necessary, in learning to teach; however, teaching is a performance art that also requires experience, intuition, creativity, and a host of other artistic elements.' This passage could not be truer (Vontz., 2020).

For some time now the disconnect in discourse between student professionalism and the 'results' we get from the clinical assessment process, the only area where professionalism is adjudicated at the SOHS, presented a conundrum. How is it that we bemoan student behaviour, attitude and practice yet students do not seem to 'fail' this when assessed? My observations suggested to me that we as educators were looking at different markers for professionalism, or different aggregates of markers, or bundling different combinations in relation to that of other clinical teachers in the same space who considered their bundle to be equal, if not more important markers. Some of us wielded the assessment of this as a threat of failure whilst others appeared to pay it no heed. Additionally, the clinical space focusses much on the acquisition of clinical skill to the point where other assessment parameters are relegated to less importance or a cursory glance yet still provide a score. There are many contributors to this practice so not all reproach can be made to the clinical teachers or even the students who tend to argue away a poor score with some form of excuse or argument, not all of which are unfounded, examples of these include that some clinical teachers do not mark as harshly, or have accepted a practice or behaviour without much fuss, or that a clinical teacher was seen presenting or exhibiting the same behaviour, attitude, practice etc. Considering my own bewilderment, I imagine that many students would possibly share this perplexity, or worse, consider professionalism inconsequential if our lack of concordance is anything to go by.

As the researcher here, I believe I was committed to finding out if and why educators have diverse views, where, if any, their focus lies and how our practices can be improved.

Having pre-conceived beliefs myself can significantly influence how the interviews are conducted as my personal biases may manifest as unconsciously guiding participants' responses through verbal cues, body language, phrasing of questions, leading participants in a line of questioning based on preconceived notions or selectively probing areas that I may favour rather than those that have contradictory viewpoints. As all participants are known to me there could additionally, be some acquiescence bias because participants feel compelled to align their

responses with my perceived stance. This required constant mindfulness to the process, my attitude and the structured interview guide, as well as including a wide range of participants both senior, equal and junior to myself so that perceived power imbalances could be mitigated. Maintaining reflectivity throughout the process was essential while seeking clarity on discussions and heeding the data in its entirety and objectively. Frequent and extensive consultation and interrogation of data with my supervisors served to buffer my own preconceptions, biases, and assumptions to study the data more objectively. My familiarity with the space and participants did, however, enhance rapport building and discussions could be probed somewhat more effectively as understanding of the context and practices were known to all.

Having searched the available curriculum information, and the lack of general agreement by all levels of academic in the school, leaving us with no substantive guide to assist in improving our practice, left me greatly disillusioned, thus steering me to this research topic. I found the proverbial ‘hornets’ nest’. I have been surprised, challenged, provoked, and in agreement with sentiments presented, until I was able to give voice to the data using a different lens and truly exploring the minutiae that surrounds this topic. Much is still to be done and for myself this of needs must start with my own personal development and self-improvement on the nuanced social intricacies prevalent in the academic space.

3.3 THEORETICAL FRAMEWORK

This study draws on Basil Bernstein's theory of the pedagogic device that offers a valuable lens to navigate and explore how dental students are taught professionalism. The pedagogic device will guide this discussion, examining how knowledge transitions from construction to classroom application. It involves three hierarchical processes: knowledge production, recontextualization, and pedagogic field dynamics, which collectively shape educational outcomes.

The pedagogic device describes how knowledge is transformed and transmitted within educational contexts (Singh., 2002). It consists of three interconnected processes:

Field of Knowledge Production: The field of knowledge production and its distributive control over what knowledge is available for learning has bearing on the implicit and explicit interpretation of knowledge. This process involves the creation and regulation of knowledge within social spaces. It determines the value of knowledge as an educational commodity and identifies who controls it. This field includes various stakeholders such as educational departments, policymakers, and accreditation bodies that influence what knowledge is available for teaching and in what form (Singh., 2010; Lim., 2017). It is of significance to note here that Bernstein classified knowledge as esoteric knowledge, the specialized knowledge derived from scientific research and often insulated from external influences. In contrast, mundane knowledge is common-sense understanding gained through everyday experiences. The interplay between these types of knowledge is crucial for educators as they guide students from their familiar contexts (mundane) into specialized academic discourses (esoteric), thereby shaping their identities and professional consciousness (Singh., 2002; Wheelahan., 2005). In the dental curriculum, students are socialised into the norms of practice through exposure to patients and role modelling of educators. This is further impeded by the discipline-based emphasis that our current health systems promote, as discussed earlier by the use of ‘quota driven’ training in the disciplines, thus amplifying the ‘unprofessional’ ways patients.

Field of Recontextualization: This field has two subfields:

Official Recontextualization Field (ORF): Here, authorities decide what knowledge from the field of production will be included in the official curriculum.

Pedagogic Recontextualization Field (PRF): This involves the adaptation of knowledge for teaching purposes by educational institutions, where specialized discourse is translated into accessible pedagogic knowledge (Clark., 2005; Maton et al., 2006; Singh., 2010; Bertram., 2012).

Dental curriculum planning is premised on the decisions, interpretations and emphasis made in this field by curriculum designers as this then guides classroom interpretation and practices.

Pedagogic Field: This field encompasses the rules of recognition and realization, determining how students demonstrate their understanding and engagement with the learned material. In dental education the design of learning outcomes and the aligned assessment practices are a demonstration of these rules at play.

The pedagogic device emphasizes that education is not merely about content transmission but involves complex interactions between these fields that influence how knowledge is perceived, accessed, and understood in educational settings. It highlights the social dynamics at play in education, including issues of power and inequality, as well as the critical role of language in shaping meaning and understanding within different contexts (Singh., 2010, Bertram., 2012). This influence of language has been extensively expounded and substantiated in work by Boughey & McKenna who add that language acts as a conduit of a message and that language (grammar and vocabulary) choices have the ability to change the meaning that is made. These authors further posit that, particularly in the South African context, language in education has been used as a political tool without due consideration of the explicit role that 'literacy' rather than language per se has on educational discourse. Literacy, they define as the things that people do with text using their contextual value system. This creates a distinct way of speaking, reading, writing, thinking and even valuing things, which can be shared amongst individuals. This then, introduces the idea of an extant of literacies that one can live by, with each literacy enabling function within a space and often not necessarily being interchangeable to another. These theories and ideas are of relevance here particularly when analysing the conceptualisation of professionalism and its impact on student interpretation. (Boughey & McKenna., 2021)

Bernstein elaborated on the concept of codes referring to the implicit rules and structures that govern the way knowledge is communicated and understood within educational contexts. These codes shape how individuals interpret and engage with information based on their social backgrounds and experiences (Atkinson., 1997; Singh., 2002). Bernstein identified two primary types of codes:

Restricted Codes: These are context-specific and often used in informal settings. They rely on shared experiences and common understandings among individuals within a particular group. Restricted codes may limit the ability to convey complex ideas, as they do not provide the flexibility needed to adapt to different contexts.

Elaborated Codes: In contrast, elaborated codes are more formal and structured, allowing for greater clarity and complexity in communication. They enable individuals to articulate ideas in a way that is accessible across various contexts, making them essential for academic discourse and professional communication (Atkinson., 1997; Singh., 2002).

Bernstein argued that access to these codes can influence educational success, as individuals familiar with elaborated codes are often better equipped to navigate academic environments. This framework highlights the relationship between language, knowledge, and social inequality, emphasizing how disparities in access to these codes can perpetuate educational inequities.

As an exemplar of restricted code at play in the dental curriculum, person centred interactions are largely influenced by student specific factors and prior exposure/lack of exposure to the dental context and patient communication processes etc., whereas the elaborated code is evidenced in the great detail in which disciplinary content is delivered- factual knowledge that is strongly defined by specific terms and not open to further interpretation.

Basil Bernstein's concepts of framing and classification are critical in understanding how knowledge is structured and transmitted within educational contexts.

Classification: Refers to the boundaries that define different types of knowledge and the relationships between them. It determines how subjects are separated or combined within the curriculum. Strong classification indicates clear distinctions between subjects, allowing for specialized knowledge to be developed within each discipline. Conversely, weak classification blurs these boundaries, leading to a more integrated approach where knowledge from different areas can intersect. This has implications for how students engage with content, as strong classification often supports deeper understanding of specific disciplines, while weak classification may foster interdisciplinary connections (Hoadley., 2006).

Traditional dental curricular have strong classification through the well-defined disciplinary subjects, for example, orthodontics, prosthodontics etc., that are taught separately, as compared to an integrated curriculum that does not recognise stand-alone subjects but an integration of concepts that addresses patient care. The integration of disciplinary knowledge can weaken classification, as the distinct boundaries of individual disciplines become increasingly blurred in the pursuit of delivering holistic care.

Framing: Pertains to the rules and expectations governing the pedagogic process, including how knowledge is presented and assessed in the classroom. It involves the control over the interaction between teachers and students, influencing how students are expected to engage with content and demonstrate their understanding. Strong framing provides clear guidelines for what is expected, thereby limiting student agency in interpretation. Weak framing allows for more flexibility and student input, encouraging a more participatory learning environment (Hoadley., 2006; Chiang., 2022). Problem based learning is an example of weak framing where students lead the process of learning, this is part of a pool of methods that contemporary dental education employs in the teaching as compared to the more set and structured characteristics of a classroom lecture that represents strong framing.

Together, classification and framing shape educational experiences by influencing what knowledge is valued, how it is organized, and the nature of student-teacher interactions. Bernstein emphasized that these concepts are essential for understanding educational inequalities, as they affect access to knowledge and the ability to navigate academic environments effectively (Hoadley., 2006). These educational inequalities have significance particularly when viewed against the backdrop of findings in this study.

Educators need support and resources on the micro-, mezzo- and macro levels of the academic institutions as multiple factors influence the educator's pedagogy of teaching and pedagogy of care (Kolaric., 2022), the latter is particularly important for all educators who are involved in clinical supervision of students. Pedagogy and pedagogical discourse are thus intrinsically woven into the conversation embodied in the research question. To do justice to the substantive influence of the findings of educational research like this, it is necessary to draw on theories that provide us with alternative lenses through which to view issues that are raised.

The analysis of this study will focus on the social realist perspective of the data, because the literature on professionalism has repeatedly emphasised that the construct is socially defined and inherently dependant on the socio-economic-political climate of the time, and because education, particularly in present day South Africa (SA) is still decidedly immersed in educational reform, with access seeking behaviour to 'knowledge and skill' as a means of joining the burgeoning global economy, continually on the rise (Boughey et al., 2021). This includes cognizing the

converse impact of the curriculum on the socio-cultural practices of their students (Ali et al., 2022).

3.4 RESEARCH DESIGN

We used a qualitative research approach to explore deeper insights into the educators' views, experiences, and understanding of professionalism. We deemed this approach necessary to explore participants' understandings of professionalism and determine if it is a well-defined and developed concept. Furthermore, we aimed to explore the extent of information available regarding the mapping of professionalism within the current dental curriculum. The qualitative approach added value to this educational research because learning usually occurs in very context-specific environments with nuanced interactions between people and space, making its contribution to this research question invaluable (Sargeant, 2012).

This study was explorative.

We chose interviews as the method of choice because they allow for greater specificity of the topics discussed rather than broad, general, or superficial statements. Interviews permitted the interviewer to probe with follow-up questions and use various questioning approaches to gather meaningful information (Flick, 2022).

We used a semi-structured interview approach with predetermined prompting questions (Appendix 4) to guide the conversation and allow for expansion to explore a deeper understanding of the topics. For example, this approach enabled us to explore and include reasons and examples that elaborate on or clarify the topics in the discussion. We created questions by reviewing the literature and following discussion with supervisors. We used open-ended questions to give participants some freedom and flexibility to explain their responses in their own words. This approach also created a space for two-way conversation, allowing participants to respond as candidly as possible (Flick, 2022). The questions were predominantly structured around the research objectives, using an open-ended format as mentioned before, and the conversation-like structure had a purpose while also attempting to create a safer space than a formal interrogation-like interview (Flick, 2022).

3.5 RESEARCH SETTING

Interviews were conducted at the SOHS, based at the Wits Faculty of Health Sciences (FHS), medical school campus. This and the adjacent Wits Oral Health Centre (WOHC) dental clinic situated in the Charlotte Maxeke Johannesburg Academic Hospital (CMJAH) are the primary sites of teaching and learning of preclinical and clinical undergraduate dental and oral hygiene students of Wits. Educators are based here or attend this site; this includes full time and those providing session based clinical supervision. This research setting permitted access to a convenience sample of participants for this study as well as being accessible and familiar to participants without the inconvenience of special time and travel arrangements.

All interviews were done face to face, except for one interview conducted using Microsoft Teams due to availability of the participant. Interviews were conducted in spaces that participants favoured, and included personal office spaces, unoccupied laboratory rooms, and the library reading room.

The setting in relation to teaching and learning, the WOHC is set up for academic teaching of undergraduate and postgraduate dental students. The undergraduate clinics train students from the 3rd year of the dental program through to the 5th and final year of the dental program, while the oral hygiene program has students in the clinic in the 2nd and 3rd years of the oral hygiene program. All clinical, as listed above, undergraduate students treat patients across a number of procedures under the supervision of a clinical teacher. All students will have passed a preclinical teaching program that uses predominantly phantom heads for skills development in intra-operative dentistry, before progressing to patient care. Students are thus still beginners and require close supervision, which is inversely monitored the more senior the student is in the program and in competence to perform the procedure. Students in the clinical space are expected to demonstrate knowledge, skill and professionalism as befits a dentist /hygienist, with respect to the clinical space and people as they would in any professional health service provider space. Students complete a prerequisite number of procedures to an acceptable standard to be considered competent in the procedure. Progression is largely dependent on completing the number of procedures, or ‘clinical quota’ as referred to at the SOHS. Quota is obtained on successful completion of the procedure to an acceptable standard. The clinical assessment, does in addition, assess more than procedural skill and includes areas of competency in

professionalism, infection prevention and control, clinical administration related to patient care. The area of professionalism has very broad descriptors for educators to assess, and these are open to interpretation by both students and educators.

3.6 STUDY POPULATION

Participants were purposively sampled based on their experiences that aligned with the study objectives as well as convenience as a member of the department permitted the researcher easy access to participants. All educators at the SOHS were invited to participate. This sample size numbered eighty individuals. This included full time academics, sessional clinical teachers and dental auxiliary staff. The full-time academics are lecturers and/ or clinical teachers based at the FHS, some of whom have the dual role of lecturer and clinical teacher, and others just one or the other. This group, additionally, comprise of specialist consultants in the dental speciality disciplines and general dental practitioners. Sessional clinical teachers are dentists or specialist consultants who attend only part time, most of whom are just clinical teachers primarily concerned with chairside teaching. The sessional dentists and oral hygienists are not involved in delivering lecturers or contributing to and of the knowledge base components of the courses. Each of the speciality disciplines, namely, Orthodontics, Maxillofacial Oral Surgery, Prosthodontics, Oral medicine and Periodontology employ sessional clinicians to supervise students in the specific discipline based clinical procedures. Both full time and sessional educators have varying lengths of employment at the SOHS. Dental auxiliary staff include full-time oral hygienists, dental therapists, radiographers and dental material scientists all involved in lectures and/or clinical supervision of dental and oral hygiene students at some point in the 5-year or 3-year academic programs respectively. This study population also represented a diversity of gender, race, ages, years of experience, clinical experiences and alma mater.

This study population was determined because all individuals identified in the preceding paragraph are actively involved in the lecturing and/ or clinical teaching of dental and oral hygiene students and are responsible for determining if, and /or recognising, and/or adjudicating, and/or providing feedback on professionalism to the students that they supervise. The perspectives, experiences and current roles of this study population are essential to form a baseline understanding of the research question (Sargeant., 2012).

As an educator at the SOHS, with access to and familiarity of the teaching and learning platform and the educators, the interviewer/researcher had an appreciation of context, influences and culture that shape the experiences of interviewees, contributing to a more specific contextualised understanding of the data. Familiarity with participants did facilitate a strong rapport enabling participants to share more openly, however, it must be recognised that this could also result in participants sharing more socially desirable responses to align with what they perceived the researcher's expectations may have been. This also holds true for power dynamics within the researcher-participant roles and the researcher made every attempt to acknowledge participants' contributions and ensure that they felt respected throughout the process (Råheim et al., 2016).

Invitations to participate in this study were emailed to all educators. This included the information sheet (Appendix 8) and consent for voluntary participation. The process was repeated fortnightly. Participants responded via direct e-mail to the researcher indicating interest in participating in the study. Arrangements to meet was then followed through via e-mail.

3.7 SAMPLE

Twenty interviews were conducted over a five-month period. Participants are representative of all the participants described in the study population representing a diverse sample of experiences, demographics, educational backgrounds, academic and clinical exposure to teaching and learning.

The interviews continued until an adequate degree of data saturation was observed, with rich information gathered and a number of recurring themes identified from the current sample. Data saturation here is explained using the 'Data saturation model' as proposed by Saunders et al, with saturation considered because of 'the degree to which new data repeat what was expressed in previous data' or having reached a point of 'informational redundancy' and the researcher acknowledges that 'data saturation' is not a straightforward point in the research process but is complex and influenced by a host of factors that include, but are not limited to, the theoretical framework in use, the type of study, whether the study is developing or exemplifying a theory, whether analysis is via inductive/deductive coding etc. (Saunders et al, 2018). Notwithstanding, participants in this study were representative of the diverse individuals as described in the study population affording a range of perspectives, experiences, roles and interdisciplinary viewpoints. As an exploratory study, the data gathered provides a significant first step in the

conceptualisation process and provides a stepping stone on which to build a framework for developing professionalism. This foray into the topic has thus provided a suitable exemplar of views at this point in time.

Excluded from the sample population was dental support staff, namely dental assistants and dental laboratory technicians as this group are not directly involved in teaching and learning of undergraduate students at the SOHS. Participants from the pilot study are also excluded from the study sample.

3.8 PILOT STUDY

The interview guide was piloted using two interviews before the actual interviews were conducted. This was to test the questions and prepare the researcher for questioning, terminology and points of expansion in the interviews. Feedback from the pilot study participants was shared verbally immediately after the pilot interviews. No changes to the question guide were deemed necessary. The results from the pilot interviews are not included in the data analysis, and participants in the pilot study are not included in the sample pool.

3.9 DATA COLLECTION

Once confirmed, we held interviews at the FHS in venues and times determined and agreed upon by the participants. These venues included personal offices, unoccupied laboratory spaces, the library reading room, and Microsoft Teams. We guided the interviews with predetermined questions that aligned with the aims of the study and supplemented them with follow-up and exploratory inquiries. Interview lengths varied between 40 minutes to just over an hour. We recorded all interviews with the participants' consent. We then transcribed the interviews verbatim using the Microsoft 365 transcription feature. The researcher reviewed the transcriptions against the recordings for accuracy. We anonymized the transcriptions by allocating a numerical descriptor.

We initiated the transcription process immediately after the interviews to allow the researcher time to review the transcripts for accuracy and become familiar with the content. The researcher-maintained field notes and comments documenting each session contextually, including observations and thoughts about the interview session. These notes included comments on the strengths and weaknesses of the interview approach, areas for personal improvement and follow-

up, points of clarity in the transcripts, and personal views and reflections of the researcher. We highlighted nonverbal cues in the field notes where possible, necessary, or significant.

We gathered basic demographic information using a demographic data sheet guide (Appendix 9). We used this information to infer if differences of opinion in the conceptualization were influenced by experience, prior training, etc. All participants were aware that they could withdraw from the study at any stage.

3.10 ETHICAL CONSIDERATIONS

The Acting Head of School at the SOHS granted permission to conduct the study on 17 March 2023 (Appendix 3), and the University of Witwatersrand Deputy Registrar granted permission on 23 March 2023 (Appendix 2). The Human Research Ethics Committee (HREC) at the University of Witwatersrand provided ethical clearance on 16 March 2023. They approved protocol number H23/01/10, which expires on 14 March 2026 (Appendix 1).

We made an information sheet available to all participants before they volunteered to participate. At the start of the interview, we gave participants the opportunity to ask questions or seek clarity on anything related to the study. All participants signed consent forms for participation, fully aware that they would not gain any personal benefit from their participation. They also understood that while we might use quotes in the research report, we would anonymize these quotes, and no personal descriptors would be used. We informed participants that we would use demographic data only as necessary for specific contextualization and that we would not include any personal identifiers if and when used in the report.

We anonymized all recordings and transcripts using numerical coding and saved them in a password-protected file. Only the researcher and immediate clinical teachers had access to the transcribed interviews.

3.11 DATA ANALYSIS

We undertook an iterative process of data analysis. Initially, we adopted a predominantly inductive approach in the content analysis of the transcripts. We conducted thematic coding using the Braun & Clarke 6-step framework for analysing qualitative data. This approach offered

some flexibility because it is 'unbound to a theoretical framework' and can be used across research paradigms (Maguire et al., 2017). We explain the steps adopted using the 6-step process as follows.

3.11.1: Familiarity with the data

As the initial step, we listened to the recordings not just to confirm that we captured everything but also to review the conversations and process the information obtained. We made initial notes during these first reviews. We then reviewed and reread the transcribed recordings to familiarize ourselves with the data, creating additional comments and notes on the data set. The researcher reviewed the transcripts more than once, initially verifying the text against the recordings. The researcher reviewed the transcripts multiple times, accruing notes with each review. This process of multiple reviews was significantly valuable as it is possible to miss nuanced statements in the data if the coding system is rushed or focused on the prevailing surface information. We then conducted the inductive analysis, focusing on the raw data and its content rather than solely on the research questions. Unmistakable similarities and coinciding views became apparent early on, particularly the view that many had not given much thought to defining professionalism or found the definition challenging to articulate. Sentiments such as

'it carries a lot of weight to it. It's difficult to answer! …But I think, how I would describe it is that it-it involves a lot: it has many faces to it.' And *'it's a whole lot of things and it's something that we speak of so lightly and loosely, I think that we assume that it's just something that's common knowledge…'* all lent to the patterns that developed along the way. Of particular interest that a few participants reflected on was the antecedent approach to professionalism that they had experienced as undergraduate students- of interest because the timeframe since graduation for the participants here ranged from 8 years to 40 years, a considerable timeframe for recollections such as the following to echo across the timeframe,

'I don't think we were properly taught. The only exposure we had was other graduates' (P12)
'And it wasn't a formal training. It was just like basically whatever we picked up alone and researched and stuff. No formal training.'(P12)
'Actually, I don't remember anyone telling me about professionalism. I think even those years they weren't assessing as it wasn't really part of the training part.'(P13)
'Most of my professionalism I have to be honest I learnt on the job.'(P15)

'No, I was given A study guide to say this is what we expect as far as professionalism is concerned. And it was just, you know. Portray that in your in your day-to-day- that's it- in your day today.'(P9)

These discussions led us to the appreciation of the complexity of the topic and in some measure added impetus to the necessity for pedagogical research of this nature.

3.11.2: Creating codes

In step 2, we used the MAXQDA data analytic software version 2023 & 2024 to assist in managing the initial coding process. We created codes by reading through the transcripts and doing an open, line-by-line coding to determine units of meaning. These units consisted of short phrases or passages that either recurred across the entire data, linked specifically to the research questions, or linked to each other in some way. We color-coded and labelled these units using the MAXQDA program to catalog units of information, thus helping the researcher break up the transcript into smaller units of information. The open coding did not depend on the research questions as the lens through which to 'seek codes' but rather on using all the text (line-by-line) to identify possible pockets of meaning. We identified a large number of inductive codes across the transcripts. However, deductive coding was unavoidable as we identified common threads throughout the data set due to the use of a semi-structured interview guide aimed at the research objectives. We also identified segments of data that overlapped codes; we reread these segments at separate intervals to confirm that the overlap had merit. For example, the following passage alludes to the educational approach of the clinical supervisor as well as the hidden curriculum message embodied in the idea that doing the procedure is enough. This participant says,

'*It's how to do a filling, and that's it-they know how to do it, they don't think about the background…Why am I doing it? What does the material do? Why are we using that material for that ingredient?'* (P12)

Or the recommendations to where we should start the process of developing professionalism, this sits within the context of the school culture that surrounds consultation and communication or shared decision making.

'What I would advise first maybe is for the different departments for us to come together and maybe like the interview we are doing now-we explain to each other how we are doing it'(P13).

Initial codes included descriptors for professionalism and the skills required for professional practice, much was said referencing what individuals themselves were doing in the teaching of professionalism or who and how they believed the teaching should eventuate. Of significance was the general consensus of uncertainty surrounding all aspects of this component of the curriculum and the provocations and forbearance needed to navigate specific contextual challenges. The latter having considerable bearing on a developing pattern on the hidden curriculum. Figure 3.11.2 is an extract of initial coding that is representative of the 2-sided meanings that presented.

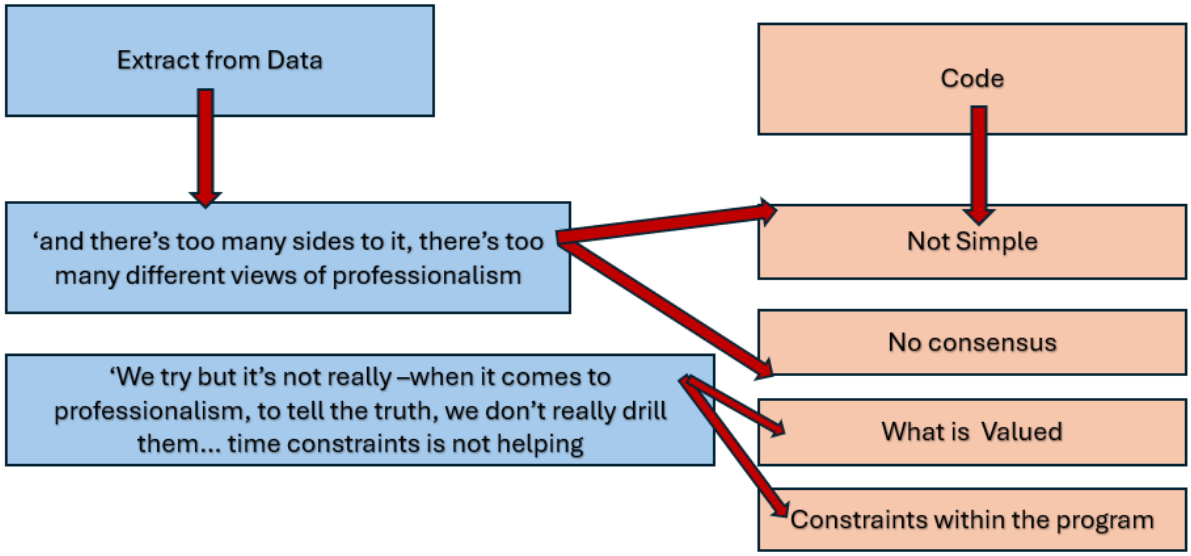

Figure 3.11.2 Initial coding representative of the 2-sided meanings

Independent co-coding of transcripts was also done by the supervisors on this study and a comparison made with that of the researcher. The results were found to be largely comparable. From the coding structure that eventuated just by comparison of the researchers coding and the supervisor coding, congruence could be found albeit in different phraseology. The researcher and supervisors committed to and met at fortnightly online check-in discussions to review the analysis process including coding, patterns emerging, positioning of outlier codes and developing themes. Given the different perspectives of the supervisors and researcher undergraduate experiences and through a collegial process of discussion and debate, with justification, consensus was reached with no great disparity of opinion. Both supervisors were part of the process and at no stage was consensus not reached.

3.11.3 Developing Themes

In Step 3, we collectively examined the codes for patterns of meaning. This involved looking at codes with similar meanings or those that contributed to each other, codes with intensive frequency or substantial recurrence, and patterns across these codes that were significant to the research questions. We developed themes dynamically and progressively through the iterative process of theme development. We sorted the codes and created first-order themes or initial themes from groups of codes that shared meaning (Figure 3.11.3), each group marked by a theme descriptor. Some codes fit into more than one theme, as mentioned previously, while others did not specifically fit a theme. We repeatedly referred to the outlier codes for relevance to the emerging patterns. At this point, we developed themes using patterns of meaning, including themes of particular relevance as well as those that surpassed the research questions and objectives. We interrogated the latter themes, which had considerable impact on the research aim, questions, and objectives, for relevance to the study, and included them in the analysis and discussion. As mentioned previously, we held fortnightly discussions to interrogate the process as it unfolded. The initial patterns that emerged from this iterative process of reviewing and interrogating the coding process included the conceptualization of professionalism, views on its importance, and views on its relevance in the overall curriculum.

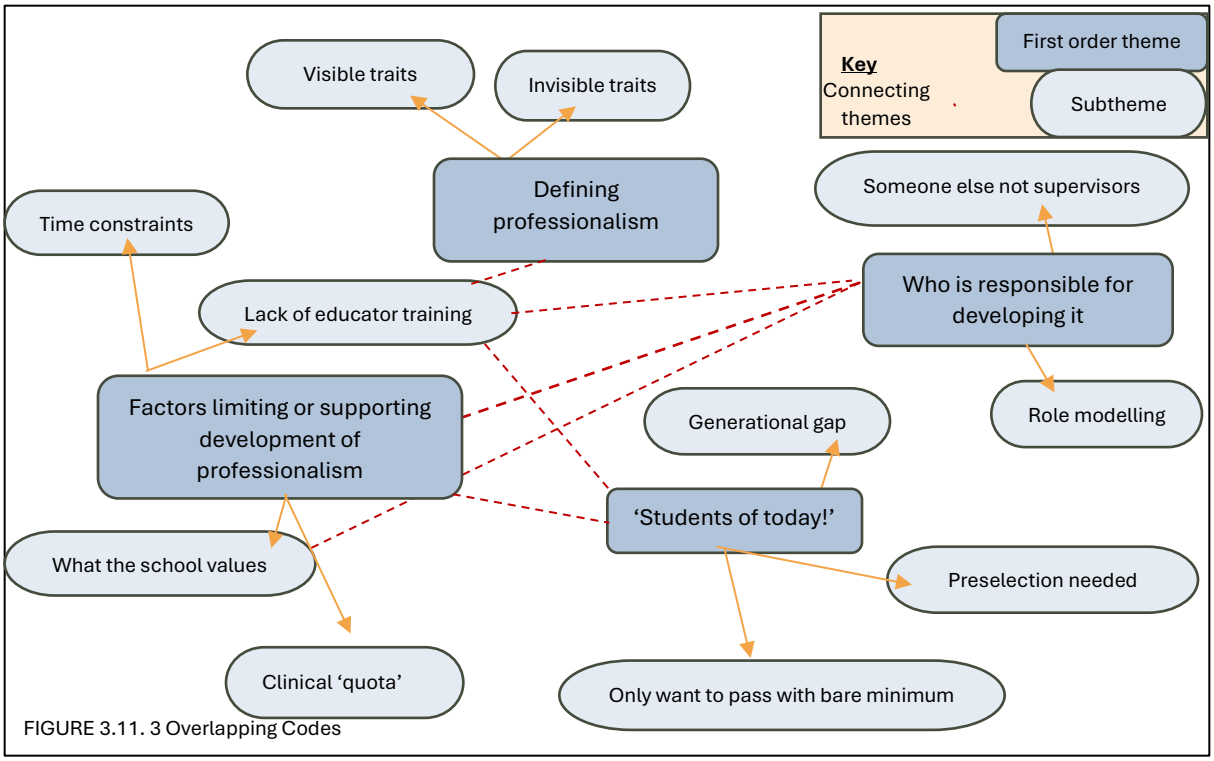

FIGURE 3.11. 3 Overlapping Codes

3.11.4: Theme review

We reviewed the themes and centred our discussion on their relevance to the study or their support of the discussion pertinent to the research question. We grouped and sequenced the information and data associated with themes to create coherence. We divided themes with a nexus into subthemes/categories that explicated the subtheme based on its individualized meaning and its contribution to the aggregate of the dominant theme. This division of themes into subthemes helped us expound findings to greater depth and acuity, aiming to optimize the findings from the rich data. We examined the preliminary themes, resulting in the agreed-on themes for relevance to the study as presented in the schematic below. We then determined that these themes had more than one line of reasoning and consequently divided them into subthemes.

We interrogated these themes and found some overlap, such as the role of the student in this process and the lack of consistent conceptualization or difficulty in articulating what professionalism means. Using the same two examples mentioned, we reframed the combinations of the above themes to create an overarching theme that we could divide into subthemes, as seen in the schematic below (Figure 3.11.4).

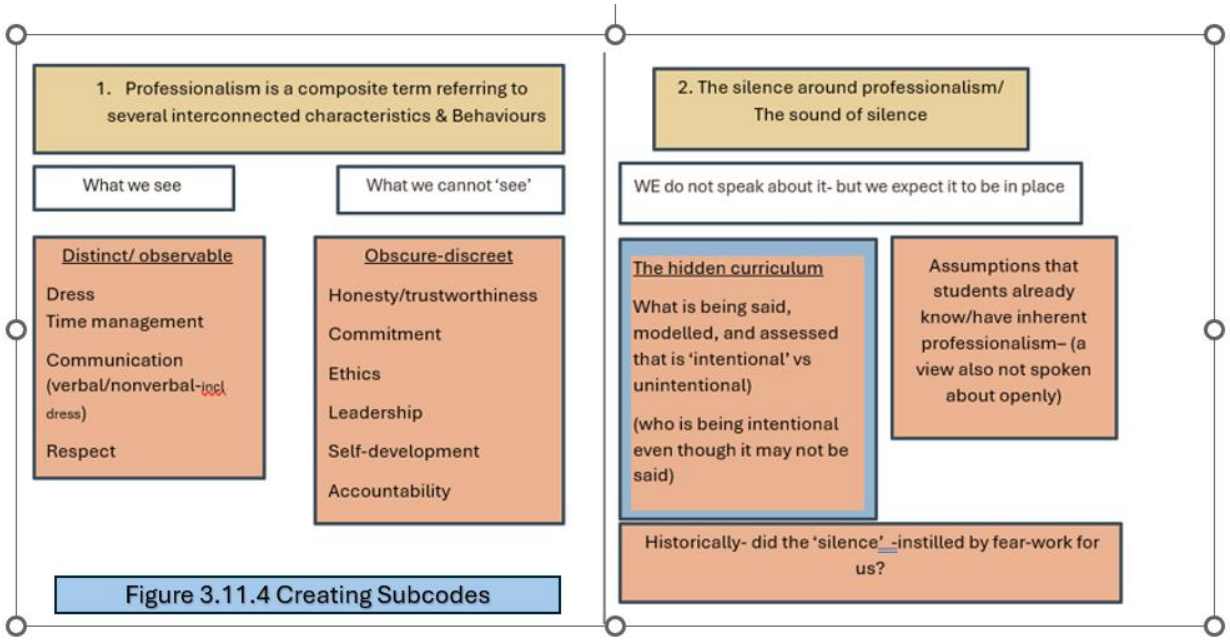

Figure 3.11.4 Creating Subcodes

To maintain focus in the rich data obtained in this sample, the focus on the research aims and objectives resulted in the following penultimate 'themes' as the anchor of the discussions ahead.

The approach here included data on what professionalism was believed to encompass, and what participants were doing to develop, reinforce, and assess students on it. The educators' perceptions on their roles and influence on professionalism as influenced by the structures and cultures that operate on all levels, namely that of the micro- or student and teacher interactions, meso- teachers as colleagues in the school, and macro or institutional/political/societal levels (Behari-Leak, 2017) provided a substantial insight into the social context of this 'microcosm' of the dental school.

3.11.5: Defining the themes

In this phase the themes were explicated to '…identify the 'essence' of what each theme is about.' (Braun & Clarke., 2021). Essential to this process was to interrogate the first order themes discussed above through the analytic framework explicated previously.

The theoretical framework was central to our considerations for defining themes, as it guided the lens through which we explored relationships in the data. For example, early on a pattern of complexity to conceptualising professionalism was observed, however, using Bernstein's pedagogic device, one can better appreciate that while professionalism has been extant for as

long as the professions themselves, and the term revised through rigorous research in multiple centres around the world, the pedagogic field appears to still grapple with an interpretation of it. This has repercussions to student development in the discipline. The gap here transcends a conceptualisation but is intricately woven into the pedagogic device as will be discussed later.

Macro, mezzo and micro, structures of influence are apparent in this discussion of professionalism, together with the contextual influences at play in the South African context, and even wider global platform, in the field of knowledge production.

In consequence, this enabled us to position the first order themes relating to educational practices, namely the combination of teaching practices, assessment approaches as well as elements of the antecedent practices within the pedagogic device as these entwined align with the pedagogic field of the device.

A third unmistakable finding from the data set was the apparent tension between educators and students as to the expectations, and criteria for assessment on professionalism, with repeated concerns about *'students today'* being more difficult than previously. An exploration of this reference to student deficits was explored and as mentioned previously the theoretical lens afforded a more comprehensive and socially significant approach to this perceived deficiency, expanding the discourse beyond the limitations of the views presented.

3.11.6: Writing up

The final step using the 6-step approach requires an analysis of the data. These are to follow in the discussion as individual themes; however, it will be noted that while these are discussed individually, there are notable points of convergence in the discussion. Additionally, following application of the theoretical framework, the interim themes developed a shape of their own as explicated using the theories and concepts of the pedagogic device. Three main themes were identified with specific relevance to this study. A subtheme is explored that has relevance to all three themes (Braun & Clarkes., 2021; Macguire et al., 2017).

3.12 TRUSTWORTHINESS

The ontological stance of the researcher was shared, and every attempt was made not to bias findings-this was supported by cross checking and debriefing with supervisors listed on the

study. Independent co-coding of transcripts was also done by the supervisors. The supervisors hail from different experiential backgrounds, SM is the Head of Department of the Centre for Health Science Education (CHSE) and SP is the Head of the Unit for Undergraduate Medical Education (UUME) at the FHS, Wits. Given the different perspectives of the supervisors and researcher undergraduate experiences and through a collegial process of discussion and debate, with justification, consensus was reached with no great disparity of opinion. Both supervisors were part of the process and at no stage was consensus not reached.

3.13 LIMITATIONS

This study focussed on the conceptualisation of professionalism by educators, but did not explore the explicit roles and backgrounds of educators in their capacities of lecturer, clinical supervisor, part-time or sessional educator. This could be of value as to how the different backgrounds may influence current practices of each group. The study, additionally, focussed on just the one school in one institution and may thus limit transferability of findings.

3.14 CONCLUSION

The study set out to gather information on what educators tasked with overseeing students' clinical practices perceive professionalism to be, and how they facilitated this development. The data

This qualitative, descriptive study used semi-structured interviews to gather data from educators in the school of oral health sciences to explore their conceptualisation of professionalism in order to understand how professionalism is understood, taught and assessed within the school. This was with the aim to explore the need for a shared, contextually relevant definition of professionalism within the school and highlight opportunities for faculty development and curriculum reform. Participation was voluntary and participants were purposively sampled based on convenience and their experience as educators within the school. Twenty semi-structured interviews took place over a five-month period. The data were analysed using a thematic analysis approach with a subsequent analysis using Bernstein's Pedagogic Device to aid interpretation.

CHAPTER FOUR

FINDINGS

The codes determined during the line-by-line coding process, included an array of code labels that provided a brief construct of the grouped codes. Appendix 6 presents the initial code labels and the quoted texts from the data (codes) that contributed to the label.

Initial coding presented as eight broad code descriptors with each label made up of numerous subcodes. These subcodes, however, were established following further analysis of the first round of coding. The subcodes were a result of identifying separate contributors or aspects of the code, each representative of a distinct contribution to the initial code. Following is an explication of the themes supported by the data.

4.1 Professionalism is….

Unsurprisingly descriptors for professionalism rendered the greatest contribution to the coding scheme. This was repeatedly supported by viewpoints on the variability of professionalism, '*To be honest, it's changed over the years. It's definitely more diluted'(P18),* how difficult it is to explain given the great diversity of the South African context, *'It's a difficult thing, especially because we are a very complex country' (P14)*, how it is continually changing, that it is an ongoing process of learning even for a seasoned educator with years of experience *'Professionalism is not a once off thing, it's a process…a lifelong one. I'm still trying to learn a few things about professionalism myself ' (P15)*, that it is influenced by context, that it is not thought of often enough to be able to define, *'and it's not something that I have given much thought about because, I mean at all really…' (P19)* and that occasionally what we think we know actually only represents a fraction of the entirety encompassed by the concept of professionalism.

Attempting to define professionalism in dental practice, a host of subcodes were determined, of these, were distinct groupings of characteristics that are easily identified through unmistakable behaviours, as noted by the following participant views, *'Being friendly and being professional is two different things.' (P12).* Characteristics such as, '*dressing a certain way' (P10), 'putting the patient first' (P17), 'respect'(P9), 'honesty' (P6), 'time management' (P18),* and *'accountability*' (P15) were emphasised. Other visible traits that were strongly considered to be

representative of professionalism included '*communication skills*' (P15)*, 'respect for patients, peers and clinical staff' (P14),* being '*well prepared for clinical sessions' (P20),* and generally demonstrating good '*mannerisms*' (P4) to everyone around. This is as opposed to characteristics that were more obscure and either missed or not given the same consideration, particularly given some of the contextual challenges and limitations that emerged as an independent thread within the data and will be discussed in a later theme. The less obvious characteristics that participants listed as components of professionalism, included, '*ethical patient care' (P10), 'ability to make decisions' (P14),* and be '*confident' (P14)* in what they do and the choices they make. Central to professionalism were characteristics of honesty; integrity; accountability; responsibility; acknowledging individual limitations and maintaining a commitment to continue learning. An observation of professionalism embodying more than outer attire, '*Even with this white coat not on it simply means what is Underneath is professionalism, so yeah, it's not just the clothes.' (P16)* was reinforced by another participant's view of '*It's the what, the how, and why we do things the way that we do that'(P15)* and that inherent to it is its complexity, *'Professionalism is quite broad… there's so many criteria along professionalism' (P6).*

The data additionally highlighted the indispensable role of Professionalism in the teaching of undergraduate students as '*We are not fixing engines and cars … [we are] providing services to human beings. So, there's a level of professionalism in that one needs to carry when treating those patients because they look up to us*.' (P14) Professionalism is essential to the role of a dentist as it encompasses a level of self-assessment, integrity and accountability that surpasses just knowledge and skill, this is adroitly expressed in the view *'I think I would put professionalism above all of them. And the reason for that is if you are professional enough you will know whether- either I don't have the right skills, or the skills are lacking, and you need to either upskill or acquire the right skill. Or you'd be honest enough in an open and transparent manner with the patient to say I can't do A; I will refer you to doctor Y'(P15).*

4.2 Antecedent Approach to developing Professionalism

This code emerged from reports on how participants had been taught to be professional during their undergraduate and subsequent training, '*I think we were frightened into becoming professional. We were almost- it felt like we were at a military school of some sort.'* (P4) The rules that they were taught to respect or live by and included recollections of how their teaching

made them feel at the time and then in turn how they had come to value the teachings. As pointed out *'It could have been seen as -like a dictatorship type of teaching. But back then, I think all of us were just like sheep. We just followed. We never questioned. We knew what the consequences were, and we were too scared of repercussions.*' (P4) For some the process was discomfiting and often accompanied by repercussions or consequences for poor behaviour. The benefit of role modelling was reaffirmed on a number of occasions, *'Our role models were consistent. Our role models were-they showed up, they were on time, they were prepared, and even if they were not, we did not know. We could not pick it up, that they were not.' (P4)* with role modelling considered essential in the process of developing professionalism in students.

For others there was no recollection of it having been taught at all, *'No, actually, I don't remember anyone telling me about professionalism. I think even those years they weren't Assessing it-it wasn't really part of the training.' (P13)* Or having had to learn it through exposure to others either senior students, or colleagues following graduation. The diametric views surrounding how participants were taught or not taught, included *'Most of my professionalism I have to be honest I learnt on the job'(P12)* and *'I was given A study guide to say this is what we expect as far as professionalism is concerned. And it was just, you know-Portray that in your in your day-to-day- that's it' (P9)* implying that the importance of professionalism may not have been adequately emphasised and as noted *'I think by 5th year I kind of had an idea of how to-What is the expected! ...Going from being a student to a fully qualified - independent practitioner - it was quite a shock at first...' (P1)*, and of significant challenge to the new graduate.

4.3 Teaching Professionalism

This code emerged from the views shared on how professionalism is being taught and often included how it should be taught. A sentiment that has particular resonance here was the view that *'One can only take someone as far as they themselves have gone.' (P19)*

This is echoing the sentiment shared previously that one cannot always be certain that what they know is indeed sufficient. For some participants the framing of professionalism in the curriculum was a concern, *'Because unfortunately when they start with the clinics, that's when you start teaching professionalism skills and by then it might be a little bit too late*' (P15), and others could not pinpoint a space where the current curriculum is addressing the development of

professionalism other than as an assessment in the clinic teaching space. A suggestion for consideration was presented that *'At least from day one, let's start developing professionalism. Because one of the other challenges as well is when you start assessing them in the clinics. It's 'bang' all at the same time they are not expecting this, it's overwhelming. While if you do it the other way, we start implementing it without necessarily assessing it, by the time we get to the assessment means now those behaviours are inbuilt.' (P15)*

There were concerns on the lack of clearly defined outcomes for the development of professionalism, and inconsistencies in practices amongst the educators, '*It needs us to be consistent, if there is lack of consistency in being professional or talking about it or implementing it, whether it is you as a person or us as a group then the students are going to gravitate towards the easy way out, which is often not sticking to professionalism and it takes a lot of work, it needs you to do the right thing.'(P4).* The salient need for a shared meaning was emphasised *'I think the standardized outline of what professionalism is- because also we all come from different viewpoints of what professionalism is. I think it's -what might not be professional to me as professional to someone else. So, I think we need a very descriptive, prescriptive outline of what it means, what it incorporates because it can be quite subjective.' (P15).*

A number of recommendations, *'I think the best way of getting a message across is by showing it and acting upon it. And being the role models…because that is what sticks into people's minds. It's not what's read on paper.'(P11)*, were shared on what should be done to teach it, of note were views on who should be teaching it, *'I think professionalism should be actually integrated across all disciplines.*'(P19) and the inconsistencies with whose responsibility it is for the teaching. As mentioned previously, role modelling, recurs with great emphasis, *'that you not only talk about and reinforce, but you must be it and act it'(P4)*, and some citing examples of poor role modelling to emphasise the negative impact of 'poor' role modelling. *'The role modelling from some sections is not what it should be.'(P15).*

A number of recommendations were made for possible approaches to teaching professionalism, these included, *'Case scenarios of 'good' examples vs 'bad' of professionalism'(P1)*, '*Video vignettes'(P2)*, '*Shadowing private practitioners then sharing their reflections'*, *'Feedback and*

reflection at the end of a patient care session'(P14), and spending more time '*explaining to them the reasons why they do certain things'(P19).*

4.4 Assessment Practices

This code ensued on the teaching practices as it is the dominant platform for evidence of educational practices involving professionalism. Dissatisfaction of the current approach to assessing professionalism was shared, particularly as it appeared to be of secondary value to students who focussed on achieving the requirements or 'quota' of clinical procedures even if it meant disregarding all else, *'The intense training of the field that we work in, students often don't put professionalism at the top of their list when they do treat patients, they want to achieve certain quota of what they need, so they almost put it somewhere at the back of their mind…So I think it's important for us not only to focus on the clinical quota or the procedure of the day,'(P14)* . Of great concern was the individualised interpretations held despite having a standardised assessment form, *'I think it's one thing having a form, that assessment form that has professionalism in it and it's a totally different story to applying it so. I think there it becomes an individual thing.'(P14)* that impacts where and how emphasis is placed on student development. The lack of consistency by educators in reinforcing professional behaviour as mentioned in extracts of the data above oftentimes facilitated this behaviour. In addition, the lack of consequence to unprofessional behaviour due to insufficient structure and a '*descriptive, prescriptive outline'(P18)* on professionalism created ambiguity in interpretation of expectations by both students and clinical teachers.

The value of having professionalism as a component of clinical practice was referred to as supportive of making students aware of poor behaviour, a response to whether the inclusion of professionalism in the assessment tool helps, the following response was shared, *'Yes, it has to a certain degree because there are times when I find that the student is not very professional. Whether it was how they manage the situation, or if they double booked the patient, you know things like that. So yes, it does, because it gives me a leg to stand on when it comes to giving them a mark.'(P2).*

4.5 Tension between students and educators/ the problem lies with students

The code on 'problem with students' or 'students of today' presented as a discreet thread throughout the data. Participants bemoaned student behaviour and attitude as well as priorities within the clinical space. Opinions included *'To be honest. I don't know if it's a generational thing, but we listened and we had very, very strict supervisors.'* (P5). And *'I think the generation of students, now they-not that it's a bad thing. But they like to challenge everything. Yes, and I think our generation will not really.'(P5)*, '*that sense of respect, accountability, and responsibility. And I don't know, I just don't see that.*'(P5) creates the idea of them and us. There appeared to be dissenting views on whether professionalism could be taught or if it's an inherent trait that the student has when entering the program as evidenced by the view '*But whether it's something that they-It's innate in them, I think it's an area of research that might actually need to be explored, you know, as to how certain students will behave certain ways while others in different ways, despite them having had the same teachings.'(P15)* Some were of the belief that certain basic attitudes, behaviours and characteristics should be in place when they enter the program and then developed as they progress through the years of study, while others felt that student selection for entry to the program must be closely managed so that the 'right kind' of student is selected for the program. Concerns on students perceived indifference to rules or self-development in professionalism, tendencies to argue sometimes indefensible behaviour, persistent transgressions and lack of accountability were discussed. There were, of the participants, those that felt unable to make definitive comments either because of insufficient information around what drives students or as a consequence of the existing inconsistencies in the pedagogic practices in the school.

4.6 Culture of the School including context (teaching space, staff)

Concerns were raised on the lack of teacher training to be able to transition from clinician- to clinician educator. *'There's a lot that we don't get taught here.'* (P7) And *'I think you know calibration as much as we do calibration in departments it needs to be calibration amongst the school. I think teaching policies I mean-And it goes back to saying that we qualify as dentists and are you coming to an Academic Institutions, we're not really equipped with that sort of thing.'* (P5) this paradigmatic shift presented challenges for those educators aware that a change in thinking as an independent practitioner was necessary if they were to fulfil their roles within a

structured curriculum approach and echo the benchmarked teachings rather than confuse students with personal preferences. '*that we qualify as dentists and are you coming to an Academic Institutions, we're not really equipped with that sort of thing.*'(P5) Additionally, the deficit on comprehensive induction into the educational space was also hailed as a problem especially as many learnt their educator roles *'on the job'(P8).*

Concerns on a lack of consensus, and a well-defined pedagogy that is used across the school, were raised, this included a lack of consistency. '*What I would advise first maybe is for the different departments to come together and maybe like the interview we are doing now-we explain to each other how we are doing it.'* (P13). Mention was made particularly that each discipline within the undergraduate teaching program worked independently of each other, and a topic such as professionalism that is essential to the well-rounded graduate and not particular to a discipline needs to be a 'school' exercise, with collaboration and integration of views, goals and teaching. Maybe it's because also the way we compartmentalize all [Discipline A] is there and [Discipline B] is there, [Discipline C] is there, we're just not working together.'

For the greater part, new educators get 'calibrated' on how to use the clinical assessment tool if clinical supervision is part of their responsibilities. This process is specifically concerned with the clinical assessment tool, domains and marking grid, it does not necessarily include what has been taught, how it has been taught and sometimes the level of expectation is not sufficiently addressed. Sessional educators who predominantly provide clinical supervision to the undergraduate students found that they were not always included in the educational discussions that form the foundations for entry to clinical practice or in the decisions made for clinical teaching, or developments in newer practices, materials etc.

For some participants, the staff 'generational' variables were cited as contributors for inconsistency. *'I think personally teaching is. It's a career on its own I, but I don't think any person doing any other career can automatically become a teacher in the discipline. I still think whatever training that you have, you need training in as far as becoming a teacher to teach what you've know, I don't think it comes automatically- because that, that's a different perspective.'(P14).*

The discussions surrounding the teaching space limitations challenges and benefits or features supportive of achieving better student outcomes especially in professionalism raised some

pertinent issues of lack of leadership, lack of support, power struggles that filter in a top-down hierarchical process as is the practice of the school. There was some sense of disappointment that not much is being done to support the teaching and learning, with individuals often feeling adrift and isolated with their concerns. The school's strong disciplinary silos intensify the disunity felt, and for some perpetuates the lack of consistency and conformity in the general practices of educators across the school.

Some discontent on leadership and power struggles perpetuated by poor leadership and guidance *'Even when I say lack of leadership sometimes. Not because we. Didn't have leadership. It's just. The leaders that were there were not leading or not leading properly because sometimes they would give power to people and people would abuse it and they would actually promote that' (P4)* that promotes inequalities and abuse of positions of authority, encouraging many to make decisions ad libitum. *'Various houses of power and it's the power struggle that we see in our school that has -it creates …each one of us feels that we are we are a powerhouse on our own and we will do what we want despite what should be done.'(P4).*

There was an explicit feeling that change is needed and must include all levels of staff *'It needs to change at different levels it's not going to help if you're going to focus at ground level, whereas there are other different levels that are not doing it. OK, it has to come down or down up, they should either way, but it must be consistent right across.' (P16),* the sentiment that the discipline specific silos create some discord is also echoed in these findings *'Maybe it's because also the way we compartmentalize all [discipline A is there and [discipline B] is there, [discipline C] is there is there, we're just not working together', 'And the only way for us to get there is to move away from this different-this thing of this department is on their own, and that department is on their own- is kind of all we have to, from us the lecturers, all come together.'(P13).*

There was evidence of an undercurrent that some educators allude to as disrespect between staff both horizontally with colleagues of 'equal' rank and vertically across all ranks within the school, *treating everyone with respect, no matter what their rank is, it doesn't matter how high or how low they are. Whether they are subordinate or not, treat them with respect. Whether it's a cleaner or whatever…',* this coupled with additional challenges of space, and resources has made a notable impact on workplace culture. The limitations and challenges that have been amplified

since the pandemic and hospital fire have greatly influenced staff morale specifically on the working conditions, and to some extent has demotivated individuals into complacence. '*I don't know because like at where we are currently, we're such we've got such so much space -space constraints, you know there's so many limitations. You know, in terms of how everybody is also just scattered and splattered everywhere'(P12) and 'So, I think maybe these things can be properly worked on once we have a have a space where we are permanent, then we can sort of like figure out… It comes back to that -it comes back to the space because now obviously- There's an increase in student intake but not realizing that there's no increase in space. So, there was a certain time where we managed with the student intake, and it was in a good balance. Now it's on an on an imbalance.'(P11).*

4.7 Hidden Curriculum

There was much to discuss on the impact of the hidden curriculum, with participants of the view that as educators *'We have mixed messages…' (16)* that can easily be misinterpreted. The things that students learn from our unguarded behaviour may speak volumes to them. *'Clinicians tend to know their Forte and know exactly what to expect from a student and not really look beyond that.*'(P14).

The consensus appears to be that focussing just on the disciplinary skill above all else was relaying the message that nothing else is as important. *'Students often don't put professionalism at the top of their list when they do treat patients, they want to achieve certain quota of what they need, so they almost put it somewhere at the back of their mind' (P14).* There were also concerns about the lack of uniformity and the subsequent confusion that could arise from that, with educators devaluing a practice to the point that it becomes accepted behaviour etc. *'Is that we as educators, what are we teaching our students by that perception that this is important or more important than this? And might not necessarily be right the way you're focusing it'(P16).*

Positive role modelling was repeatedly hailed as essential, '*And whether we like it or not, for professionalism to work and be applied consistently- Those who are role models -who our students look up to have to practice and behave in a professional way. For them to model and say- this is the right way, this is how it should be done …'(P9).*

The concerns surrounding role modelling and the negative impacts it may have been a source of frustration; the sentiment below has resonated within the data. *'My answer to that is a mixed bag. There are certain sections that are supportive, actually understand the role of being a teacher. And there are sections that, for whatever reason- I don't want to say but couldn't be bothered! (15). Maybe the level of knowledge I don't know, but yeah. The role modelling from some sections is not what it should be.'(P15). I think you would want to professionalize the institution, the whole institution. If that is even possible.'(P15).*

The unintended messages that educators relay have become pervasive, the attitude of individuals across all ranks to each other, the students etc, was a matter of concern and quoted as needing urgent redress. For some individuals practicing consistency becomes an enabler for being labelled strict and thus feared by students, isolating the educator from the team. *And I think we want to be loved or liked by these students …if so, many students like you, and You (pointing to themself) come as this strict person, I'm sure you know I'm regarded as being [the one] who you know is strict. And then sometimes we let go, although we are uncomfortable- it's not supposed to be like that.'(P16).*

4.8 Contemporary Dentistry

Exploration on perceptions of the dentistry in the 21st Century revealed the importance of self-directed learning especially in light of the knowledge and technological explosion, graduates will need to be able to source reliable and relevant information, while providing treatment that is in the patient's best interest. Accountability and building trust were considered significant characteristics to nurture. *'Especially you know, accountability because when patients come to us, they come with a certain level of trust, certain level of expectations and whatever actions that we take or meant to take for that matter we need to be accountable and be able to justify our actions.'(P15).* The demands are high; graduates can expect to work hard in the dual role of clinician and sometimes business owner. '*And there's no break here because there's no going back', ''By the time I get home because, it's exhausting.'(P2).* High stakes decisions are needed and have to be made efficiently in short periods of time, while considering all the complexities that a patient may bring. '*You decide to do an endodontic procedure. And it doesn't go well and now we're doing a surgical- who's at fault. The patient looks at you-Do you refer out? Do you take do the surgery for yourself,' (P1).*

The most consistent attribute noted was that of good patient care, echoes of '*it's all about the patient'(P14)* was evident throughout.

The code descriptors above (4.1-4.8) were used to create four overarching themes as indicated in figure 4 below. Professionalism is and contemporary dentistry contributed to the discussion of theme 1, the antecedent approach to developing professionalism, teaching professionalism and assessment practices contributing to theme 2. Tension between students and educators formed the foundation of theme 3 and the culture of the school and hidden curriculum contributed to theme 4.

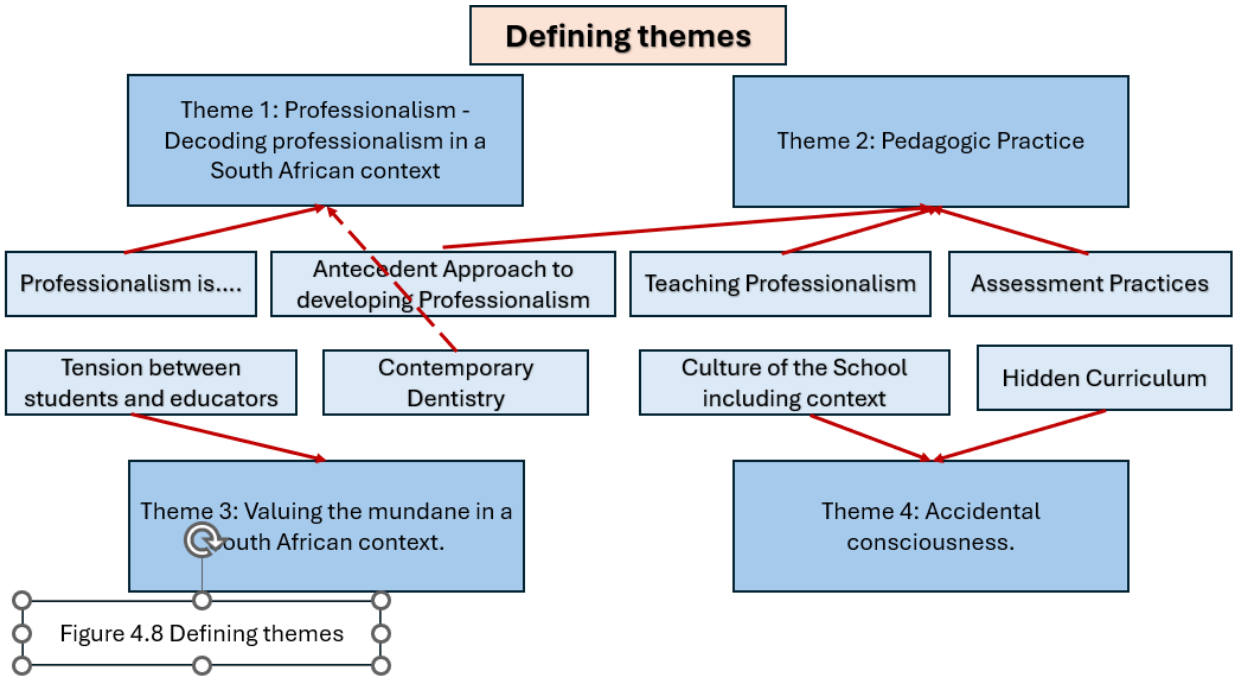

Figure 4.8 Defining themes

4.9 CONCLUSION

Referring to Figure 4.8, the code descriptors as outlined in this chapter, in combination, contributed to development of the overarching themes that will be explored in the following chapter. While the code descriptors professionalism is… and contemporary dentistry contributed to the theme of professionalism in a South African context, these descriptors also lend some insight to the pedagogic practices that were found. The same is found with assessment practices and the influences on accidental consciousness demonstrating the great influence of the hidden curriculum at play here. The themes should then not be viewed as isolated topics but rather as parts of the whole in this complex challenge of developing professionalism.

CHAPTER FIVE

DISCUSSION

5.1 Theme 1: Professionalism- Decoding professionalism in a South African context

This theme investigates how professionalism is understood and practiced within a South African context. It addresses the first objective of this study to explore the educator's conceptualisation of professionalism. It highlights, if one references the interpretation present in the literature review here, the potential gaps in discourse on professionalism in the SOHS, particularly vertical discourse, and the lack of sufficient decoding of the various interpretations of professionalism particularly those that reflect local values and expectations while aligning with global standards.

The findings here demonstrate a strong resonation to the values of old, particularly those of observable traits like looking the part, communicating with respect and being honest, essentially, the skills that are ostensibly understood as part of the fabric of society. However, contemporary medicine, as the literature demonstrates, expects a lot more from its healthcare professionals, and is underpinned by deeply engrained attitudes, behaviours and skills like leadership, advocacy, self-regulation and lifelong commitment to learning that are more abstruse requiring a deeper interrogation of the specific expectations. The esoteric nature of these characteristics situates it at the periphery of much of educators' inherent knowledge, particularly in light of the views shared that professionalism was given insufficient focus in their antecedent learning and that often it is not thought of in great depth lending to the idea that educators themselves have insufficient access to the vertical discourse and are functioning from a rather restricted coding system in this area. It is not just the students that *'almost put [professionalism] somewhere at the back of their mind…'* (P14) but they educators as well.

The medical professions have evolved from being predominantly occupied by middle- and upper-class men to now encompassing individuals from diverse cultural backgrounds and genders (Cleaton Jones et al., 1996). Professionalism, primarily defined by the global North, is influenced by various sociolinguistic and cultural factors, including the dynamic relationship between language and society. Language serves as a tool for communication and expression, while literacy acts as a social construct that helps individuals access the values and practices of specific disciplines. Understanding this interplay is crucial for appreciating how professionalism

is shaped by context and cultural norms (Clarke., 2005; Singh., 2010; B&M., 2021; Christie., 1995). This impact cannot be ignored in this educational context and if viewed through the framework of Bernstein's code theory, professionalism is a highly codified conceptualisation that may not be of comparable utility or value, at least not instantaneously and not until the necessary literacy skills are acquired to make sense of the disciplinary code. This is in no ways downgrading the authenticity of the construct, nor the value it has to the profession everywhere, but this interpretation is highly coded for environmental and cultural circumstances through the process of strict vertical discourse (thus codified within the distinct disciplinary realm) far removed from the South African context.

The process of defining professionalism, particularly through Bernstein's pedagogic device, highlights that the various interpretations of professionalism in the global North are rooted in knowledge production. South Africa continues to follow codes of conduct established by countries like Canada, the UK, the USA, and Australia, which shape its understanding of professionalism. This knowledge holds intrinsic value and serves as educational currency, governed by the distributive rules controlled by policies and politics, particularly through the regulations set by health professional accreditation bodies such as the HPCSA. (Health Professions Council of South Africa, 2014; Singh., 2000; Boughey &McKenna., 2021)

Epistemic norms play a crucial role in shaping the knowledge deemed appropriate for educational curricula (Boughey &McKenna., 2021; Wheelahan., 2005). This knowledge is communicated in classrooms, facilitating students' understanding and instilling values. By controlling this knowledge production, authorities can maintain stability and uniformity throughout the educational journey of healthcare professionals (Singh., 2002; Smith 2022).

The gap between official discourse and classroom pedagogy in South Africa perpetuates social inequalities, as the official codes for medical practice remain largely unfamiliar to educators (Boughey &McKenna., 2021). Many educators lack proper induction into the esoteric knowledge of professionalism, often being compelled to conform without developing the literacy skills necessary for this official pedagogic discourse. This results in a strong insulation of knowledge that remains 'uncoded' for educators, thus making it inaccessible to students. To achieve uniformity in educational outcomes, it is essential to provide clear conceptual frameworks and teaching for educators, ensuring that all students receive the necessary knowledge in a structured

manner. Currently educators have, through past experience, developed individualised coding orientations to be able to adapt to a variety of contexts, including the educational platform that is not sufficiently specific for the task at hand (Association for Dental Education in Europe; Scheele., 2012) Educators in medical education are intensely familiar with the literacy practices and codes related to patient care and are able to comfortably engage in discussions on diagnosis, treatment modalities patient care etc., however, with regards to specific and formal socialisation to teaching, there is an additional gap as identified in this study. A study by Bartlet et al. who explored the motivation and socialisation of 'Becoming medical educators' of medical educators in formal educational teaching programs, concluded that 'We have identified that medical education registrars [MER's] need to be better supported in the clinical environment. An orientation at the start of the post would assist them to define personal goals for the post and understand expected outcomes. Providing a supervisor with sufficient knowledge of education would also better support MERs to evaluate their own projects and other educational interventions.' (Bartlett., 2023). In the South African context, clinicians transitioning into academic roles often develop their educational approaches informally. This practice underscores the need for a structured reconceptualization of knowledge tailored for educational purposes, which requires specific development and support to be effective. This is particularly important for knowledge domains like professionalism that lie almost entirely within the affective or attitude and value structuring area of development, an area that most clinicians (not just medical educators) rarely, if ever, have to articulate or explain in the execution of their clinical duties. Understanding and engaging with the vertical discourse of knowledge is crucial for educators to prevent ambiguity and confusion among students. Proper knowledge structuring influences students' social identities, aligning them with professional norms that may initially feel alien and require substantial support from faculty. This support is essential for students to develop recognition and realization of these norms effectively (Sarraf-Yazdi., 2024; Singh., 2023; Chandran., 2019).

The decontextualization of knowledge at macro levels is not understood by its beneficiaries, who are unaware of the underlying power dynamics involved in this process. Educators, while primarily engaged in knowledge distribution at micro levels, must recognize the hierarchical influences on knowledge production and dissemination. This understanding is crucial for them to effectively decontextualize and recontextualize knowledge to suit the evolving social contexts

within universities and among students (Potter., 2023). The dental curriculum in South Africa lacks access to discourse and influence regarding revisions made, leaving educators and students as beneficiaries without meaningful engagement. When revised knowledge is incorporated into the curriculum, it often remains overly encoded, leading to significant loss in translation. Participants in the study frequently referenced outdated concepts of professionalism, such as integrity and respect, which date back to the late 1900s, rather than adopting a more contextual understanding. Consequently, there is a tendency to focus on superficial aspects like dress codes instead of developing a more relevant representation suitable for clinical environments.

In a study by Mokhachane et al, a pertinent observation by a student in the South African context, sums up this idea of conformity very aptly as ‘I think there’s that generational gap, there’s that expectation from the generation that was trained twenty years ago, [that] a medical doctor should come out like this. Should come out wearing a white coat, with a haircut, combed hair every day, and a tie’ (Mokhachane et al., 2023).

The educators' emphasis on professionalism may stem from their own rigid training experiences, which often involved intimidation and strict adherence to traditional Western ideals of medical attire. Many educators either received little guidance on professionalism during their training or interpreted it personally, leading to potentially outdated and misaligned expectations for students. Without student input, it can be assumed that these strict norms may not resonate with current realities, causing confusion about their significance in promoting respectful and appropriate attire for patient care. Emerging evidence suggests a need to reassess historical approaches to medical attire within the context of contemporary sociocultural environments, as these practices may not adequately reflect the current understanding of professionalism in clinical settings (Mokhachane., 2023; Ruzycki., 2022). This emphasizes that professionalism encompasses much more than mere outward appearance, highlighting its complex and nuanced nature. It acknowledges that educators may lack a full understanding of professionalism due to their own training experiences, which may not have adequately conveyed the necessary knowledge within a South African context. This gap in understanding can lead to unconscious incompetence among educators, depriving them of the agency needed to effectively teach professionalism (Boughey &McKenna., 2021). The shared literacy among faculty members is influenced by the university's ethos and culture, suggesting that a deeper comprehension of the

knowledge base is essential for educators to foster professionalism in students (Birden., 2013; Mnguni., 2023; Stern., 2003).

The data indicates that educators struggle to articulate a clear understanding of professionalism, often due to their limited access to the esoteric knowledge necessary for the role of clinician educator. As a result, the concept of professionalism becomes ambiguous and is subject to personal interpretation. Many educators may focus on more easily defined aspects, such as dress code and time management, rather than the core principles of professionalism, which include integrity, truthfulness, commitment to learning, self-awareness, and altruism. Additionally, key roles such as leader, health advocate, collaborator, communicator, and scholar are underrepresented in discussions about professionalism. This gap may stem from educators' own historical experiences and limited exposure to developing a nuanced understanding of professionalism. The existing AfriMed framework is seen as too broad and vague for newcomers in education to effectively apply in a classroom setting. The implications of these issues for students will be explored further in subsequent discussions.

In summary, there is agreement that it is complex, and there is evidence that this construct is greatly esoteric in nature and currently highly insulated; there is agreement that not enough is known by educators and there is evidence that the specialised language and nuanced meanings are not adequately made apparent to the educators, additionally, central to the consciousness of the educators is the common/crude knowledge acquired through their individual lived experiences, and interconnection with the world around them. Educators carry great influence in transmitting institutional epistemological norms but if they themselves are knowledge blind, then the students access to disciplinary coding is compromised, to say the least. (Boughey &McKenna., 2021).

This field of knowledge production is lacking a concerted South African voice. As an example of the kind of agency required here, in 2016 Abdel-Razig et al issued an initial consensus framework of professionalism for an Arab Nation that reads, ‘[There] was considerable overlap with accepted Western definitions, along with important differences in 3 aspects: (1) the primacy of social justice and societal rights; (2) the role of the physician's personal faith and spirituality in guiding professional practices; and (3) societal expectations for professional attributes of

physicians that extend beyond the practice of medicine.' (Abdel-Razig., 2016, p165) South Africa itself has an inherent rich and diverse sociocultural voice that should not be ignored.

Professionalism is the process by which medical professionals make sense of the world around them, and it is the imperative obligation of contemporary medical education to help them develop appropriate literacies to be able to do so.

5.2 Theme 2: Pedagogic Practice

This theme addresses foundational elements of educational practice. Addressing the question of how it is taught and assessed within the SOHS. It refers to the approaches that educators employ to facilitate learning and support students' development. The most pertinent drawback highlighted in this study is represented by views such as '*we all obviously come as clinicians. I was a clinician with no formal background in health education'(P12)* supported by *'And it goes back to saying that we qualify as dentists and are you coming to an Academic Institutions, we're not really equipped with that sort of thing.'(P5)* Furthermore, the lack of appropriate capacitation for the role of educator resounds in the comments of *'there was no really like formal training'(P12)* and *'there wasn't any induction'.(P17)* Educators draw from *'self-capacitating basically.'* and *'I just read articles mainly'.(P13)*

It is essential that pedagogic practices are grounded in educational theories that inform how teaching and learning occurs, while considering student diversity in culture, knowledge, backgrounds and a consciousness of how students learn. Educational standards are not static and, therefore, requires a thoughtful approach to teaching and a commitment to ongoing personal development that ensures that teaching remains relevant and effective (Goddard et al., 2023)

Educators undoubtedly approach their educational practices from an inherent and unique value system. In Dental education, not many educators are trained for teaching but are clinicians involved in teaching, learning the art of teaching '*on the job'*, (P10) or '*getting advice from other colleagues*', or '*through watching what others are doing'* and '*I was taught by the other sessional doctors who were here.'(P13)*Furthermore, not all educators share the same commitment or motivation in their approach to teaching as echoed in the sentiment, *'There are certain sections that are supportive, actually understand the role of being a teacher. And there are sections that, for whatever reason, I don't want to say- but couldn't be bothered*?'(P15)

Education does need, at minimum, a consensus in practice for students to value the teaching, and for '*professionalism to work and be applied consistently- Those who are role models -who Our students look up to have to practice and behave in a professional way.'(P9)*

To expand on the discussion from the previous theme, the official discourse has great influence on the development of curriculum, while curriculum practices vary in outcomes, the influence from the macrolevels can substantially influence the recommended and written curriculum, and then inevitably the taught curriculum. The structuring of knowledge at the levels of official discourse significantly embeds or recreates the power struggles from the official field of recontextualization thus shaping the consciousness of teachers and then by extension, students. (Singh., 2002; Wheelahan., 2005) Macro-structuring of knowledge, on the other hand, if very specifically iterated, can support comprehension at micro levels. If the generally accepted assumption is that the educational process is to develop the students scientific disciplinary knowledge by shifting consciousness from common knowledge to esoteric knowledge there is then a disjuncture here in that this process is thought of as being exclusively unidirectional-meaning students are taken from common sense knowledge to specialised knowledge, yet the reality is that for this socialisation to work there needs to be bidirectional influence so that students use what they already know to create meaning. (Boughey & McKenna., 2021) This requires an acknowledgment from institutions and educators alike, of the inclusivity of co-opting both ways of thinking in the educational process. In this study possible distortions of interpretations could well be influenced by the disillusion that staff have in school leadership coupled with inefficient capacitation and educator training for the education space. The inconsistent focus on the topic of professionalism as highlighted on numerous occasions are the products of both aforementioned concerns. Consistency and comprehensive understanding of professionalism has been highlighted as essential in the teaching of medical professionals as does an environment 'conducive to the ongoing development of explicit and appropriate professional behaviours in its medical students, faculty, and staff …' that can only be supported by providing a concrete definition that is embodied in the curriculum and pedagogy (Morreale et al., 2023). It goes without saying that the influence of coding as mentioned in the previous theme significantly underscores the breadth and depth of decoding possible to educators, particularly if the educator themselves is still in their own socialisation process to the academic space and the intensive expectations of a sound pedagogue.

Bernstein rules of realisation or the way in which the student demonstrates or communicates their consciousness of a topic that most closely aligns to what others within the profession consider acceptable. If the educators are blind to this 'ideal' realisation then students will not only remain unschooled in it, but judgement of achievement is questionable at best, or unreliable and flawed, at worst, rendering false judgments of competency. As just alluded to without a clear conceptualisation, there is much lost in translation in the classroom pedagogue, including recognition of what entails legitimate acquisition of knowledge (Singh., 2002; Boughey & McKenna., 2021).

Pedagogic practices are the theories, methods and specific practices that educators use in the classroom to stimulate and achieve learning outcomes. Good pedagogic practices can accelerate development, provided that the educator themself is proficient in the course/subject content. For course requirements that are overarching and not specific to one discipline, such as professionalism, it is incumbent for all educators within the educational space to embody, reinforce and remain consistent in professional practice (Scheele., 2012; Ziljstra-Shaw et al., 2011.) The educator themself is bound to professional practice in their employment of sound educational theory, in developing elaborated code orientations, and in teaching explicitly articulated course content, values and behaviour. Educators, as such, have influence over the social identity and ways of viewing the world, of students. Educators, are themselves influenced through vertical discourse, constantly acquiring official pedagogic coding practices, as well as horizontally through shared discussion with fellow educators. They in turn draw on their coding orientations to recontextualise content for classroom practice (Chiang., 2022). While classroom content is legitimated by official discourse, the educator assessment practices may be less overt to students and other stakeholders, thereby creating space for uncertainty on what the measures are in assessment or what the explicit expectations are. Assessment itself is a science requiring as much planning and resources as the content is afforded, and educator training in this capacity is essential (Pearce et al., 2015). Evidence in this study is supported in its entirety by the abovementioned theory, the lack of vertical, horizontal discourse, the accompanying obscurity of what constitutes achievement of professional values and behaviours, the lack of formalised induction and educator capacitation for the role of an educator are all systemic voids within the school.

Of considerable consequence to the process of student development are the values of framing that occur at classroom level. Framing is not just about the student and teacher dynamic in the classroom, but also the space where existing boundaries regarding values and norms can be challenged or contested, as well as, where it can be defined. Educators influence here is of significance because they are able to transmit the university and disciplinary codes, as well as their own coding orientation and thus influence student identity. Not realising the power struggles inherent in the educational process and unmindful of contextual influences on students and the complexities of coding, educators may perpetuate the inherent social inequalities still prevalent in higher education in SA (Boughey & McKenna., 2021).

A strong regulative discourse supports student development because it promotes explication of educator assessment criteria thereby supporting students in developing rules of recognition and realisation or the ability to realise appropriate from inappropriate contextual responses (Morais., 1992)

As the data here has exhibited, educators in the study struggle due to a lack of well-defined conceptualisations and expectations regarding professionalism. The statement *'I think the standardized outline of what professionalism is [is necessary]- because also we all come from different viewpoints of what professionalism is. I think it's -what might not be professional to me as professional to someone else. So, I think we need a very descriptive, prescriptive outline of what it means, what it incorporates because it can be quite subjective.*'(P18) epitomises the essential concepts that coding practices have enormous influence on rules of recognition and realisation, if educators are using personalised coding orientations with students, and these code orientations are not aligned with curriculum outcomes then this paucity will be mirrored in the educational practices, and therefore translated to student practices. As will be discussed in a subsequent theme, students have often been 'blamed' as the problem. However, using Bernstein's rules of classification and framing inherent in pedagogical practice, the concern arising from the data set is the nonextant of both the classification and framing for professionalism-non extant because the curriculum structure is vague in defining specific content, learning outcomes or assessment criteria for professionalism or, if these are available, the educators have not had access or have not been adequately inducted into the program requirements and expectations (Singh, 2001b). Framing is dependent on the classification or

positioning and value that the topic is given within the curriculum structure and the explicit allocations of roles and responsibilities in this structure that comes from strong classification, of note here is the dearth of information as to who is or should be leading the teaching as illustrated for example by a statement such as '*So maybe as I said that professionalism- we can have a separate module maybe under [department X]… And then reinforced by everyone*.'(P1) If framing, as Bernstein proposes, affirms who has control in the classroom context, then, the students here have more control, and hence are able to debate a grade both for lack of clear criteria and because the educator role here has been ineffectual and unclear. The current framing, as described by an educator is '*I think that at the moment they've given us free reign. So, I think it depends on each individual teaching the student -what they're going to teach.'(P2)*

This lack of definitive curricular mapping of professionalism has as such affected both the 'what is being taught' and the 'how it is being taught' significantly. Coupled with the additional division here in the roles of full time and part time educators, part time educators are not included in discussions, and are of the view that they are less anchored in the theoretical underpinnings of students teaching and learning and thus less able to influence outcomes as much as they could. Ergo, agency is reduced for a number of essential educators active in the clinical teaching space, and the location of learning appears restricted to just one space within the teaching program, namely the clinical platform, and not all learning contexts (Jónsdóttir, 2022). Regulative discourse has not specifically addressed roles of all educators sufficiently to enable smoother orchestration of learning processes, and instructional discourses lacks a concerted informed educator voice on the topic. This has translated to a predominant passive realisation practice of students based on the allusive premise of 'how teachers think they need to do something and why. This aspect involves their own beliefs and values.' Rather than the preferred educational outcome of active realisation where the student development echoes 'what teachers actually do through teacher-pupil interactions.' Educators need to embrace the responsibility of how their attitudes, ideas and actions elementally impact student learning. Educator induction to the elaborated code of the discipline is instrumental in achieving active realisation (Chiang., 2022; Jónsdóttir, 2022). Mezzo levels of educational structuring are responsible for inculcating an ethic of care so that educators take responsibility and accountability for the classroom influences on student's identity, creating space for enactment of the inevitable struggle that students will go through as they grapple with the change in contextual coding, literacies and

expectations. Students need to be supported as they flex and stretch their newfound wings. This is not an instantaneous process but the result of patient and consistent development throughout the program (Bourne., 2008)

To sum up, a participant succinctly shared, as referring to this project *'I feel that this project can revitalise/reintroduce the 'practice' of professionalism'.* Educators themselves recognise that more needs to be done here.

5.3 Theme 3: Valuing the mundane in a South African context. / 'Legitimat[ing] common sense knowledge

The focus of this theme is the apparent shift in responsibility from educator to student. It dwells on the perception that reinforces negative generalisations about student attitude, behaviours and abilities as the reason for unsuccessful educational outcomes, while overlooking systemic issues within the institution and educators (Singh., 2000; Kwok., 2023).

Education as a widespread phenomenon cannot be understood solely as the result of individual effort. The primary challenge for contemporary mass higher education in countries like South Africa is to effectively address the needs of a more diverse student population than it was originally designed to serve (Boughey & McKenna., 2021).

Students seek higher education opportunities to be able to have a fighting chance to be part of the global platform that is now so much more accessible through means of computers, smart phones and the internet, thereby gaining 'access to societies conversation.' (Wheelahan.,2005; Boughey & McKenna., 2021). For South Africans there is still a great socio-economic discrepancy that cannot be ignored because access to knowledge is still a substantial means of 'contributing to the greater wellbeing of the societies in which we live.' Knowledge serves as a conduit, for young people of all backgrounds, to global communities. Indispensable to the knowledge currency conversation is an appreciation of the impact that socio-economic backgrounds have on the success of students in university environments. Evidence supports the view that disadvantaged economic backgrounds impact students' success in the academic environment. Students cannot be viewed as blank slates entering academic institutions to 'filled' with knowledge but rather as social beings with pertinent social influences from home, society and previous schooling. They have preconceived ways of viewing the world and inherent value structures independent of the

university environment. In parallel, the university itself is entrenched with historical norms, and value systems that are enacted daily in its distinctive social cultures. University practices are deeply ideological, and perhaps insufficiently disputed to be relevant to many students from diverse backgrounds, thus unconsciously reinforcing the unjust social inequalities. Antiquated meritocratic approaches may create bias against students because success and currency within the university environment is still highly dependent on grades (Boughey & McKenna., 2021; Wheelahan., 2005; Singh., 2002).

Profound appreciation of the transitions that students experience in their university journey is essential to educators if they are to become adept in navigating the intricacies of these transitions of students in a supportive and inclusive redress of the disparities that perpetuate inequalities. Essential to the discourse on students is an understanding of literacies versus language as mentioned earlier in this discussion. As espoused by Boughey and McKenna, literacy refers to the way in which individuals engage with language through reading, writing and interpretation. Much the same as Bernstein's contextually defined codes, literacy practices are dictated to by a context, students enter the university environment with literacies developed during their previous engagement with the world. 'People engage with certain kinds of texts in certain kinds of ways because they see value in doing so' aptly explains this theory, so for example in academia literacy practices includes questioning and challenging texts and evidence and then amending these views as new and additional evidence comes to light (Boughey & McKenna., 2021). This is often an unfamiliar literacy to students, particularly those with little to no exposure to the disciplinary practices or mentors and role models from the disciplinary field. As alluded to in the data here, much has been said about student selection and academic abilities as entrance requirements, however, this then limits entry to only students who have already developed some rules of recognition, who have had the privilege of exposure to a diversity of social context by virtue of higher socio-economic standings. The concept of students with talent can additionally be debunked here as a student entering a program never having had any contextual exposure remotely similar to that of the university versus a student of middle class privilege, nurtured with a value structure more closely aligned to university cultures and norms (via parents, siblings and social circles who have passed through university for generations) adopting the university literacy is a very different and sometimes alienating and intimidating experience. Prior

epistemological access and not talent is a greater indicator of success (Singh., 2000; Boughey & McKenna., 2021).

Attitude of educators here can support the discrepancy as views of student 'talent', as mentioned previously, motivation and commitment cannot be viewed separate to the students preceding context, and practices of inclusivity of only those perceived as 'able' and of the right fit, fundamentally marginalises everyone else-this begs the elemental question of how the university and academics/educators value the ways of 'being 'of its students ((Boughey & McKenna., 2021).

Before defaulting to student deficit as the basis of student disputes, tensions and inadequacies, educators need to reflect on their pedagogical practices, their ability to facilitate epistemological access, to decode the discipline to its simplest and most explicit form, recognizing how personalised and institutionalised values have bearing on the process, and remembering that as academics the rules of realisation have become so innate as to make one forget that specific step by step iterations are essential to the novice, and very much intimidated student (Boughey & McKenna., 2021; Singh., 2023). Educators need deep knowledge of the field to be able to explicate concepts, values, norms, and practices in a variety of ways to meet a diverse student population. Intrinsic to teaching is the realisation that acquiring new literacies impacts the sense of self, the student's identity, and that the educational space must be flexible to accommodate the enormous uncertainty associated with this transformation as they make sense of this newer way of doing and being while holding on to their inherent values. As educators, there is need for an evolved way of thinking about students, about personalised ways of 'thinking, doing and being' that is better oriented to the South African context. Educators must respect that horizontal discourses accompany students and therefore, attempt to entwine these in their pedagogic practices (Muller et al., 2006; Bourne., 2003).

5.4 Theme 4: Accidental consciousness.

This theme is defined as accidental because learning here occurs when insufficient attention is paid to the 'unspoken' messages of verbal, behavioural and normative practices prevalent in the educational spaces. It addresses the implicit messages that occur through interactions with peers and authority figures that contribute to what students deem acceptable behaviour regarding professionalism.

Formal terminology in education refers to this as the hidden curriculum which the process where 'Wittingly or unwittingly, norms and values transmitted to future physicians [that] often undermine the formal messages of the declared curriculum.' (Mahood., 2011). This author is of the view that 'professionalism can be confused with getting along with superiors, not rocking the boat, being subservient, or remaining 'flexible' Showing up on time, finishing the workload, and covering up minor mistakes often get more recognition than adhering to avowed professional values or patient-centred care. In the development of professionalism, these unspoken messages, particularly within a context where classification and framing have noticeable deficiencies as alluded to by the observations in this study as of lack of clear conceptualisation, allocation of roles and responsibilities of educators on the domain of affective development, leadership, support and consistency, the unspoken messages can easily mirror unchallenged colonial and Eurocentric influences thus shaping the values and assumptions made by educators (Ali et al., 2022). The coding process on professionalism highlighted an extreme emphasis on dress code and presentation, with formal attire and hairstyles referred to as needing to be '*very formal, very structured…rigid and strict' (P18),* a view that is challenged by contemporary students who prefer to show up as 'their authentic selves' (Mokhachane et al., 2024 p302).

Weak framing has the potential to perpetuate classroom divides and even strengthen the informal learning to take precedence over the formal learning that are 'experiences generated during formal learning, such as principles, emotions, attitudes, interests, values, and acquiring the will to learn.' (Rossouw et al., 2023) There is the view by some authors that 'the hidden curriculum has its origins in the inequalities and social norms that existed in the school environment' (Rossouw et al 2023). These are important considerations to make in relation to both the previous two themes relating to pedagogic practices and valuing students' individual socialisations as when combined with accidental consciousness has the potential to derail the intent and purpose of the written or documented curriculum. Students as inadvertent recipients of these hidden messages, develop coding practices that are inconsistent with the disciplinary code, disadvantaging them for future practice (Sebastian et al., 2022).

5.5 CONCLUSION

In summary, educators' limited familiarity with the established conceptualization of professionalism contributes to inconsistent and fragmented teaching and assessment practices.

The prevailing use of a restricted code further exacerbates this issue, creating barriers for students from diverse backgrounds and with varying levels of prior exposure to professionalism. Addressing these challenges is essential to foster a more inclusive, coherent, and effective approach to professional development in education**.** The pervasive influence of the hidden curriculum is further undermining the achievement of intended learning outcomes, as it often conveys implicit messages and values that conflict with formal instruction, thereby impeding students' holistic development and understanding.

CHAPTER SIX

6.1 CONCLUSION

In exploring educators' conceptualizations of professionalism at the SOHS, Wits, this study reflects a restricted code dynamic characterized by superficial interpretations of professionalism that rely heavily on implicit, shared assumptions and unspoken institutional values. While educators articulated explicit, procedural norms (e.g., dress codes or clinical protocols), there was limited engagement with the elaborated code of professionalism—a deeper, universalistic framework encompassing ethics, accountability, and societal responsibility as defined in academic literature. This has perpetuated ambiguity in teaching and assessing professionalism, as educators default to positional rather than person-oriented teaching methods. The resulting uncertainty mirrors Bernstein's observation that restricted codes, when dominant in hierarchical systems, reinforce rigid power structures and inhibit critical dialogue. Consequently, students internalize these fragmented norms, mirroring educators' impassivity—a cycle rooted in the lack of elaborated code practices that explicitly articulate and interrogate professionalism's socio-moral dimensions.

Clinical teachers shared mixed views on who must teach professionalism and when in the program it must be introduced, with no clear consensus on whose role it is to teach it or clear direction of their individual responsibilities in this regard- at this stage they recognise some responsibility in observing clinical behaviour of students but do not own the responsibility to teach it as a collective.

Professionalism is undoubtedly a complex yet essential concept in medical and dental education. The current practices, however, appear to support the view that unless explicitly defined in the curriculum, there is the potential to advance inequalities in education that are still ubiquitous in the SA context. Unless educators are explicitly informed about the unintended consequences of their practices, institutional values, and unconscious role modelling, they risk perpetuating a flawed narrative that blames students for poor learning outcomes, rather than addressing the systemic factors that truly influence academic success. Curricula for teaching professionalism need strong classification and flexible framing to support student development, there is a need for consensus on the interpretation of professionalism, supported by specific and achievable objectives and measurable learning outcomes. Furthermore, students should be able to express

themselves through discussion, debate and reflection exercises on their practice. Since professionalism is inadequately represented in the current dental curriculum, and not clearly interrogated in the recommended HPCSA framework for the SA context, it needs a concerted collaborative and distinct SA approach that benefits the SA healthcare professional of the 21st Century.

The data here supports the observation of inadequate use of rules of recognition and realisation, particularly due to a deficiency in educator capacitation in disciplinary coding practices. Those who believed they understood what professionalism is did not entirely reflect this in the way assessment was practiced. Much was shared about students needing to be carefully selected for this teaching program yet not much was known on whether professionalism characteristics are innate or can be taught. The evidence supports a constancy of pedagogic approach, and collaborative support structures for educators, yet the same educators fail to agree on basic expectations of who should teach, what to teach, how to teach and finally how to manage this. There is acknowledgement that it's important, yet no one wants to take responsibility for it. Essentially, the regulative discourse needs to strengthen the approach by determining content that is specific and focusses on the 'being and becoming' a dentist (encompassing values of ethical, professional practice) and the instructional discourse should be about agreed-upon teaching (content, skills etc) (Chiang et al., 2021).

6.2 RECOMMENDATIONS

6.2.1 Recommendations for practice

Expanding the discussions to create a framework for developing professionalism in dental education.

Implementation of a standardised approach for induction to educational practice specific for the dental clinical teaching space, with staff development high on the agenda in the educational program. Formal Training programs should be developed to standardise the approach to teaching professionalism that better aligns with the recognised definitions as outlined by the HPCSA guidelines.

6.2.2 Recommendations for future research

Exploring student perceptions on existing educational practices of developing professionalism.

Exploring how past educational and clinical practice and contexts influence educator approach to developing professionalism.

6.3 LIMITATIONS

6.3.1 Limited Scope of Educator Roles and Backgrounds

The study focused on educators' conceptualization of professionalism without examining the specific roles and backgrounds of educators, such as their capacities as lecturers, clinical teachers, or part-time/sessional educators. This omission may overlook how different educator backgrounds and roles could influence their practices, potentially limiting the study's ability to capture a comprehensive understanding of professionalism across diverse educator profiles.

6.3.2 Institutional Constraints

The study was conducted within a single school in one institution, which may limit the transferability of its findings to other educational settings. The results might not be generalizable across different institutions or contexts, potentially restricting the study's broader applicability and relevance. While this is noted as a limitation, the dental schools in SA operate with the approach as guided by the HPCSA - so the likelihood of some transferability of outcome expectation across the South African dental institutions is high.

Additionally, as mentioned previously, the researcher familiarity with participants may refel responses towards the social desirability of responses.

6.3.3 Participant Disclosure and Confidentiality Concerns

The study may be limited by participants' reluctance to provide candid critiques of the assessment system due to concerns about confidentiality and potential impacts on their professional reputation. This could lead to biased or incomplete feedback.

6.3.4 Self-Reported Data and Recall Bias

The study relies on educators' self-reported reasoning after they have assigned marks. This retrospective approach may be susceptible to recall bias, which could affect the accuracy of the

reported data. As a result, the findings may not fully capture the complexities of the marking process as it occurred in real-time.

6.3.5 Reliance on Reported Behaviour

The study's findings are based on reported behaviours rather than direct observations of the marking process. This reliance on self-reported data means that the results may not accurately reflect actual practices, potentially leading to discrepancies between perceived and actual behaviours.

6.3.6 Potential for Implicit Biases

The study did not explicitly investigate implicit biases (such as cultural, gender, or personality biases) that could influence how professionalism is perceived and graded. These biases may affect the consistency and fairness of grading, and their absence from the study's focus could limit the depth and accuracy of the findings regarding the assessment of professionalism.

CHAPTER SEVEN

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CHAPTER 8

APPENDICES

8.1 Appendix - Ethics Certificate

8.2 Appendix - Permission: Acting Head of School (SOHC) and Acting CEO (WOHC)

8.3 Appendix - Interview Guide

8.4 Appendix - Plagiarism Form

8.5 Codebook

8.6 Information Sheet & consent

8.7 Professionalism Descriptors

APPENDIX 8.1- ETHICS CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Kolia

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H23/01/10**
PROJECT TITLE	Perceptions of Oral Health Science Educators on developing skills for professional practice in Wits Oral Health Science students
INVESTIGATOR(S)	Dr S Kolia
SCHOOL/DEPARTMENT	School of Oral Health Sciences/
DATE CONSIDERED	27 January 2023
DECISION OF THE COMMITTEE	Approved Risk Level: Minimal
EXPIRY DATE	14 March 2026
DATE 15 March 2023	**CHAIRPERSON** (Professor J Watermeyer)

cc: Supervisor : Prof S Moch and Prof S Pattinson

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **A SIGNED COPY** returned to the Secretary electronically. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

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 be contemplated from the research procedure as approved I/we undertake to submit an amendment of the protocol to the Committee. **I/we agree to completion of a regular progress report. For Minimal and Low Risk studies, this is due annually on 31 December. For Medium and High Risk studies, this is due twice annually on 30 June and 31 December.**

_____ _____/_____/_____

Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX 8.2-PERMISSION HOS

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

School of Oral Health Science

Department of Oral Biological Sciences – Research, Unit 7 York Road, Parktown, 2193. Tel: 011 717 2045 Email: Julitha.Molepo@wits.ac.za

13 March 2023

Dr S. Kolia
General Dental Practice Department
Faculty of Health Sciences
University of the Witwatersrand
Johannesburg

RE: PERMISSION TO CONDUCT RESEARCH

Your request for permission to conduct a research has been provisionally approved by the Committee.

Final approval will be granted after submission of the following information and documents:

1. The ACEO should be informed as those educators are her employees, maybe on the letter addressed to AHOS should copy ACEO. Or a stand-alone letter
2. Replace "the Hospital Research Committee at Charlotte Maxeke Johannesburg Academic Hospital (CMJAH)" under Ethics with Acting CEO.
3. Ethics Clearance Certificate

Regards,

Jay Shackleton

Acting HOS – Prof J. Shackleton

Date: 14-03-2023.

Acting CEO – Dr M. Thekiso

Date: 14-03-2023

APPENDIX 8.3

Interview Guide

Perceptions of Oral Health Science Educators on developing skills for professional practice in Wits Oral Health Science students.

Demographic data sheet.

1. Are you a lecturer (involved in formal teaching, namely, lectures, tutorials, small group teaching) and/or clinical supervision of dental students?

2. How long have you been a lecturer and or clinical supervisor?

3. Have you received formal education on education in the health sciences?

4. Have you received an induction/short course to assist you in education from the School of Oral Health Sciences?

5. Do you, or have you worked at another dental academic institution?

6. Have you received an induction/short course to assist you in education from any other dental academic institution referred to in question 5 above?

7. Have you worked in private dental practice?

8. If yes, how long have you worked in private dental practice?

9. Have you worked in government clinics?

10. If yes, how long have you worked in government clinics?

Question prompts for semi structured part of the interview for the above-named study.

1. When we speak or refer to professionalism -what does the term mean to you?

2. What skills do you think dental professionals need to be independent practitioners?

3. Explain what you believe is your role in developing professionalism in students?

4. What recommendations do you have on how to teach and assess professionalism?

APPENDIX 8.4-Plagiarism Form

Turnitin Originality Report

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APPENDIX 8.5

Participant Information Sheet (PIS)

Dear Sir/Madam

My name is Shehnaaz Kolia. I am a master's student in Health Science Education at the University of the Witwatersrand, Johannesburg. My supervisors are Ms Shirra Moch & Dr Stuart Pattinson. I am conducting a research study about development and assessment of professionalism in dental students. The study title is Perceptions of Oral Health Science Educators on developing skills for professional practice in Wits Oral Health Science students.

I am inviting you to take part in an interview and answer demographic questions, both are needed for this research. In the demographic questions, I will ask for some personal information about you, including the nature of your role as an educator at the School of Oral Health Sciences, how long you have been involved in dental student teaching and training, the type of training that you received for this role, other educational experience and exposure, public and private practice experience. The demographic information will be used only for contextualising the research findings. No personal indicators of yourself will be used. You may choose not to answer any question posed in the interview.

If you decide to take part, your participation in this research study will last about 45 minutes to an hour. The interview will take place in a private room/office on campus once you have agreed. This can be done at a time convenient to yourself.

With your permission, I would like to audio record the interview. The recordings will be anonymized during transcription, and all data stored in a password protected cloud-based file. Transcriptions will be done by myself, and data analysis will be done on the anonymised transcriptions. This data will be stored for 5 years. Only I and two supervisors named below, will have access to the data.

When I share the results of the research study, I will not include your name or anything else that could identify you.

If you decide to take part in the research study, it should be because you want to volunteer. You do not have to take part. You can stop being in the study at any time. You do not have to answer any questions if you do not want to. You will not get any direct benefits if you choose to join the research study. You will not lose any services, benefits, or rights that you would normally have if you decided not to join. Taking part in the research study will not cost you anything. You will not be paid for being in this research study.

The risks for this research study are no more than what happens in everyday life.

This research study will be written up as a research report and for publication. The report will be available on the university library website. If you would like to receive a summary of this report, I will be happy to send it to you.

If you have any questions during or afterwards about this research study, feel free to contact me or my supervisor on the details listed below. If you have any concerns or complaints about the ethical procedures of this research study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za.

Yours sincerely,

Shehnaaz Kolia

Researcher:

Shehnaaz Kolia,

Shehnaaz.Kolia@wits.ac.za

0769919585

Supervisors:

Shirra Moch,

Shirra.Moch@wits.ac.za

Stuart Pattinson,

Stuart.Pattinson@wits.ac.za

APPENDIX 8.6-Professionalism Descriptors

Professionalism subcode Statistics- MAXQDA

	Visible	**Tacit**	**Behaviours**	**Attitude**	**Value**	**Skill**
			One's actions	**How one feels**	**Measure of Worth**	**Ability**
Conflict resolution		x				x
Self-assessment		x			x	x
Responsibility	x		x			
Accountability		x			x	
Interprofessional skill	x					x
Continual self-development		x		x	x	
working under pressure	x					x

Problem solving		x				
Record keeping	x					x
Initiative		x	x			
Example of a student						
Knowing limitations		x		x		
How we treat peers & auxiliary staff	x		x			
Discipline		x			x	
Ethics		x			x	
Complex concept						
being prepared	x		x			
Strive for excellence		x	x		x	
Flexibility		x	x			
Respect Diversity		x			x	
Reflection of each other in the profession						
Confidentiality -Ethics!					x	
Human touch	x		x			
Integrity		x			x	
Patient Care	x			x		
Empathy & consideration	x			x		
Conduct/Behaviour	x		x			
Communication	x					x
skill	x					
Knowledge		x				
Attitude		x		x		
Time Management	x		x			
Dress	x		x			
TOTAL						