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Research report

# Professionalism in healthcare professionals

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# Foreword

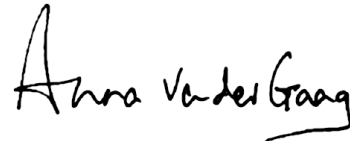
I am delighted to welcome this monograph as the fourth in a series on research relating to the professions registered with the HPC. It is part of our commitment to building the evidence base of regulation and being innovative in our approach. We will produce further publications over the coming years, each of which will explore different aspects of the regulatory and professional landscape.

We hope that over time these pieces of work will contribute not only to our own understanding of regulation in the health and social care sector, but also to a wider audience with an interest in this area.

More than a century ago, George Bernard Shaw famously observed that all professions were ‘a conspiracy against the laity’. Since that time, much has been written about the nature of professional practice and the contribution of professionals to society. In the health and social care arena today, patients, service users and their families want the professionals they interact with to offer specialist skills but also to treat them with respect, communicate clearly and behave in a way that reflects high standards of personal probity. The HPC standards reflect this requirement, and much of the work we do centres around upholding standards of conduct and behaviour as well as competence.

There is, however, very little published research on ‘professionalism’ in the professions we regulate, or any that explores the perceptions of students and educators in this way. This report is therefore an important contribution to increasing understanding of what professionalism means and how it might be promoted and enhanced amongst future generations of health and social care professions.

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**Anna van der Gaag**  
Chair

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# Executive summary

This study was commissioned by the Health Professions Council (HPC) as part of a wider research programme exploring aspects of professional practice. Many fitness to practise cases referred to professional regulators are linked to a broad range of behaviours, often distinct from technical ability, and generally termed 'professionalism'. Similar trends have been observed early in training for some healthcare professions. Identifying what professionalism means, and how lapses can be identified in practice, is also important to any future decisions about revalidation processes. Whilst the desirability of addressing and improving professionalism is relatively unchallenged in the literature, the concept of 'professionalism' is not well-defined, conceptually or methodologically.

The current study sought to increase understanding of professionalism within three HPC regulated professions (chiropodists / podiatrists, occupational therapists and paramedics), to explore what is perceived as professionalism by both students and educators, and why / how professionalism and lack of professionalism may be identified.

Four organisations delivering training programmes to the three professions were recruited. Two paramedic training organisations were included to reflect the different training routes in that profession.

Twenty focus groups, with a total of 112 participants, were conducted, addressing:

- interpretation of the term 'professionalism';
- sources of understanding of professionalism;
- indicators of being professional or unprofessional; and
- the point at which people are perceived to become 'a professional'.

Participants' interpretation of 'professionalism' encompassed many and varied aspects of behaviour, communication and appearance (including, but not limited to, uniform), as well as being perceived as a holistic concept encompassing all aspects of practice.

The data indicates that professionalism has a basis in individual characteristics and values, but is also largely defined by context. Its definition varies with a number of factors, including organisational support, the workplace, the expectations of others, and the specifics of each service user / patient encounter. Regulations provide basic guidance and signposting on what is appropriate and what is unacceptable, but act as a baseline for behaviour, more than a specification.

The personal characteristics underlying professionalism may develop early in life as well as through education and work experience, but role modelling is also important in developing the necessary awareness of appropriate action in different contexts.

Views of professionalism did not diverge widely, regardless of professional group, training route or status as student or educator. All saw the interaction of person and context, and the importance of situational judgement, as key to 'professional behaviour'.

Rather than a set of discrete skills, professionalism may be better regarded as a meta-skill, comprising situational awareness and contextual judgement, which allows individuals to draw on the communication, technical and practical skills appropriate for a given professional scenario. The true skill of professionalism may be not so much in knowing what to do, but when to do it. The role of the educator is to raise awareness of this.

Employers and regulators have an important role to play in supporting professionalism, and enabling it to flourish and develop. The relevance and role of professionalism needs to be presented positively and proactively.

Professionalism may be further developed through employer-led initiatives aimed at providing supportive environments in which professionals feel valued – this should be in the form of management support, and the recognition of other professions. Professions which are newly ‘professionalised’ may find it harder to gain this support and recognition than more established ones. The context-specific nature of professionalism means that further work in this area should address the development of professionalism as a dynamic judgement rather than a discrete skill set.

# 1 Introduction

'Professionalism' is under increasing scrutiny across the health and social care professions, with many of the issues that emerge later in people's careers being linked to a broad range of behaviours distinct from their technical ability. Fitness to practise cases heard by regulators such as the Health Professions Council (HPC) and the General Medical Council (GMC) often include components of inappropriate or unprofessional behaviour which would not be captured by competency testing. These behaviours are not trivial, including issues relating to substance abuse, theft or sexual assault against patients or service users. Identifying and addressing these issues is also a problem to be faced by possible revalidation processes. However, there is evidence from medical professionalism research that issues presenting in later careers may be associated with similar concerns in training. For example action against doctors by state medical boards in the United States was found to be predicted by factors such as disciplinary action in medical school<sup>1</sup> and a low supervisor rating of their professionalism during their residency year.<sup>2</sup>

This potential association has value if the identification of concerns early in training allows early remediation to be attempted, in the form of targeted training, or in extreme cases counselling away from that professional role:

"Attempts to identify... risk of subsequent professional misconduct should be encouraged because this offers the opportunity for support and remediation if possible, or if not, redirection of the student into a more suitable area of study. This is not just a matter of public protection; students deserve support and assistance and must have realistic career expectations."<sup>3, p.1041</sup>

However, while the desirability of addressing and improving professionalism is relatively unchallenged in the literature, the concept of 'professionalism' is not well-defined, conceptually or methodologically: "the word is full of nuance and as with words such as 'love' or 'quality', perhaps each of us is clear what we understand by the term, but we find it difficult to articulate."<sup>4, p.2</sup> This difficulty in articulation extends to the academic literature and to attempts to engage with professionalism as a theoretical construct.

Much of the recent literature around medical professionalism has focused on professionalism as a competency, or something which can be taught, developed, measured and assessed.<sup>5, 6, 7</sup> One recent review of this area<sup>8</sup> identified many measures and approaches, but found no clear consensus on validity. It outlined five 'clusters of professionalism' found in existing measures, which were:

- adherence to ethical practice;
- effective interactions with patients and service users;
- effective interactions with staff; and
- reliability, and commitment to improvement) which illustrate the behavioural focus of many of these approaches.

A study with paramedics,<sup>9</sup> one of the professional groups involved in this study, found a similar range of dimensions, from integrity through teamwork and careful delivery of service, to appearance and personal hygiene. The variation in the precise dimensions identified in the literature illustrates the semantic difficulties in labelling such broad constructs, but there is a common pattern of identifying attitudes and ideals, communication, and good practice.

Professional behaviours are seen to be the expression of professional attitudes – and significant work in medical professionalism literature in recent years has stressed the importance of assessing observable behaviours rather than attitudes,<sup>10</sup> with attention to the contextual framing of those behaviours.<sup>11</sup>

However, there is another level to professionalism, related more to professional identity than to behaviour: individuals' perception of themselves as professionals. Professional behaviour in this view may arise because it is a performative element of the identity, rather than because it is explicitly prescribed: "Identities are what we do."<sup>12, p44</sup> Professional identity may be reinforced by performance – doing what is expected of a professional can make people feel more professional.<sup>13</sup>

Professional identity may be related in part to the status accorded to the historical notion of 'a profession', as a role which has high social status and value, high entry requirements and a degree of social responsibility. This is referred to often in the medical professionalism literature. For example Swick's<sup>14</sup> 'normative definition' of professionalism stresses elements of professionalism which may be seen as 'virtuous' rather than grounded in practice.

Whether an occupational role is described as 'professional' may be in part determined by its legal status, such as whether it is subject to regulation: "A key marker of professional status is professional regulation".<sup>15, p536</sup> The current study includes three professions – chiropodists / podiatrists, occupational therapists and paramedics – which have very different histories.

While all have developed relatively recently compared with medicine or law, chiropody / podiatry and occupational therapy date back several decades, whereas paramedics have had a professional organisation since 2003 (the College of Occupational Therapy was

established in 1978 with precursor organisations dating back to 1932; the Society of Chiropodists and Podiatrists was established in 1945 from constituents dating back to 1912; in contrast the British Paramedic Association, latterly the College of Paramedics, was established in 2003). All three professions were regulated by the Council for Professions Supplementary to Medicine (CPSM) before the establishment of the HPC in 2003 – chiropodists / podiatrists and occupational therapists were regulated from the 1960s, paramedics from 2000. This is not surprising when considering that the term, 'paramedic', was not coined until the 1960s, and only associated exclusively with emergency medicine much later. It serves to illustrate the difficulty of applying structural definitions to modern professions.

### 1.1 The current study

The study reported here is a component of a project commissioned by the HPC, which explores professionalism in the healthcare professions. Study 1, reported here, investigated healthcare professionals' understanding of professionalism, while Study 2 is exploring ways to measure the breadth of the construct and its association with short-term career outcomes.

The stated aim of Study 1 was 'To explore student and educator perceptions of professionalism, and what constitutes professional and unprofessional behaviour', with four objectives:

- to explore what constitutes 'professionalism' in three health professions;
- to identify how professional identity and an understanding of professionalism develop;
- to clarify what is perceived as professional and unprofessional behaviour, and the role of context in that perception; and



- to identify indicators and analogues of professionalism which may inform quantitative data collection.

To answer these questions, research with three of the fifteen professional groups regulated by the HPC – chiropodists / podiatrists, occupational therapists and paramedics was carried out. These were identified as representing a range of the professional groups registered with the HPC. In 2009 – 10 these groups represented 29 per cent of registrants (7.3%, 6.2% and 15% respectively)<sup>16</sup>, and over 40 per cent (21.1%, 9.8% and 10.1%) of fitness to practise cases heard by the HPC.<sup>17</sup>

### 1.2 Participating organisations

Organisations were recruited to reflect the training routes for the different professions. While for chiropody / podiatry and occupational therapy this was more uniform, more care was taken in the selection of paramedic organisations, where more variation was anticipated.

Paramedics historically have had an in-service training route, and a degree-level qualification has only become an option in recent years. Different regions employ different training routes: some are all Higher Education (HE) (although with a range of diplomas, foundation degrees and honours degrees), while others use short, in-service training courses, often functioning as conversion courses for non-regulated technician staff.

Some examination of the different routes was desirable in this study, to reflect the different populations and different training experiences, and while limitations of time and resources meant that comprehensive coverage was not possible, two organisations were recruited. One ('University A') was a higher education institution delivering two routes to qualification: a three-year foundation degree, and a four-year sandwich honours degree. On both

programmes students spend time as staff with one of two ambulance trusts, but spend at least the first year (the first two years of the honours degree) in the University. The majority of students were school-leavers and few had worked in the ambulance service before.

The second organisation was an NHS Ambulance Trust ('Ambulance Trust B') which delivers a two year Foundation Degree entirely in-service. The degree is awarded by a local university, but most classroom teaching takes place in the Trust's education centre. All trainees must be employed by the Trust before admission to the Foundation Degree, and many are existing staff – technicians, emergency care support workers (ECSWs) or control staff – before entry.

Chiropody / podiatry and occupational therapy on the other hand have had long established HE qualification paths, and a degree is the only route to registration. One institution was therefore recruited for occupational therapists ('University C') and one for chiropodists / podiatrists ('College D'), reflecting the relative homogeneity in training across the country.

# 2 Method

## 2.1 Ethical approval

Once access to the organisations involved had been negotiated and meetings held with key personnel, the proposal and draft materials were reviewed by the Durham University School of Medicine and Health Ethics Committee. Once University ethical approval was obtained, it was necessary to follow NHS research governance processes, as some participants were NHS employees. A favourable ethical opinion for both studies was obtained from the Leeds (West) Research Ethics Committee in September 2010, and with this in place registration with the Research and Development Department of Ambulance Trust B was also obtained in advance of any data collection.

## 2.2 Participants

Participants were recruited from the trainee / student and trainer / lecturer populations in each organisation. Where possible, those responsible for trainees in practice were also invited to separate focus groups. While different organisations used different terms, for simplicity the terms 'student', 'classroom educator' and 'placement educator' will be used in this report to refer to these three groups. Students in first and final years were invited to take part, to capture the breadth of student experience.

Information sheets and letters (Appendices A, B and C) inviting potential participants to focus groups were distributed through the training organisations. Where appropriate a choice of dates was provided and in other cases a session was timetabled. Educators were also offered the opportunity to have a telephone interview instead, but in practice none were carried out. It was thought that telephone interviews would be appropriate for placement educators, but other than indicated in Table 1 it was not possible to obtain the necessary information in the timescale available.

Table 1 summarises the number of focus groups which were conducted in the different organisations. Altogether twenty focus groups were conducted, with a total of 112 participants.

**Table 1 – Number of focus groups carried out with each participant group**

Organisation	Students	Classroom educators	Placement educators
University A	5 (3 first year*, 2 final year)	1	0
Ambulance Trust B	4 (final year)	1	0
University C	1 (final year)	1	3
College D	3 (2 first year, 1 final year)	1	0

\*Two of these were conducted as interviews, as only one participant attended the session. The format was the same as for the focus groups.

### 2.3 Focus group format

All focus groups followed the same format. Participants were given the information sheet to re-read, and a consent form (included in Appendix D) on which they were asked to agree to the audio recording and transcription of the group discussion, and to the use of anonymised quotes in reports and publications. No participants declined to give consent, or raised any concerns about the recording.

The first part of the session involved the participants individually considering four questions (see Table 2), derived from the research questions stated in the introduction. These were printed on sheets on the table, and on flip-chart paper on the walls. (Questions 3a and 3b were presented together, so as not to bias participants towards positive or negative responses).

**Table 2 – Focus group questions provided as prompts – X was replaced with the professional group in question.**

1: In relation to the profession of X what does the term ‘professionalism’ mean to you?
2: In relation to the profession of X where does your understanding of ‘professionalism’ come from?
3a: In relation to the profession of X what would make you think someone was being ‘unprofessional’?
3b: In relation to the profession of X what would make you think someone was being ‘professional’?
4 (students): Do you feel like a professional X now?
4 (educators): When does someone become a professional X?

Participants were asked to write down their individual responses to each of the questions on Post-it notes. These were then collected by the group facilitator(s) and put on the flipchart paper under each question. The facilitator then summarised any key points on the flipcharts. Post-its were retained at the end of the session and transcribed. The intention of this stage was to ensure that all participants had the opportunity to respond to all questions, without being influenced by the specific group dynamics or the direction the discussion may take.

Each of the questions was then discussed. Standardised prompts were used to develop the discussion if needed, and to move the discussion on. In some cases the discussion organically developed to address the different questions, and the questions were not necessarily addressed in the order they were presented. The Post-it responses were also referred to, to ensure any novel or ambiguous points were developed in discussion.

Groups took between 50 and 110 minutes – the duration varying with the amount of discussion generated, and the time available.

### 2.4 Analysis

All recordings were transcribed verbatim, and coded using NVivo qualitative data analysis software<sup>18</sup> to aid the data analysis.

A ‘framework’ approach to analysis was adopted.<sup>19</sup> This involved an initial familiarisation with the data by repeatedly reading the transcripts to identify the main themes in relation to the research questions. Responses generated on Post-it notes were also used in this stage of the analysis.

The second stage involved the discussion of these codes between the researchers to agree the framework to be used.

Considerable consistency was found between professional groups, and between students and educators, and so the framework was developed to be applicable to all transcripts. A single transcript was coded jointly to

establish the usability and relevance of the framework. All transcripts were then coded using this framework. The codes used are given in Table 3, with definitions provided in Appendix E.

**Table 3. Codes and sub-codes used in framework analysis**

Code	Sub-code
Definition of professionalism	Adherence to codes / regulations / protocols Appearance Appropriate behaviour / attitudes / communication Context Development over time External perceptions Good clinical care Holistic construct Ongoing development (keeping up to date) Other definition Part of self Role boundaries
Source of professionalism	Education / training Learning on the job Media Organisational environment Other source Personal background Previous employment (paid / voluntary) Regulations as source Role models
Examples of professional, unprofessional and ambiguous behaviour (separate top-level codes for each)	Appearance Clinical practice Communication Conscientiousness Other example

## 2 Method

The next stage of analysis was the identification of the emergent themes from the coded data – that is, synthesising the responses to provide the most explanation and elaboration in response to the research questions. This analysis was again agreed in discussion between the researchers analysing the data, and reviewed during the drafting and revision of the results section, with constant comparison to the data to ensure the results accurately reflected the meaning found in the data.

# 3 Results

The analysis identified a great deal of variability in people’s understanding and interpretation of ‘professionalism’. While some participants were able to provide straightforward responses to the question ‘What does professionalism mean to you?’, there was no overall consistency in the specifics of their definitions, reinforcing the findings from the literature that it is a complex and problematic concept. However, despite this variability, the data does provide some insight into the dimensions or parameters of professionalism.

A dominant theme was that professionalism is a highly contextual concept, and what is classed as ‘professional’ will vary with a number of contextual factors, including the organisation, the workplace, and the specifics of each clinical encounter. This contextual variability was coupled with a sense that professionalism is based on well-established, or even innate, personal qualities and values. This creates a dynamic tension for developing and assessing professionalism, as it is both an extremely personal, internalised belief, while being very much situated in the immediate environment.

Views of professionalism came from a wide variety of sources – from upbringing, through experience in education and work before joining the profession, to explicit teaching within their training (including codified rules and regulations), and role modelling from colleagues. Table 4 illustrates some of the specific sources mentioned. The interaction of these different sources may in part explain the complex picture of professionalism that has emerged from this study.

**Table 4 – Examples of sources and experiences informing people’s professionalism**

Personal experiences around time keeping (eg missing flights when travelling, school)
Personal experience at work (time keeping, working to appointments in community care)
Observing other professionals in another work context (before starting training)
Experience of interacting with patients
Experience of meetings and being part of a team
Documentation such as a student handbook and policies such as manual handling policies
Role models in placements, or tutors in classroom
Peers
Models encountered in the media

The following sections describe different definitions, and ways of approaching the concept or construct of professionalism identified by participants. These include viewing it as an holistic construct, as an expression of self, as a set of attitudes and behaviours, including appearance, and as a fluid, contextually defined concept. Quotes from focus group participants are included to expand and illustrate the points made. In parallel, the boxes distributed through these pages illustrate how these views were expressed as discrete examples of behaviour – including ‘good’ examples of professional behaviour, examples of unprofessional behaviour, and examples of behaviour which was ambiguous, or explicitly identified as contextually dependent.

More examples of raw data from the focus groups, illustrating how the themes were presented in the discussions, are included in Appendix F.

While there were no substantial differences in the views of the different professions when considered thematically, some differences related to specific professional contexts were identified. These are summarised in Section 3.6.

### 3.1 Ways of understanding professionalism

The data highlighted that there was no single definition of professionalism; rather it is a concept that can mean different things to different people, in different contexts. This complexity was linked to the diversity of the sources and influences which lead to individuals' perceptions of professionalism.

#### 3.1.1 Professionalism as an holistic construct

Several definitions did not break down the construct of professionalism into components, but presented it as an holistic, all-encompassing concept ('everything you do'), an overall way of being which comprises a range of attitudes and behaviours.

"It's everything really, it's the way from the minute you get to the station to the minute you get home, it's the conduct of work."  
(FG1, paramedic student)

Some definitions were similarly holistic, but more explicitly focused on the clinical or technical elements of practice, with performance of the clinical role being the main definition of professionalism.

"It comes down to basically doing the job correctly, that and intermingling it with your patient contact and not being a robot and just reading everything out of a book."  
(FG3, paramedic student)

Several respondents defined professionalism reflexively, by thinking of it as the standard of treatment they would want for themselves or a family member. This could be a way of expressing an holistic view of professionalism, and also a 'benchmark' for their own behaviour.

"I think we're in a caring profession, a caring role, so you're treating people how you want to be treated and earn the respect of people and being quite intent when listening to their kind of worries." (FG13, occupational therapy placement educator)

#### 3.1.2 Professionalism as good clinical care

Good patient care was, in this sense, the essence of the job and therefore how professionalism was interpreted. Specific attitudes and behaviours were identified which constitute this competence: the knowledge, skills and ability to do the job, following procedures and protocols, putting the patient's interests first, and maintaining standards of care at all times. Good practice was linked to an awareness of limitations, of knowledge and skills, and acting appropriately.

"There's no shame in actually admitting at times that you don't know everything but you will go and look something up or you will consult with another colleague, and then by the next time they come in for a consultation you'll have an answer for them." (FG15, chiropody / podiatry student)

"I think it's about insight as well...it's about having the skills and choosing the appropriate level or the appropriate skill at the right time so that you're not over the top, but additionally you're not taking any risks with doing something incorrectly."  
(FG6, occupational therapy classroom educator)

### **Box 1: Demonstrating clinical judgement and competence**

Professional behaviours: "I think it is important because if you are not auditing the right information or like drawing out the right information from assessments, that's important to share, that wouldn't be very professional would it, if you weren't sharing the right information?"

(FG19, occupational therapy student)

Unprofessional behaviours: "...I followed him [podiatrist] on visits in and out of houses, it was get in, get out, finish as early as I can, not checking if the patient's medication had changed or anything like that down to really poor infection control with instruments... the whole time I was there he never changed his instruments, apart from the actual blade itself, he never changed his blade handles, he used the same scissors for every patient."

(FG15, chiropody / podiatry student)

Ambiguous: "You can be over meticulous and you can be, not over professional but over kind of thorough and a lot of people like that they can spend two hours on a scene and I think there's again, there's got to be a point where you've got to say we are actually just here to treat what we've seen and take to hospital or leave at home but some people do spend a lot of time on scenes..." (FG9, paramedic student)

This awareness and insight was related to the motivation to keep up-to-date with developments in good practice, to ensure good patient care and to engender trust and confidence in the patient. Both students and educators highlighted reflection on practice as key to professional practice.

"I think it's very important that we all keep ourselves updated... so that the information that we are giving our patients is up-to-date, it is most current, so that if they do go back and look on the internet, they will think 'oh, hang on, yeah, I remember him saying something about that' and it gives them the confidence to come back to us."

(FG15, chiropody / podiatry student)

### **3.1.3 Professionalism as an expression of self**

Many behavioural and attitudinal descriptions of professionalism, such as those reflecting empathy and caring, framed it as an expression of fundamental, inherent qualities on the part of the professional. When talking about this personal level of construct, with professionalism as a 'part of the self', there were many references to people's own moral and ethical codes, their 'core beliefs' (such as a belief in helping people) or their 'standards' (such as standards of 'decent behaviour' and how people treat each other), underpinning practice. In this way professionalism was seen by both educators and students as 'intrinsic', referring to qualities which may be innate or at least pre-existing, exemplified by statements such as 'you have it or you don't' and 'you should just know'.

"To me, people's values underpin everything they do as a professional... and so, from my point of view, professionalism has come from before I even entered the profession... it's not about the job you do or anything like that, it's about what is decent behaviour to another person."

(FG18, paramedic classroom educator)

"I think you have a core belief as well, it's your core standards of what you think is acceptable and not acceptable." (FG13, occupational therapy placement educator)



“When I said intrinsic I meant I just thought that you should know what a professional should be, you should know how a professional should act because it’s a term that’s just like, you should know... how to be a professional. If you don’t, you’re not.” (FG9, paramedic student)

A similar idea presented by some educators was that professionalism is ‘a way of life’, implying that it is external to work. One felt that it involves an alignment between the self and the expectations of the profession. In this sense, rather than being inherent or pre-existing, professionalism becomes part of the professional.

“Even when I [...] did an apprenticeship, I had the same values as I do have now really, you know, I don’t ever change.” (FG18, paramedic classroom educator)

“It’s about an alignment of who you are with the expectations that are placed on you... and it’s become a part of who they are and therefore it’s represented in every aspect of their own life.” (FG6, occupational therapy classroom educator)

This was identified in the potential for students to express their professionalism by their attitudes and behaviour outside work as well as within. Some students were seen by educators as professional in their whole approach to life because of their values, whilst some others were seen to display a distinction between work and personal life. There was a tacit, and sometimes explicit, assumption that professionalism should be maintained at all times, even away from the workplace.

“I think there’s a level of communication and of respect for other people that comes out in their whole lives and I find it really hard with the people who turn it on at work and turn it off at home.” (FG18, paramedic classroom educator)

#### **Box 2: Outside Work**

Unprofessional behaviours: “When I was at university Facebook was sort of flagged up as a big no-no when we were on placements, we were told we weren’t allowed to even mention we’re on placement... there had been some incidents in the past where people had sort of mentioned educators or said or complained about what a horrible time they were having and it just obviously the message that gives for the people it comes across as very unprofessional...” (FG13, occupational therapy placement educators)

Ambiguous behaviours : “If you bump into one of your patients... I think that might be different if you bump into a patient, you’d have to say ‘oh hello’ and you would have to try and look sober and but apart from that, you don’t think about your job when you are out and about do you.” (FG15, chiropody / podiatry students)

Participants spoke of either a merging / blurring or a distancing between their professional and personal selves – how far professionalism should or did extend into their personal life and the implications for behaviour outside work, including on social networking websites. This relates to the perceived importance of external views of the health service and of individuals working within it, and awareness of the public health role, as attributes of professionalism. There were mixed views about the separation between work and private life, and the professional and private self, and how far people considered themselves to be defined by their job. Some recognised that they needed to be able to separate work from their personal lives for their own wellbeing, to ‘let their hair down’.

“That’s one of the big problems I have with it, I want to do the job, I’m really happy about doing the job but I don’t want it to cross into every single part of my personal life, I don’t define myself as a paramedic, I define myself as a person that does that job... and I don’t want my whole life to be defined by that, I think it’s really hard, that’s a massive problem because it does reach out into your personal life so much.”  
(FG11, paramedic student)

“It kind of goes with you all the time doesn’t it, like I don’t think it’s something that I can switch on and off, I don’t think that anything I do or put on Facebook could ever be considered totally separate from what I am and who I am as a professional because it’s part of who I am.”  
(FG19, occupational therapy student)

The view of professionalism as being an aspect of the individual, rather than something which is gained in the professional role, was linked to feelings that the image of professionalism was gained early in life, with people mentioning their culture, upbringing, parents and grandparents, and the values and definitions of acceptable behaviour they were brought up with (eg politeness, manners and respect). However, participants’ views were also influenced by experiences and role models encountered during training and practice.

#### 3.1.4 Attitudes and behaviours

##### Box 3: Attitudes

Unprofessional behaviours: “If people are turning up late for work what are they going to be like going on a home visit or seeing someone in their home that it’s not conveying a good image to other people going to meetings and case conferences, it needs to be on time” (FG13, occupational therapy placement educator)

Many specific elements of professionalism were described as reflecting attitudes – good and bad. ‘Attitudes’ were discussed in terms of attitude to study (such as willingness to learn and to question), attitude to the job, attitude towards colleagues (such as displaying respect), as well as attitude towards patients or service users themselves. A professional attitude to the job included ensuring being fit for work (eg not being hung-over, ensuring that you get enough sleep during the day when on night shift). Educators identified attitude as important in relation to students’ relationships with patients, and enthusiasm for their work.

“[The] attitude of my personal presentation before I get to work, attitude towards my work once I’m there, and attitude towards my patients, again for me it’s attitude more than anything else.”  
(FG2, paramedic student)

“I think it is something about people that are willing, and I think it is about having this caring about how you are perceived to be behaving to people around you, and having that little bit of pride and... genuinely thinking I want to join in with the rest of the group, I want to participate in this, and then when you get out into professional practice you think, oh yeah, I do want to do this, I want to engage with my patients, I want to do the best I can.”  
(FG18, paramedic classroom educator)

Communication was a common area in which attitudes – to the job and to patients and service users – could be expressed. Politeness, being trustworthy and honest, acting calmly and confidently, being personable, and treating patients as individuals were all seen as reflecting underlying attitudes. These behaviours could affect how relationships were established with patients, how patients responded and ultimately patient care.

“If you get it wrong you’re unlikely to get a full history from them which means that the hospital don’t have all the information or you’ve got egg on your face when you turn up at the hospital and the patient then reveals the rest of their history to the nurse.” (FG11, paramedic student)

#### **Box 4: Written Communication**

Professional behaviours: “...you have to write your notes so that anyone can understand them but even the patient because the patient is allowed access to the notes....” (FG19, occupational therapy student)

Unprofessional behaviours: “It [written communication] needs to be polite and respectful and appropriate [...] I get the students that email me, all in small letters and it’s got like kisses at the end and things like that, to me that’s really unprofessional...” (FG18, paramedic classroom educator)

Verbal, non-verbal and written communication were linked to building relationships with patients, and to good patient care. Poor communication and attitude could be displayed through gestures, shrugging, crossing arms and hands in pockets. Professionalism meant being ‘a good communicator’, listening and being receptive to patients, displaying sensitivity, and an appropriate use of medical terms. It meant sharing information and health messages in a manner appropriate to the individual, for example checking understanding and how much the patient wants to know, as well as being polite and not condescending, and maintaining confidentiality.

“The way that you speak to people and the gestures that we use, we’re not kind of rushing people in and rushing people out again.” (FG15, chiropody / podiatry student)

“Using medical terms in front of somebody and they are just... looking at you like ‘What are you talking about?’. Yeah, appropriate use of language in front of patients.” (FG2, paramedic student)

Professionalism was also discussed in regard to communication with colleagues, for example building positive relationships, showing respect and not being rude, and helping, instructing and explaining to others as appropriate. Poor colleague relationships were also seen as a factor in patients’ perceptions of the team, and good relationships were seen to impact positively on good patient care.

#### **Box 5: Treating people equally**

Professional behaviour: “But it is quite hard when you’ve done a job where you’ve had a real abusive [patient] and then you go to your next job and it’s the same and you go and you get the same again, it doesn’t happen all the time but it does happen where you’ve been Saturday night, Friday night, whatever, you’ve had a load of abuse and then you go to the next one and because you’ve had it 20 minutes, you go in with a professional [attitude] but then everybody does it, you do get a bit agitated.” (FG3, paramedic student)

Professional behaviours: “...you’ve got to treat everyone equally, I mean say even if you go to someone who has just murdered someone else, you’ve still just got to treat them just as a person and don’t worry about any of the other things in their life.” (FG10, paramedic student)

“Well you know my team leader, he always asks your opinion of everything and he always appreciates anything you do for him, anything. He always thanks you for it and he always values your opinion and if he thinks your idea is better than his he’ll use your idea.” (FG4, paramedic student)

“I think most people in our [team] enjoy working with each other... I think that's probably when we get the best patient care.” (FG11, paramedic student)

Another expression of professional attitudes was in relation to treating patients equally and without prejudice in terms of politeness, equality, dignity and respect (including for other cultures and religions, and for gender issues during treatment). This could also include not becoming jaded within a shift, and treating the last patient the same as the first. Within this, there were some references to not displaying prejudice, and hiding feelings, suggesting that the appearance of professionalism, what it looks like to others, and the reputation of the profession, were a consideration. Patience and understanding were important (for example, with inappropriate 999 calls), as well as appearing knowledgeable and displaying confidence.

“It's keeping away from stereotypes and types of patients and types of people... no bias or prejudice there, you know, every person is new each time round.” (FG2, paramedic student)

“Making sure you are treating people with respect, treating people as people, not thinking of them as patients but as individuals with their own set of priorities and needs.” (FG19, occupational therapy student)

### 3.1.5 Appearance

Appearance (including cleanliness, hygiene and neat hair as well as uniform and suitable clothing) was considered important for public perception of the profession. For example, it could impact on a patient's or service user's first impressions of the individual and the profession, and on patient or service user confidence in the individual and the standard of care they will receive. Students were given guidelines about appearance and presentation.

It is interesting that while the three professions' use of uniform varied, all identified appearance and presentation as an important element of professionalism. There were also a small number of references to appropriate dress extending beyond work, highlighting their awareness of public perception of the role and the need to distinguish between the personal and the professional.

“You can be as skilled as anything, but if you're walking into somebody's house looking like a right tramp it just doesn't look professional.” (FG2, paramedic student)

“I think that gives the patient confidence. If you come along looking a bit grubby and a bit scruffy they're going to worry about how clean your instruments are... and if you don't have a standard in your own appearance then what's your standard of treatment going to be?” (FG16, chiropody / podiatry student)

“It's not just uniform, it's your vehicle, your equipment and everything else that you have to look after, it's all part of your professionalism isn't it?” (FG5, paramedic, classroom educator)

For some, uniform was regarded as playing a part in feeling like a professional, in giving a sense of identity, and in representing the profession. In the latter sense, care of uniform and behaviour whilst in uniform were therefore particularly important. Uniform provides a marker to separate the professional and the personal.

#### **Box 6: Uniform**

Professional behaviours: “I wouldn’t dream of now going into the NHS and turning up in a pair of jeans and a t-shirt and treat somebody, it’s just not something you would think of, even if I was stuck out in the wilds in the middle of nowhere, I would still turn up in a uniform because I would want people to see me as a professional.” (FG15, chiropody / podiatry student)

“... uniform has to be clean, pressed, you know, hair tied back, no big chunky jewellery.” (FG15, chiropody / podiatry student)

Unprofessional behaviours: “We have this uniform now which we’ve had for two or three years, [there are] people on the road with the uniform they [have] had [for] five years, totally different... I blame the management for letting that person wear the uniform, that’s an old uniform.” (FG3, paramedic student)

“For me it really helps because I’m quite a shy person, I always kind of see it as a mask if you’ve got this uniform on, it’s sort of creating this invisible barrier where I’m sort of taking my personal self, obviously elements of that, into my professional self, but kind of, you know, any kind of worries I have of what’s happening in my personal life you kind of keep that inside, then I’ve got my uniform projecting a professional image and sometimes that helped.” (FG13, occupational therapy placement educator)

“You felt more professional when you were wearing a uniform... I’ll put this on and this is who I am, kind of feeling. Whereas when you come to work in your own clothes you don’t have that.” (FG13, occupational therapy placement educator)

For occupational therapists, who in many cases do not wear uniform, the use of clothing to present a different professional image in different situations, with colleagues and clients, illustrates a similar importance placed on appearance. For example, there was awareness of sensitivity regarding client confidentiality and privacy, whereby being seen with an occupational therapist in uniform in the community or home would draw attention to the client and was also potentially intimidating. However, for a client attending multi-professional meetings, uniform can help service users identify different roles.

“It links in with confidentiality that you don’t want to necessarily advertise to the whole world that you are working with this person in the community, that maybe your ID badge etc is best in the work setting.” (FG13, occupational therapy placement educator)

“I think the patients [on the ward] quite like you to be in uniform because [...] they can identify you instantly as a member of staff.” (FG13, occupational therapy placement educator)

#### **Box 7: Public health messages**

Unprofessional behaviours: “Well I think grossly overweight don’t you? Paramedics especially. I think that’s extremely unprofessional because we are kind of promoting, well I think as self care professionals we are promoting healthy lifestyle and we turn up and they’re horrendously obese, you now, and the patient is just going to look at you and just go ‘oh what on earth is that?’.” (FG9, paramedic student)

There were elements of appearance related directly to practice. For example dressing smartly could also serve as behaviour to be role modelled for some occupational therapy clients. For chiropodists / podiatrists, there were pragmatic elements around dress – such as the wearing of appropriate footwear, to provide a consistent public health message and model good behaviour.

“We use it as well for social role modelling... there is this expectation between us as OTs in our service to really think about what we’re wearing, how we’re presenting ourselves, particularly because our client group [...] difficulties with personal care and so on and so forth, it’s about us... dressing in a good way for them to feel they can dress in a good way too.”

(FG13, occupational therapy placement educator)

“If you’re going to go into somebody’s house and say those shoes aren’t any good, with 15 inch heels on.”

(FG16 chiropody / podiatry student)

The wearing of uniform can help create a boundary defining appropriate distance between professional and client; however it can also create a barrier which may hinder care. One paramedic participant noted that the association of uniform with authority can have a negative connotation for some service users.

“I’ve never liked uniforms and I sort of see them as a bit of a boundary sometimes when you’re working with service users. I never want to look too smart because I want to be approachable... some expect you to dress a certain way and act a certain way whereas others would see that as quite an intimidating thing, so it’s that boundary.”

(FG13, occupational therapy placement educator)

Attitudes to uniform and appearance were partly influenced by individuals’ previous background (in particular a military background for some paramedics) and their personal standards. Pragmatics tended to be learned on the job as well as through college guidelines (eg leaning over patients in a low cut top; hair getting in the way). In all three professions, attitudes to appearance were also related to awareness of a public health role, to educate or model good behaviour to the public (with chiropodists / podiatrists the wearing of inappropriate footwear; with occupational therapists the social modelling described above, and with paramedics smoking while on duty, and being overweight to an extent that it hinders their work).

### 3.2 The role of regulations and codes of conduct

There are a number of sets of regulations, standards, protocols, codes of conduct and ethics, and trust policies providing parameters for safe and ethical practice. Some areas of professionalism are also framed by law – theft, substance misuse, racism may all be subject to criminal action as well as professional sanction – for this reason they did not form a significant part of the discussion. These sets of rules serve two functions as identified by participants – to provide a guide for the minimum standards of practice, and to provide sanctions when practice falls short.

Regulations acted as a baseline level of professionalism that would not be breached, but behaviour beyond that level was viewed as adaptable to the situation. Interestingly, the focus of educators was often on the role of regulations as examples to be followed, and of students on regulations as rules not to be breached.

“If [trainee paramedics] follow the code of conduct, then they should be professional all the time.”

(FG5, paramedic classroom educator)

### 3 Results

“It’s like meeting HPC standards isn’t it? You meet the standards but you would strive to it or excel, or at least you would argue that you should. You can meet the threshold, or you have to meet this particular standard, but I think were you to go over and above it demonstrates your professionalism.” (FG7, chiropody / podiatry classroom educator)

“You’ve got to cover your own back and that’s why really doing everything by the book, if you do everything by the book, then they [HPC] can’t get at you for going outside your scope of practice and it’s learning really to work within these limitations, to them [sic] standards.” (FG3, paramedic student)

Students in all professions had some explicit course content on professionalism. They were given relevant guidelines and handbooks, and had some teaching sessions on professionalism, although in some cases it seemed these focused on transgressions and their consequences in disciplinary terms.

“We’re trained to standards and protocols which we are duty bound to stick to, so consequently if we are dealing with a patient then we’ve got to remain within those parameters, and obviously to go out of those parameters would lead to disciplinary action, so really you’ve got to have a good understanding of where you stand.” (FG1, paramedic student)

The various guidelines did not appear to be presented in such a way as to address the personal and contextual elements of professionalism. However, individuals recognised that regulations and rules must be contextualised in practice to define professionalism. The innate, personal qualities which define professionalism were viewed as at least as important as the regulatory prescription of behaviour. The individual’s professionalism is, for these people, their own creation within the parameters of regulations.

“It’s being able to read between the lines of those documents [statutory or professional] and understanding how we should behave based on that, but it’s much more than those few rules there.” (FG6, occupational therapy classroom educator)

“It’s an inner drive really to be the best that you possibly can at something, and that kind of sums it up really, people who are actually motivated to actually be that way and for a reason, as opposed to just sticking to the guidelines.” (FG2, paramedic student)

The role of context in establishing the boundaries of professionalism, even where codified rules are clear, was identified by one participant as potentially problematic if those boundaries are adjudicated by other professions who may not be aware of the situated context of that profession. This was stated in relation to HPC disciplinary committees, but there may be other situations within trusts (for all professions) where the issue may be relevant.

“If you go to an HPC disciplinary committee there’s one paramedic on that and the rest of them are other professionals, so what we would define as professional in an ambulance service environment might be one thing, what other people who are not ambulance service might define as being professional might be totally different.” (FG2, paramedic student)

### 3.3 Professionalism as a fluid construct

Professionalism therefore was not seen as a static well-defined concept, but rather was felt to be constructed in specific interactions. Consequently, definitions of professionalism were fluid, changing dynamically with changing context. The following sections describe how this contextual influence was perceived, both in terms of the clinical, patient-centred context, and of the organisational and inter-professional context. The expectations of patients, and of other professions, were key influences.

#### 3.3.1 The influence of the patient-centred context

Participants felt that the important quality of professionalism when interacting with patients and clients, particularly in the area of communication, was the appropriateness of behaviour to the specific context, more than specific behaviours or attitudes. The context may vary in many ways: the physical environment (eg a hospital, a patient's home, a pub car park), the specific clinical demands of each case, and patients' personalities and expectations of a professional.

“What may or may not be appropriate will depend on circumstances and things that may occur in a community situation and a person's own home may not be what necessarily happens within a department within a hospital... intrinsically you are the same person but your behaviour may adapt according to the circumstances within these very thick boundaries.” (FG6, occupational therapy classroom educator)

An important aspect of professionalism therefore is situational judgement, meaning the ability to judge circumstances in order to identify the most appropriate way of acting / responding / communicating in a particular context, whilst still following a code of conduct.

#### Box 8: Communication in context

Ambiguous behaviours: “what I sort of struggled with is who makes that judgement because what's inappropriate for one person is not inappropriate to [...] I've been to a patient's house where someone has said to us I don't like being called that, I don't like being called darling and stuff like that. So is that inappropriate behaviour or might someone, you know not mind being called that and in their age group they might think that is totally appropriate... it's the patient that makes that decision for you.” (FG2, paramedic student)

“It is difficult for us and it's difficult for students because it can get confusing because we've got again a young client who works on black humour and you know jokes and some of that and it's hard for, because sometimes you do joke with people and if you step back from and listen to it it's not PC but it's how they're dealing with their injury...” (FG8, occupational therapy placement educators)

The ability to ‘read’ patients and clients as people, as well as clinical cases, was often described as important for assessing the appropriate register for communication, for example identifying how patients and service users would prefer to be addressed, in terms of the level of formality they would like, the appropriate vocabulary they would understand and respond to, and the appropriateness of using humour. More clinically it also related to gauging what information they needed, and wanted to know about their situation, and the best way in which to convey that information in a way they could understand.



“It’s a really big part of it... you go in, you look at the patient and you’ve got to judge how the patient is going to react to you being in their house within a couple of seconds and you need to make a good estimation of whether you can actually talk to that patient using sir or madam, whether you can use first names or Mr, Mrs, whatever, so you’ve got to be a really good character assessor, and it’s a big part of it because then, once you talk to the patient and you know how far you can go with them, or if you can crack a joke, get them smiling, laughing, more relaxed, which eases the patient.”  
(FG1, paramedic student)

For paramedics particularly, the need to read a situation in terms of potential physical danger was highlighted. A potential need for self defence – verbal or physical – was mentioned, which would in normal circumstances be unprofessional, but if threatened would be essential.

“If it came to it and you had to use some form of self-defence, that’s not dropping your professional standards, that’s self-defence and if a patient is swearing and being aggressive and abusive at you and you have to get them off the ambulance in case they cause some injury to you that’s not dropping your professional standards, that’s all about being professional with the levels that we’ve got... it doesn’t matter what’s wrong with them, if they are going to cause an injury to you or your crewmate the professional thing is to look after one another.” (FG1, paramedic student)

#### **Box 9: Gift Giving**

Ambiguous behaviours: “Yeah because it depends on the setting, like some you can do it where you accept it as a team gift, a gift to the team so then it’s not singling out anybody individually but it depends what it is as well to what the gift is and what rules are in different places.”  
(FG19, occupational therapy student)

“...there isn’t a notice up, there isn’t a clear sign in a department to say please don’t give these things and I think when patients come and they’ve thought about something they’ve wanted to buy you then you feel it’s a personal insult to them if you say no and it’s a really awkward situation and again it’s not always clear in departments anyway to say you can or you can’t isn’t it.” (FG8, occupational therapy placement educators)

“We don’t know how many take money from patients and don’t tell. Not that we have a problem with that if a patient was to give a, if a patient wants to give a student a tip, they can. We don’t have any rule to stop it... it’s usually a couple of quid and a hairy humbug.” (FG7, chiropody / podiatry classroom educators)

The use of humour was a particular area raised by all professions, recognising it as a means of developing a relationship and putting a patient at ease, but also a potentially risky approach.

“Some paramedics do joke around and involve the patient, but I think they sort of assess the situation as to whether it’s relevant or not, because like if someone is trapped in a car you don’t sort of bring up jokes but if someone is sort of mucking around and they are with a few friends and they’d fell over or something, just something quite silly, you know, you’d see whether it was worth putting a joke in, but then actually it depends entirely on the patient.” (FG10, paramedic student)

“Some people would be very professional and very formal and that approach doesn’t work for everybody, sometimes you have to be able to be a bit more informal and jokey and chatty, and that’s what works for that relationship doesn’t it, between the client and yourself.” (FG8, occupational therapy placement educator)

“Sometimes language can be used to diffuse a situation... I don’t mean like at the expense of a patient but having a bit of a laugh, it’s fine but sometimes it’s the way it’s done or if it’s at the expense of somebody else.” (FG17, chiropody / podiatry student)

Communication was also important in maintaining appropriate boundaries between professional and patient or client. ‘Reading’ the patient and the situation could often be required in order to establish appropriate boundaries and maintain safe practice. Negotiating boundaries could be more difficult in some contexts, for example when building trust with service users with mental health issues. The appropriateness of showing emotion was also discussed in terms of situational judgement and the therapeutic relationship. Participants from chiropody / podiatry and occupational therapy, professions that may involve building longer-term relationships with clients than paramedics, spoke of the importance of maintaining boundaries with patients and service users whilst still engaging them in conversation. The balance between showing empathy but not giving personal details such as home address / location or developing friendships was something students seemed to have been well informed about during training. Building a trusting and longer-term relationship with patients or service users sometimes meant being offered gifts by them, which could be awkward for students and, although there were Trust and organisation policies, was something they had to learn to deal with in each situation.

“You’re told you shouldn’t kind of do that thing [give a client a hug] but sometimes if you know your client well and... you have a frail old lady who is very upset it might be appropriate to just put your arm around them because we’re human, it’s compassion... it’s kind of knowing your client.” (FG13, occupational therapy placement educator)

“I think you have got to keep a balance, because you don’t want to be like too standoffish and just like, well, you know, the old ‘I’m a professional’... I think you’ve got to have some kind of a rapport with patients in order to do the job effectively, so I think it’s a fine line.” (FG19, occupational therapy student)

“Disclosing something about yourself can be a good sort of breaking the ice, so it’s kind of knowing that level of what you’re willing to disclose, so I mean for example it’s ok to say ‘Oh I also like that TV programme’ or something like that, but when it becomes really personal information that’s when you kind of put yourself at risk.” (FG13, occupational therapy placement educator)

The issue of disclosure also arose for educators with regard to the staff-student relationship and was seen by some as a grey area. Regarding relationships with colleagues, some spoke of the importance of behaving in a way which would not lose their respect.

The internet and social media were discussed as a threat to the boundary between professional and private selves, and this extended to privacy, and the boundary between practitioner and patient.

“I think most professions now, or even any job, the boundary between your work life and your social life is blurred with things like Facebook and things like that... you can't keep your private life private now because you see things in the media and things like that and you have to be always in your mind that actually I am supposed to be a professional and I've got my job.”  
(FG11, paramedic student)

“It also goes as far as Facebook, where patients have been known to look you up on Facebook to find out where you live, you're married, you've got children, and then they'll come into the clinic next week, 'oh, I've had a look on your Facebook page', there's got to be a line drawn but when a little old dear is sat in the chair and she just wants a little chat, you can't dismiss them because I think that's unprofessional.”  
(FG17, chiropody / podiatry student)

#### **3.3.2 Patient and public expectations**

Participants were conscious of wanting to promote a good image of themselves and of the profession as a whole to patients and service users in order to gain respect and to inspire trust and confidence in their ability and professionalism.

“Having that awareness that you can sort of, not necessarily intentionally, but you could do something that could be seen as abusing your position of power as well, I think a lot of professionalism is about how you are viewed by other people... how you're representing the profession and representing yourself.”  
(FG19, occupational therapy student)

There was a feeling that the level of professionalism expected by patients and service users could be shaped by a number of factors, including previous experience of a service. There was a sense that it was important to overcome any negative perceptions and set a standard or an example through appearance, behaviour and interactions. Participants from all three professions commented on professionalism being linked to their public health responsibility.

“We are the face of the ambulance service... the only thing the patients see from the ambulance service is people like us, and if you go in there into somebody's house and you're larking around or, you know, even if you are just in a bad mood and you're just not interested that's all they see and they tar everybody with the same brush, and you've got to keep a standard applicable to a professional service, you know, we're responsible for a professional service.”  
(FG5, paramedic classroom educator)

“Making a good impression, promoting a good image is what I think it comes down to, is the first port of call.” (FG13, occupational therapy placement educator)

The relative infrequency of exposure to these services compared to other professions (eg doctors and nurses) may mean that any negative examples are more easily established and harder to overturn. A single occupational therapist may be the only exposure to the profession a patient has, while a single nurse is likely to be one of many.

“Because there's so few of us you can live or die by those that have gone before you... there's a whole host of nursing staff around all the time... but if you get a bad OT and there's only one of them, then that becomes occupational therapy is a load of old nonsense... I think that is a problem for us as a profession sometimes.” (FG13, occupational therapy placement educator)

It was also suggested that it can take years for the public to perceive a role as ‘a profession’, and there is a possibility that patients may not readily identify the expertise of newer professions. Consequently they may not provide the appropriate information to them, but rather save it for a professional whose clinical expertise is more familiar to them. The changing roles and / or titles of the professions involved may not yet be fully understood by patients and service users or even other healthcare professionals. For example, there are now many levels of qualification and skill within the ambulance service, but the out-dated perception of all staff as clinically unskilled ‘ambulance driver’ was felt to persist amongst the public. Similarly, with regards to chiropodists / podiatrists, some in the profession have moved away from the term ‘chiropodist’ and so feel that the continued use of the term indicates limited awareness on the part of public and healthcare professions alike.

“I think even though they are registered professionals now, it still takes a long time before the public hold you in the esteem of being a professional, a lot of years.”  
(FG11, paramedic student)

### 3.3.3 The influence of organisational context

Professionalism, both in its definition and the behaviours that demonstrate it, was felt to be influenced by the organisational context. This is distinguished from what was termed the ‘patient-centred’ context above, as it describes the organisational and management structures within which the professions work, as well as their interactions with other professions.

Respondents indicated that it was important for organisations to support professionalism, and provide an environment in which it can flourish. Paramedics particularly identified management support as important, but the other professions identified relationships with the wider health and social care system as providing a context within which professionalism may or may not easily develop. There was a feeling that professionalism should be set by management example, and that the way staff are treated elicits the appropriate response in attitude and behaviour. This was not in terms of modelling explicit behaviour, but management displaying what was seen as appropriate behaviour for their role.

“The organisation as a whole should come across as professional from the top man all the way down, and if you’re not getting the right image from above how can you be expected to present the right image to the members of the public?”  
(FG4, paramedic student)

“If you haven’t got the correct support, you don’t feel like you are being looked after, none of your ideas are being listened to, whatever, from an organisational basis, then you tend to be more unprofessional... it’s when people look knackered or they’re disillusioned that they tend to let their behaviour slip, so it’s about catering to the people underneath you as well, professionalism breeds professionalism, you lead by example.”  
(FG20, paramedic student)

Management were also felt to be responsible for the working environment and resources, which could impact on morale and, potentially, performance. Pressures of work and targets were also seen as an influential factor.

“I’m lucky I’m on a nice, brand new station but you go to other stations, they’re dark and dingy and... things don’t work, nothing ever gets fixed, you put in a request for that light to be fixed and six months down the line it’s not done.” (FG1, paramedic student)

All groups felt the demands of the health service overall impacted on professionalism. There was a concern amongst some students that the pressures of working in the NHS were detrimental to professionalism, and that the demands of timed appointments may impact on their professionalism.

“I would [like to] do this, this and this, but in the NHS you have not got time to do that, that and that, you’ve just got time to do this, so your professionalism from being such a very high level when you leave here will certainly drop to a level that’s acceptable within the NHS, but you’re still being professional.”  
(FG15, chiropody / podiatry student)

The expectations of other professions were also significant. There were comments that their treatment by other professions could undermine professionalism, or act as an incentive to appear more professional with other groups. This may be related to a perceived lack of understanding from doctors and nurses of what other healthcare professions are qualified to do. For example, some chiropodists / podiatrists felt their role and / or skill level was not understood by other healthcare professions, including the GPs who may refer patients to them.

“My [relative] is a doctor and I explained to her some of the things that you do out on the road and she’s, like, ‘Do you do that?’. People just don’t know, that’s the problem, and I think it takes a long time before you’re held in regard.” (FG11, paramedic student)

“The HPC want us to be professionals and if we can’t be given the tools to be professional, ie we have to treat patients in a cupboard on a box, how on earth do they expect us to be professional? And that patient can easily turn round and say ‘right, that treatment was poor’.”  
(FG15, chiropody / podiatry student)

“If I go into a meeting [with other professions] that I know is going to be challenging I may actually dress more formally to present a more formal professional image. I think about the language I’m using and the way that I’m communicating kind of really to sort of up the stakes in professionalism to be seen as a professional, whereas with the clients I want them to see me as [name deleted] the OT.” (FG14, occupational therapy placement educator)

#### 3.3.4 Workplace environment

Some more localised elements of the workplace environment were also important in the framing of behaviour as professional or unprofessional. The difference between the patient environment and other working environments was important in defining the acceptability of some behaviours, particularly around humour. Behaviour with colleagues could be seen as ‘unprofessional’, but could be beneficial in allowing de-stressing and ‘letting off steam’, or simply informal debriefing.

“It’s a coping mechanism... you have a bad job, you know, whatever the outcome may be, but you need to talk about it or have a crack on about it, but somebody looking in from outside would think ‘how can they make a joke about what’s just happened?’ and it’s that kind of thing, so it’s the way things are perceived I suppose.”  
(FG5, paramedic, classroom educator)

“Without realising there was still a patient in the next cubicle we started to talk about what we’d done and the treatment, and then realised there was someone still sitting there which is you know completely unprofessional but it was just the excitement and lack of experience that made us do that... we were talking about what we had just experienced and obviously that’s not professional in front of another patient who’s in the next cubicle... it certainly wasn’t malicious or deliberate or it was just thoughtlessness I suppose.”  
(FG16, chiroprody / podiatry student)

Some paramedics spoke of reduced opportunities for this de-stressing in the modern ambulance service, commenting that they spent less time at their work base than in the past. However, norms on such behaviour were not universal, and there was a need to know which behaviour was appropriate with which colleagues.

“Some colleagues you can have a laugh with and other colleagues you’re a lot more sort of serious with, but you never do anything that is completely derogatory or anything like that.”  
(FG2, paramedic student)

Organisational culture could also be important in creating or reinforcing professionalism, or allowing unprofessional behaviour to go unstopped.

“There’s still this real culture against whistle blowing... if you were to report somebody, no one on your station would ever talk to you ever again, you would have to move and live somewhere else... you know, if he’s a good bloke, how could you say something against him even if he is a terrible practitioner?”  
(FG18, paramedic classroom educator)

### 3.4 Experience and role modelling

The areas of situational awareness and contextual influence discussed above were often related to experiences during training. These included direct experience gained in practice, and from role models encountered at work.

“There’s a lot of people come into the service... and they can’t talk to different groups, old people. They find it very hard actually to talk to old people and that’s something that you learn on the road... it’s something that you’ll never learn out of a textbook.” (FG4, paramedic student)

“You have different people you work with as well, so professionalism is going to change day to day with people you work with as well.” (FG1, paramedic student)

Role models could be positive or negative, and participants spoke of developing their ideas of professionalism and good practice by drawing on different elements observed in different role models. Some students also spoke of learning from their peers, while some tutors referred to their responsibility to act professionally and display a professional approach in their teaching. Students felt they could identify the bits from good and bad role models they would like to adopt and to avoid, indicating they felt their judgement to identify the good and bad examples was good enough to do so. The possibility of adopting unprofessional habits through complying with others’ behaviour was also raised.

### 3 Results

“Taking bits from all the different people that you meet... you’ll see something and think that’s really good, and then it’s taking the best bits from everyone, saying they’re really good at talking to the client and getting their attention, and then... they’re really good at putting equipment together and this is the best way to do that... and I’ve learned a lot from other people in the team as well and I think that’s really important.”

(FG19, occupational therapist student)

“We’ve all been shifted around to different people, most of us have, and you kind of get... to see the good people and the bad people and you can kind of like pick and choose all the little bits that you want to take from different people’s practice, so it’s quite nice.” (FG11, paramedic student)

Educators recognised that this modelling occurred, and were aware of the risks of inappropriate modelling. The vast majority of educators have been in practice or are still active practitioners and they were often aware of their own potential as role models.

“There will be a demonstration of professional practice just by the way we conduct ourselves.” (FG6, occupational therapist classroom educator)

“If you treat somebody right they tend to treat you right as well, and I think it’s the same with the students. If you are professional, you are on time, you have everything prepared, you can answer their questions and things, it looks professional and they want to learn, and it’s the same out there on the road.”

(FG5, paramedic classroom educator)

The enthusiasm of some educators was identified as a positive example by some students.

“We’re quite lucky because we get put with practice placement educators who volunteer to do that job to teach... because they’ve volunteered for that you know they are really quite good at their job and quite professional because they want to advance the profession by teaching others... you learn a lot about... your bedside manner and definitely how to be professional.” (FG11, paramedic student)

“I remember going on placement and I had a fantastic educator and just a brilliant OT and I remember thinking that’s kind of how I’d like to be and to kind of conduct myself really, so I think I could see how they worked with the client... I thought yeah that’s good practice, that’s how I’d like to be as an OT.” (FG13, occupational therapist placement educator)

Role models were not limited to the students’ own profession. Good examples could be found in other professions.

“I think looking at other professions, not just podiatrists, but GPs, nurses, doctors, physios, dentists, how do they conduct themselves in a professional manner, what’s their understanding of professionalism? Looking at how other people present themselves professionally, not just medically but in business as well and just throughout general life.” (FG15, chiropody / podiatry student)

Peer learning, with students modelling behaviour from each other and establishing their own norms of professional behaviour was also identified as important.

“It’s surprising what peer pressure can do with a student because the students will let another student know if they’re unhappy with their [...] behaviour.” (FG7, chiropody / podiatry classroom educator)

“They’re quite sort of practice affirming with each other, they’re quite nurturing. I think it depends on the group obviously, every group’s different, but I think they’re quick to say that’s not right, but equally if somebody’s done something really good they would aspire to be like that.” (FG7, chiropody / podiatry classroom educator)

### 3.5 Achieving professionalism

Student participants were asked whether they ‘felt like a professional’. The intention of this question was to elicit opinions on when professionalism or professional identity may ‘begin’ or be adopted, and whether it is related to the regulatory status of being a registered professional. Interestingly, there was a range of opinions, illustrating different perspectives on what professionalism means, and how it relates to ‘being a professional’. Some stated that professionalism is distinct from being ‘a professional’, and that the use of ‘professional’ as an adjective (‘being professional’) or as a noun (‘being a professional’) carries very different meanings.

“I think being a professional as a sort of professional body if you like, being regulated, then yes that’s different from actually being [professional].” (FG18, paramedic classroom educator)

The majority of students felt that professionalism began as soon as they began their training – for example, even if they didn’t feel like a ‘professional paramedic’, they felt like a ‘professional trainee paramedic’, that is, professionalism to them was centred on practice, not status. In the sense that professionalism may be ‘part of the self’ as described in an earlier section, and something that is essentially inherent to the individual, it may be brought by students to their training in their underlying values, and carried through with them into practice.

It may therefore be possible (and desirable) to ‘be professional’ and act in a professional manner before acquiring all the necessary knowledge and skills and becoming a registered professional. Indeed it may not be possible to qualify without being professional.

“I think [feeling professional] is an absolutely individual thing. I think I’m a professional since the day I started this course and always given it everything, always done my best.” (FG15, chiropody / podiatry student)

“I definitely feel like a professional [but] I don’t feel like a paramedic, and I think that’s purely down to my lack of confidence about my knowledge.” (FG11, paramedic student)

“When you first start training as an OT you don’t have all the knowledge that it takes to be an OT but you should still be professional.” (FG13, occupational therapist placement educator)

At the same time, professionalism was still seen by both educators and students to develop over time through education and learning on the job, and some reported changes in their attitudes and behaviour. Some educators felt that professionalism was there from selection and admission to the course, others that it developed, or in some cases remained a concern. Some students described feeling like a professional once they went out on the road or into practice, and some said that this feeling emerged or was strengthened when they returned to their place of training and reflected on their experience.

“There are others at the early stage that you think you have got concerns about and you think, ‘Oh my God, I don’t know what we’ve got here’, but actually you very quickly notice that they are learning, they are changing the way that they approach.” (FG18, paramedic classroom educator)



“I think there is a point leading up to [registration] at which a student decides they are going to accept the obligations placed upon them, they take responsibility for their own actions, and at that point they themselves become an occupational therapist... and for some students that will happen before they arrive on the programme, for some it will happen somewhere near the end of year three... and I don't think we can push it upon the students and their expectations of placement, but I don't think they ever take that on until it becomes innate.” (FG6, occupational therapy classroom educator)

“A lot of them don't change between level one and level three so I think it is a personality issue and it's difficult to change. Not saying you can't change, but it seems quite difficult for a lot of people to change.” (FG7, chiropody / podiatry classroom educator)

Some thought they would feel like a professional chiropodist / podiatrist, occupational therapist or paramedic when registered with the HPC, or when they were practising independently; others thought it would not be until they had a few years experience and were teaching others. At the same time, it was noted that being registered was not synonymous with being professional. Some educators referred to professionalism as 'evolving' or as a 'journey' and one that continued as a 'lifelong journey' throughout practice.

“You can be a professional to the standard where you're talking to patients with respect and things like that... but the fact of having the underpinning knowledge and experience to have the confidence to make the decisions – it's years, isn't it.” (FG4, paramedic student)

For some students, their own developing professionalism raised issues about how far they could, or should, challenge what they considered to be unprofessional behaviour in others.

### 3.6 Differences between professions

While the main themes defining professionalism were similar for the three professional groups, there were some inherent differences between professions relating to their different organisational contexts, and the different clinical environments leading to different professional demands and patient relationships.

Paramedics see patients in the most acute circumstances, and are effectively at the beginning of any episode of healthcare (they may be responding to a referral, but even then, they are the first patient contact on the way to a hospital). Chiropodists / podiatrists and occupational therapists on the other hand receive patients through referrals, and will often see patients over a period of time in which the gradual development of a relationship can occur, allowing the professional a longer period in which to establish an appropriate level and form of communication. The acute nature of paramedic care also has implications for the physical environment of the job, and the risk analysis regarding their own safety. The emergency nature of the paramedic role also meant that they had dealings with, and compared themselves to (and felt themselves compared to by others), the fire and police services as well as other healthcare professionals.

“You've had all three of us lined up and I think the public straight away would say the police are probably the most professional, then fire and we'd be last.” (FG3, paramedic student)

“Also I think we do as a body, I think we often, and we get sympathy from the public, we hide behind the guise of oh it’s their stress relief, they’re not racist, that’s just the way they, there’s no stress, there’s stresses like getting off on time and things.”  
(FG18, paramedic classroom educator)

By contrast, while any health or social care contact contains risk, and chiropodists / podiatrists and occupational therapists may enter community or domiciliary settings where risks are not controlled (and prison settings where risks may be controlled but heightened), visits are likely to be planned, and any risk analysis conducted in advance. The different environments in which chiropodists / podiatrists and occupational therapists work may influence service users’ expectations, for example they may be more comfortable to try things in their own home than in a more public environment.

“When you’re working with a client within a department when there are other people around there are certain things that you do that might embarrass that individual because of the more public nature of what you are doing... which, with the individual in their own home you would be able to do.” (FG6, occupational therapy classroom educator)

All professions have different time constraints to their practice, but the circumstances are different. Chiropodists / podiatrists and occupational therapists will tend to have scheduled appointments, some of which will be in clinics, but others will be in the community, in people’s homes, with different expectations. Paramedics have less defined schedules, being responsive to calls, but once on a job there are time constraints, such as target response times, and limits to how long can be spent on handover at a hospital.

“Even simple things like once you’ve handed your patient over at hospital and you come back to the ambulance, usually you green up straight away once you’ve finished... we might be at hospital five minutes and then we’d go onto the next job, but if we were with an old hand, they just stay at hospital for like an hour because they want to relax, read their paper, things like that, because that’s how they would have done it 20 years ago and if you sat there and greened up after five minutes they’d [not be happy] and then for the rest of the year you’d be known as the person on the station who greens up really quickly so you’ve got to be careful.”  
(FG11, paramedic student)

Of the three groups, the chiropodists / podiatrists differed in that many of their cohort expected to go into private practice as a matter of course. While there may be opportunities for private practice in the other professions, they were training with the expectation of working in the NHS.

The professions differ in their history as professions, and some responses highlighted a contrast between the professionalisation of a role, meaning its formal status and regulation, and the emergence of professionalism in its culture. Paramedics are a relatively young profession, and the majority of the current workforce trained in the pre-graduate system. It also still has the legacy of the IHCD short course route to registration, meaning that new paramedics are entering the workforce with very different training experiences to those already there, including senior management.

It was suggested that because of this, there may be a mismatch between the aspirations of training programmes and the consequent professionalism of graduates emerging from programmes, and the culture of the organisations in which they are then employed. Individual professionalism may be developing

at a very different rate to that of the employing organisation. This may be the seed of longer-term change, or may lead to frustration, and attrition of those individual attitudes.

“Our very own... [Trust] Chief Executive came here and told the students that studied for [a degree] that they will be no different... they'll be paramedics and so will everyone else that trains in his service... on an in-service training course. Which was less than helpful.”

(FG18, paramedic classroom educator)

Paramedics were also particularly aware of the role of the media – drama and ‘reality’ television programmes – in constructing public perceptions, although as the educators pointed out, this also affected the perceptions of potential applicants.

“It seems like a lot of the things in the media, the paramedics get blamed for something, possibly quite minor, [and] get really taken to the dogs kind of thing. And yet a lot of the perceptions of the public are like, well, that we shouldn't be doing that anyway, that we're just taxis to hospital, so what are we doing that kind of thing [for] anyway?” (FG11, paramedic student)

“That's where people get the wrong image of us – if people don't watch Casualty they think we are just taxi drivers, people who do watch Casualty think we save everyone's life and everything they go to is life threatening, and so everyone gets the wrong idea.” (FG11, paramedic student)

There were also a small number of references to identifying role models in media representations, with the dramatic representation of a paramedic emphasising positive qualities of the job. Educators pointed out that those who came for interview with such expectations were often not felt to be suitable for the job as their expectations were likely to be unrealistic.

### 3.7 Implications for selection and education

The belief that the qualities required to be ‘a good professional’ are pre-existing, if not innate, may have implications for the ways in which health or social care professionals are selected. Some educators commented that a belief in the profession itself could be a key aspect of professionalism and this could be displayed during, or before, training as well as after qualification.

“You couldn't come into a healthcare setting if you didn't have some values and beliefs about, you know, helping people... I think for me as well to come into OT it's about having the values and beliefs of the profession before you come into it almost, because you need to believe in the profession to be a professional OT.” (FG14, occupational therapy placement educator)

“We find it time and time again, don't we, that, not always but in a lot of the cases, the students that do really well on placement and are perhaps middle of the road or even struggling academically, but on their placements they do very well because they have the belief and the right personal attributes to be able to do really well on placement.” (FG14, occupational therapy placement educator)

Similarly, if professionalism is a reflection of a set of core beliefs or attitudes, rather than knowledge-based competency, there are implications for how professionalism is taught or developed in training. The part played by morals and values raises questions regarding the teaching of professionalism, for example how deep-rooted values are and how amenable they are to change. Is it the holding of values or the ability to put one's own values to one side if they are dissonant with the values of the profession that is the important quality?

“Things like empathy can be learned and improved upon within their learning perhaps, whereas other aspects are just there or they’re not.” (FG7, chiropody / podiatry classroom educator)

“They can’t change their values, they can’t change their perceptions.” (FG18, paramedic classroom educator)

“To try and get an attitude change, I mean how do you get an attitude change? You can’t.” (FG7, chiropody / podiatry classroom educator)

“If students don’t have those inbuilt values as soon as they leave, you know, they’ll virtually forget everything they’ve learned.” (FG7, chiropody / podiatry classroom educator)

While the majority of educators saw the inherent, pre-existing qualities as important, the need to develop and bring out the best of students was important in their own professional role. Educators’ roles mean they must engage with ‘professionalism’ as something that can be taught or improved in an educational setting. Educators’ views also varied with their relationship with the students. Those who were responsible for progression within the educational programme (‘classroom educators’) saw the educational role as different to those who saw the students only in a practice environment.

“We have to hand over that responsibility to educators in practice and in the past they haven’t always been clear as to whether to expect the student to follow what’s expected in the workplace or allow them to be a student with quite sloppy habits... they were saying things like, well, you know, I’ve passed so and so but I wouldn’t employ them, and we’re having to say well actually you’re the gate keeper to the profession and there’s an expectation, why

are you passing that person, we would like you to fail them if you are saying they are unprofessional.” (FG6, occupational therapy classroom educator)

The complexity of professionalism also raises the issue of how easy it may be to measure. This question is being addressed in part by Study 2 of the current project.

“It comes from so many different places and it’s so many different things... I think that’s what makes it hard to measure.” (FG13, occupational therapy placement educator)

## 4 Discussion

Focus groups were conducted with educators and students drawn from chiropracist / podiatrist, occupational therapist and paramedic populations to explore professionalism. The study had four objectives – to explore what constitutes professionalism as perceived by students and educators in the three professions, to identify how professional identity and an understanding of professionalism develop, to identify examples of professional and unprofessional behaviour, and to inform the development of the quantitative data collection in Study 2. The last of these will be dealt with in the interim report on Study 2. The others are discussed below.

With regard to objectives one and two, the analysis illuminated the complexity of the concept of professionalism, echoing findings in the earlier literature, but also increasing our understanding of the factors which influence it and how they inter-relate. The results have also identified pertinent issues for the development of professionalism in education, training and practice.

The analysis has identified dual perspectives on professionalism – as an holistic concept, and as a multidimensional, multi-faceted construct consisting of professional identity, professional attitudes, and professional behaviour. Earlier work on professionalism in clinical contexts has often focused on the last of these, identifying professionalism as a competency which can be taught and assessed.<sup>5, 6, 7</sup> However, it has been acknowledged in the literature that such decomposition of professionalism may be problematic, and that it may be more usefully considered as an holistic construct.<sup>20</sup> The holistic construct was often linked by respondents to good clinical practice – professionalism is ‘doing the job well’.

Discussion of where people felt their views of professionalism came from identified two main sources of influence: the first, the respondents’ personal qualities and the second, the context of the immediate situation. Many respondents felt that professionalism was a consequence of qualities that the individual brought to the profession – perhaps not actually innate, but certainly pre-existing. A consequence of this was that many felt that professionalism was something which was an essential part of themselves, and that as a professional they should always be ‘on duty’; any lapses would not only let themselves down but also diminish the profession in the eyes of the public.

A common theme was that ‘the right sort of person’ will be attracted to a profession (for example, a caring person will be attracted to a caring profession), and that if they have the right qualities, they will succeed. If people of a certain ‘type’ are suitable for a profession, one implication is that some form of personality-based aptitude testing may be appropriate for selection, although with the risk that the profession would be more limited as a result. Chamberlain and colleagues<sup>21</sup> found some evidence that students who had similar personality profiles to qualified dentists (on the ‘big five’ personality dimensions of extroversion, conscientiousness, neuroticism, openness to experience and agreeableness) did better in first year coursework, suggesting personality may be linked to aptitude. However, the use of such methods would require a great deal of development to ensure their high-stakes usage was valid and reliable.

When viewed as a product of individual qualities, professionalism was therefore substantially focused on values and beliefs that influenced practice. However, it was also felt to be significantly determined by the context of practice. This included the immediate clinical context, with the needs, demands and expectations of patients varying case-by-case, and the organisational context, including management support and the expectations of other professionals. Organisational and management structures may encourage or inhibit the emergence of professionalism, the implication being that if professions are treated with respect, and with the expectation of professional behaviour, then that behaviour will follow. Organisational influences involved being valued and supported, having realistic targets and expectations from the profession, and not expecting people to work in poor conditions and with unreasonable workloads or deadlines. Working under pressure with poor resources increased the pressure on the profession to cut corners and risk practice that was unprofessional or close to it.

There were also issues around the perception of the status and expertise of these professions compared to other health professionals and (for paramedics) emergency service workers. Feeling that expertise was undervalued or unrecognised in comparison to other professions could also have an undermining effect.

Morale was therefore an important contextual element for the development of professionalism. This could stem from practical aspects such as resources and facilities, to less tangible elements such as a culture of professionalism as a positive, rather than punitive, concept. Considering the extent and history of an occupation or organisation's professionalisation may provide a way of engaging with their attitudes towards professionalism.

It may be that attempts to address concerns about professionalism need to look beyond the educational setting, and the behaviour of trainees, to also seriously consider how the working environments and organisational cultures those trainees enter can be developed, to ensure that professionalism is maintained post-registration and does not deteriorate in practice.

The need to see the appropriateness of behaviours as being determined by clinical context is not a new observation<sup>10</sup>, although much of the literature does not take account of this, perhaps because it is not expedient to assessment where standardised tools and clear metrics are the primary aims. The role of management and organisational influences in determining professionalism was not identified in the literature reviewed to date. Increased awareness of their responsibility to support professional behaviour may set new challenges for both educators and regulators. The tension between the influences of individual and context would also appear to be of concern to educators and regulators. Teaching and assessment (or revalidation) of something which is dynamic, and bound to specific individuals and environments, is difficult. While Objective Structured Clinical Examinations (OSCEs) or similar simulated patient exercises may provide some insight into the appropriate judgement, they may not explicitly examine professionalism, and where they do, have been found to have questionable reliability.<sup>10</sup>

The adoption of professional identity, that is the categorisation of oneself or another person as a member of the professional group, is another way in which the development of professionalism may be viewed. One indication of this was the feeling that professionalism was something that reflected on the profession as a whole, with a driver of professional behaviour being the desire to represent the profession well. The perceived attitudes of others – patients and professionals – to the professional group as a whole reinforced this identity.

The importance of identification as a professional was also apparent in students' discussions of when they felt they became, or would become, a professional practitioner. While rooted in personal values and beliefs, becoming a fully-fledged professional was seen as a work in progress, to be influenced by the professionals around them. Role models both within the profession and the wider clinical team were important for students to identify what type of professional they wanted to become.

The emergence of professional identity therefore also appears to be a result of an interaction between the individual and experience, with some respondents basing it on their perceived qualities, some on experience, and some on the statutory achievement of professional registration. Theoretically, these different elements may indicate different dimensions of the professional identity which individuals may attend to, and against which they may judge the 'fit' of the professional identity to their current role.<sup>22</sup> One study with medical students found a number of factors influenced their identification as doctors, including experience of practice, apprehension about being a doctor, and interpersonal problems.<sup>23</sup> If the adoption or experience of professional identity is related to professionalism, it is clear that again personal as well as contextual factors should be addressed. Educators, in describing the sort of person who would make a good professional, also invoked identity, as what a professional is rather than qualities they have. This may be a risk for recruitment, as it may lead to a confirmation bias (recruiting people who fit a stereotype rather than who have the right qualities). Consideration of identity may also be useful for formative assessment though, as it may be a means of establishing the extent to which individuals are assimilating themselves into the culture of their profession and are ready to take the step into practice.<sup>23, 24</sup>

The third objective of the study was to identify examples of professional and unprofessional behaviour. The examples discussed in the focus groups reflect those identified in the literature where review papers have consistently identified core themes of ethical attitudes, good communication, and competence, all of which were raised in the data presented here. Appearance was important, both on a symbolic, social level ('being smart') but also pragmatically in terms of hygiene. This went beyond personal appearance into professional spaces such as vehicles and equipment. Professional behaviour was recognised and involved maintaining good standards of practice and keeping up to date as well as showing the appropriate respect for patients, colleagues and the profession. Unprofessional behaviour was the inverse of these, and poor attitudes identified as those which might lead to the emergence of unprofessional behaviours.

However, the complexity of professionalism, and its dual nature and dual origin, means that while it is relatively easy to define, it is not simple, and it is not easy to recognise in absolute terms whether behaviour is professional or unprofessional. Many examples were coded as 'ambiguous', because even while describing them, participants were expressing the specific contextualised nature of their appropriateness.

'Professionalism' therefore may be defined in the interaction of practitioner, patient or service user, and context. The professional brings relatively stable beliefs, traits and attitudes, but they must respond to the demands of the patient, personally as well as clinically, and the organisational and physical environment must allow professionalism to flourish. It is so localised in specific interactions therefore that any absolute approach to defining what is or is not professional will be problematic.

However, perhaps this is not a problem. A more constructive approach to professionalism, for educational institutions and regulators alike, may be to recode 'professional behaviour' simply as 'appropriate behaviour' in relevant communication and technical skills, and so to be dealt with in the relevant existing areas of a curriculum. At least some of the participating organisations in this study already integrate professionalism throughout the curriculum, so this is not necessarily a change in practice. Questions of 'professionalism' may then be refocused on the 'meta skills' of situational judgement and contextual awareness which enable individuals to identify what is appropriate, and adapt elements of their available skill-set (including communication skills, practical skills and clinical skills) to the given context. The literature provides an example of a situational judgement test addressing professionalism which may indicate an approach to this,<sup>25</sup> although no data are provided on its use.

Reframing professionalism as a capacity for judgement, rather than discrete skills, may benefit those who must develop it, and those who must monitor it. This capacity has been presented as a form of practical knowledge, which must be developed in practice.<sup>26</sup> That this area of professional judgement is worthy of attention was implied by many students in this study. Whether through qualities they bring to the profession or teaching they had received, many seemed confident that they were able to distinguish between professional and unprofessional behaviour, could identify unprofessional practice if faced with it, and would identify and resist negative role models. Potential problems for their later professionalism would be a risk if this judgement was not as true as they suggest.

Finally, the representation of the three professional groups in fitness to practise cases varies, with paramedics being over-represented and OTs under-represented. The findings here do not suggest that this is due to any particular difference in the conception of professionalism or its determinants. The professions did not appear to have different approaches to professionalism, and identified the same values, influences and good and bad examples. Rather there were differences in the work of the two groups which meant that their contextual influences may be very different, both in terms of clinical work and organisational processes. Further work investigating professional lapses may need to look in more detail at how specific problems emerge.

### 4.1 Limitations

All research operates within limitations, and this study is no different. The focus group method cannot be sure of comprehensively uncovering every viewpoint, although the number of groups and participants here is substantial for this method. The use of Post-it notes to record all members' views before beginning discussion helps to ensure that potential minority views are taken into account.

The exclusion of Institute of Health and Care Development (IHCD) students was a deliberate choice, and may mean that certain perspectives were lost. However, one of the paramedic sites did include a similar population in terms of experience in the ambulance service, with in-service training, and so substantial difference is not anticipated.



### 4.2 Questions arising and future research directions

This study has identified professionalism as an holistic construct which is linked to a range of attitudes and behaviours, including meta-skills of situational awareness. The on-going quantitative study is developing a questionnaire to establish the relationship between these elements, and relate them to an objective measure of conscientiousness. The questionnaire development has been informed by the analysis presented here.

This study has identified a possible model of professionalism as a meta-skill of situational judgement, allowing professionals to select appropriate behaviour from a toolkit or repertoire. The development of the repertoire may be different from the development of that judgement. Professional judgement may be therefore seen as analogous to clinical judgement, and that analogy may bear further examination.

The study did not identify any particular differences between the views of students of different years, and educators. While the overall understanding of professionalism may not differ substantially, there may be differences in their experience of professionalism. These differences may not just be between professionals, but also the different training routes and relationships between students and educators. Educators employed by higher education institutes and by the NHS implied different perspectives on their roles. Further work may examine how the interaction of personal qualities, context and role is dealt with in educational and practice settings.

# 5 Conclusion

This study has identified key themes in relation to professionalism, from a sample of chiropodists / podiatrists, occupational therapists and paramedics. The participants perceived 'professionalism' both as an holistic concept, and as a set of specific appropriate behaviours. This was related to a professional's sense of self, to pre-existing values, and identification with a profession, but was also firmly rooted in the context of practice. What is seen as professional in a specific instance will vary with the expectations of the patient or service user, the demands of practice, and the environment.

'Professionalism' then is not perceived as an absolute, but constructed in the interaction of individual and context. Identification of 'unprofessional' behaviour in the workplace may therefore be inferred to be subject to the same judgements. Beyond basic minimum standards, which may be set by regulations and codes of conduct, identification of these behaviours cannot therefore be assumed to be clear-cut.

Questions of professionalism (and lack of professionalism) may be better framed more in terms of the ability to identify when behaviour is appropriate rather than always in terms of absolute behaviours. It is suggested that professionalism may be better regarded as a meta-skill of situational awareness and contextual judgement, allowing individuals to draw on a range of communication, technical and practical skills, and apply the appropriate skills for a given professional scenario. The true skill of professionalism may be not so much in knowing what to do, but when to do it.

The role of organisational context in encouraging and facilitating professionalism was also an important observation. This could be in the form of management and resources, or the structure of work and the perceptions of other professional groups.

These key points, of professionalism as a judgement rather than a skill, and of the role of organisational support, may be developed to explore new ways of encouraging professionalism in trainees and existing staff. Implications for education, assessment, as well as revalidation, should be explored.

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# Appendix A – Letter of invitation to prospective participants



**Durham**  
University

School of Medicine and Health

Shaped by the past, creating the future

4 October 2010

Dear Student

## **Invitation to attend a focus group**

This letter is to invite you to take part in a research project looking at the development of professionalism.

The study has been commissioned by the Health Professions Council (HPC, please see enclosed letter of support), and will be carried out by the Medical Education Research Group at Durham University. The HPC will have no access to data - they will only receive summaries of results.

We are interested in your views on professionalism, and you are invited to take part in a focus group on **Wednesday 10 November 2010, at 1pm**. All trainees in your programme are being invited. There is no obligation to take part, but your contribution may help us understand more about professionalism.

An information sheet on the project is enclosed. Please read it carefully and feel free to contact us with any questions.

If you would like to take part in a focus group, please return the enclosed reply slip on the following page.

Yours sincerely

Jan Illing  
Principal Investigator

# Appendix B – HPC letter of support sent to prospective participants

Park House  
184 Kennington Park Road  
London SE11 4BU

tel +44 (0)20 7582 0866  
fax +44 (0)20 7820 9684  
www.hpc-uk.org



Chair: Dr Anna van der Gaag  
Chief Executive and Registrar: Marc Seale

September 2010

To whom it may concern,

**Research Project: The professionalism and conscientiousness of trainee health professionals**

I would like to invite you to take part in the above research project which is being undertaken by Durham University. The research, which the Health Professions Council has funded, will involve two studies, one looking at how professionalism and professional behaviour are defined and experienced, the other aiming to investigate issues related to the measurement of professionalism.

Attached is an information sheet from the research team explaining more about the study and what your participation would involve.

Individual data will remain wholly confidential to the independent research team and will not be shared with anyone else, including the HPC.

We thank you in anticipation of your contribution to the research.

Yours sincerely

A handwritten signature in black ink that reads 'Anna van der Gaag'. The signature is written in a cursive style with a long horizontal stroke at the end.

Dr Anna van der Gaag  
President of the Health Professions Council

# Appendix C – Focus group information sheet

## Professionalism and conscientiousness in healthcare professionals

### Focus Group Participant Information Sheet

We would like to invite you to take part in a focus group as part of our research study. Before you decide, we would like you to understand why the research is being done and what it would involve for you.

Please read this sheet carefully. If you have any questions, there are contact details at the end of this sheet. Talk to others about the study if you wish.

#### What is the purpose of the study?

Many problems faced by health professionals are identified with 'professionalism' rather than clinical proficiency. This study is looking at what trainees and trainers in different professions mean by 'professionalism', how perceptions of professionalism develop, and how professionalism may be measured.

#### Why have I been invited?

All students in the first and final years of the x programmes at x University are being invited to take part in focus groups. Trainers are also being invited to take part in separate focus groups – we are interested in how the views of trainees and trainers compare. Other professions are also involved in the study.

#### Do I have to take part?

Participation is entirely voluntary. If you agree to take part now, you can change your mind at any point.

#### What am I being asked to do?

You are being asked to take part in a focus group at x to discuss your views of what professionalism is, and how unprofessional behaviour may be identified.

The focus group will involve 10-12 other trainees and will take up to two hours. Before the group starts you will be asked if you are happy for the discussion to be recorded and transcribed, and to sign a consent form agreeing to the recording being made.

The recording will be confidentially transcribed, and will be erased following transcription.

#### What are the possible disadvantages and risks of taking part?

It is possible that the discussion may address issues of professionalism you are uncomfortable with. Remember you do not have to say anything you may be uncomfortable with. If there are any issues raised that you would like to speak to someone about, there are contact details at the end of this form.

If anything is said which clearly identifies criminal behaviour likely to be damaging to patient safety, it will not be possible to maintain confidentiality. If you are aware of any such behaviour, you are encouraged to discuss it with a tutor or supervisor. If you describe any such behaviour so that individuals cannot be identified, confidentiality will be maintained.

#### What are the possible benefits of taking part?

In finding out more about professionalism, this research aims to improve the experience of health professionals, and patients. It may help ensure that any assessment of professionalism is appropriate, and inform the development of training in professionalism. It may be that through taking part you feel more able to reflect on and explore your own professionalism.

**Will my taking part in this study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence.

The recording of the focus group will be anonymised during transcription, and the transcript will not include your name. All transcripts will be stored securely on Durham University's secure network, to which only members of the Medical Education Research Group will have access.

Quotes from the focus groups and interviews may be used in reports and papers, but will not include any details which could identify anyone personally.

**What will happen if I don't want to carry on with the study or am unable to?**

Once the focus group is completed, you will not be expected to have anything more to do with the study. You may be separately invited to complete a questionnaire.

If you decide you have said something you would prefer not to be used as data, for example quoted in results, let us know within two weeks of the focus group, and we will send you the anonymised transcript for you to identify the statements and remove them.

**Who is organising and funding the research?**

The research is being funded by the Health Professions Council, which regulates your profession. However, they will have no access to data and will only receive summary reports from the researchers, in which no individuals will be identifiable.

The research is being organised and managed by the Medical Education Research Group at Durham University (see <http://www.durham.ac.uk/school.health>).

**Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Leeds (West) Research Ethics Committee. It has also been reviewed within the Durham University School of Medicine and Health. It has been registered with the x NHS Trust.

**Further information and contact details**

If you have any questions or concerns about any aspect of this study, please feel free to contact the Principal Investigator who will try to answer your questions:

**Dr Jan Illing**

Medical Education Research Group  
Durham University  
Burdon House  
Leazes Road  
Durham  
DH1 1TA

email. [j.c.illing@durham.ac.uk](mailto:j.c.illing@durham.ac.uk)

If you would like to talk to someone not directly linked with the study, you can contact the Durham University School of Medicine and Health:

**Professor James Mason**

School of Medicine and Health  
Wolfson Research Institute  
Durham University Queen's Campus  
Thornaby  
Stockton on Tees  
TS17 6BH

If the project has raised any other concerns, you may contact x

The Health Professions Council may also provide information about professionalism and professional regulation – their website is [www.hpc-uk.org](http://www.hpc-uk.org)



# Appendix D – Consent form

## Consent form

Title of Project: Professionalism and conscientiousness in healthcare professionals

Name of Researchers conducting focus groups:

Please **initial** each box

1. I confirm that I have read and understand the information sheet dated 27 September 2010 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
3. I understand the focus group will be audio-recorded and confidentially transcribed. I agree that anonymised quotes may be used in reports and publications.	
4. I understand that in the event of any information regarding criminal activity which may be detrimental to patient safety being raised, the information may be passed to x University.	
5. I understand that relevant data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust in order to monitor the quality of the research. I give permission for these individuals to have access to my anonymised data.	
6. I agree to take part in the above study.	

Name of participant: .....

Date: .....

Signature: .....

Name of Person taking consent: .....

Date: .....

Signature: .....

PLEASE SIGN ONE COPY OF THIS FORM AND RETURN IT TO A RESEARCHER.  
KEEP ONE COPY FOR YOURSELF.

# Appendix E – Codes and definitions used in framework analysis

Code	Definition
<b>Definition of professionalism</b>	
Adherence to codes / regulations / protocols	Any references which explicitly mention codes of conduct / regulations / protocols.
Appearance	Anything referring to what they look like to patients / other professionals; uniform, tidiness, personal hygiene, obesity, tattoos, hair.
Appropriate behaviour / attitudes / communication	Generic code for any descriptive level of professionalism – doesn't need to be specific, but specific examples should also be coded under 'behaviours'.
Context	Contextual awareness and situational judgement. Any reference to professionalism varying with physical context, including the people worked with (patients and colleagues).
Development over time	Anything relating to how professionalism changes over time. Will include responses to Q4 around when people feel like / become a professional.
External perceptions	Anything relating to how the profession / professionalism is seen by others – patients and other professions. Include elements of social responsibility and role of profession in health promotion and education, anything relating to obligation to set a good example, practice what they preach.  Also public image as presented in media, and perceived image amongst other professionals.
Good clinical care	Explicit mentions of clinical workplace or clinical work – competence, safe practice, knowing limitations, critical self-reflection.
Holistic construct	Won't / can't break down 'professionalism' into specific areas. 'It's a bit of everything'.
Other definition	Anything else which is probably a definition, but which doesn't clearly fit into any other codes. To avoid creation of ad hoc codes when we're independently coding.
Part of self	'It's what you are'. Definitions which focus on quality of self rather than behaviour. May overlap with holistic in analysis. Also personal qualities, beliefs.
Role boundaries	Personal / professional boundary and not overstepping it. Related to situational awareness, knowing what the limits of professionalism are and when those limits should / can be extended or drawn in. When does behaviour become appropriate / inappropriate.

Code	Definition
<b>Source of professionalism</b>	
Education / training	References only to tertiary and professional education in this code.
Learning on the job	References to workplaces in this profession only.
Media	Perceptions of profession as portrayed in media.
Organisational environment	References to what the organisation context allows or encourages. Include pragmatism (eg 'You can't work like that in the real world'); how the organisation treats the professional group; constraints in practice; management and service demands.
Other source	As 'Other definition'; anything which doesn't fit, to avoid ad hoc coding.
Personal background	References to family, childhood, upbringing, primary and secondary education. Cultural background. References to innate / learned values and morals. Implicit and assumed values, unwritten rules.
Previous employment (paid / voluntary)	References to any employment before starting in this profession.
Regulations as source	Codes, regulations, policy documents, standards.
Role models	References to individual or groups who are explicitly described as providing models (whether positive or negative). Can include peers – other students. Include references to norm setting within peer groups.

Code	Definition
<b>Examples of Professional / Unprofessional / Ambiguous behaviour</b>	
Appearance	References to specifics of appearance.
Clinical practice	References to clinical skills in the workplace.
Communication	Anything referring to verbal or non-verbal communication, language. Some references may be vaguer than others (eg 'politeness'), so judge whether definition or example. Include instances with patients and colleagues in clinical and educational contexts.
Conscientiousness	References to the sort of thing which may link to Conscientiousness Index (but not as restrictive). Timeliness, assignments, diligence.
Other example	Any specific behaviour which doesn't clearly fit into above

# Appendix F – Raw data giving examples of professional, unprofessional and ‘ambiguous’ behaviours

These quotes give further illustration of how participants described professional and unprofessional behaviour, as well as examples which were ambiguous or which illustrate the contextual dependency of professionalism. They expand upon the boxes included in the results section, and the headings reflect the codes used in the initial analysis.

## Demonstrating clinical knowledge and competence

### Professional behaviours

“I think sort of honesty and recognising your own limitations as well so if you’re struggling with something it’s about going I’m finding can I get some help from someone rather than just burying your head in the sand” (FG13, occupational therapy placement educator)

“Throughout the whole thing, just working when you’re supposed to work and ask for the help when you need it and clarification if you needed that, it’s very easy, you know, there’s the other side of it, slack off on the other page, it’s very easy to do that and not do the learning that you should be doing and blame everybody else when you fail” (FG5, paramedic classroom educator)

“Yeah documenting notes is definitely a skill that you learn on placement that does make you part of being a professional OT” (FG19, occupational therapy student)

“I think that’s going to be the same standard, that’s going to be a professional standard you can have the same standards of hygiene regardless of where you are just as an you know it wouldn’t be any different between clinic and someone’s home would it...” (FG16, chiropody / podiatry student)

“I think it is important because if you are not auditing the right information or like drawing out the right information from assessments, that’s important to share, then wouldn’t be very professional would it if you weren’t sharing the right information” (FG19, occupational therapy student)

### Unprofessional behaviours

“Poor standard of care, someone I know worked with somebody who refused to give a drug because it was a rectal drug so that’s poor standard of care” (FG11, paramedic student)

“...I followed him [chiropodist / podiatrist] on visits in and out of houses it was get in, get out, finish as early as I can, not checking if the patient’s medication had changed or anything like that down to really poor infection control with instruments [...] the whole time I was there he never changed his instruments, apart from the actual blade itself, he never changed his blade handles he used the same scissors for every patient...” (FG15, chiropody / podiatry student)

“Well a patient being dropped, not reporting things that should have been reported, you know, failing to disclose” (FG6, occupational therapy classroom educator)

“Not getting consent properly. Yeah, explaining like the side effects of a drug, you know, little things like that” (FG11, paramedic student)

“Not being aware of risks perhaps, you know, in a kitchen with a client without realising the consequences of leaving that client with a sharp knife or with a boiling kettle and them being quite frail and those sorts of things, that’s just about naivety” (FG6, occupational therapy classroom educator)

“I used to do a clinic where I followed this girl who was on the day before and the unit and the material it was just absolutely filthy and grubby, bits of all sorts in drawers...nothing getting tidy, it was all her values, no value set [...] So then you go in a bit early to tidy everything up and clean it because you knew that every time you went in the clinic it was going to be a mess, the young ones had left from the time before” (FG7, chiropody / podiatry classroom educator)

[when a neighbour or friend asks you for treatment] “Again from that professional point of view, you’d say no, come see me on Monday [...] even in your own home environment you’ve still got to show that kind of professionalism where no sorry, there is a line that you can’t cross sort of thing but I’m sure there is professionals out there who do that” (FG15, chiropody / podiatry student)

“Leaving the doors open on the back of the ambulance I hate that [...] it is a clinical error isn’t it you’ve got to be shut away, anyone can walk past [...] I don’t say it to them but I think that’s really unprofessional because it’s, you’re treating a patient there’s certain things you might have to do that might have to expose them and it’s just not fair on them” (FG9, paramedic student)

“Yeah, there was one story that was told by one of our lecturers who actually witnessed unprofessionalism amongst one of her work colleagues and it was somebody had been brought in drunk on an ambulance to A and E and what the paramedic had done was she’d covered the person and the girl was completely drunk and motionless so from anyone looking, would think that that was a dead body being brought in and that is a form of negligence and unprofessionalism and that person was reported as a result of that” (FG10, paramedic student)

### **Ambiguous behaviours**

“Well like a couple of shifts ago we’d both finished me and my crew mate this was about twenty five to seven and we finished at 6.30 and they gave us a job and we asked the manager, you know we’ve just finished and they said, oh it’s just round the corner... We ended up being two and half hours later off but I think it’s kind of going out of your way to help patients because technically we could have said no” (FG9, paramedic student)

“I don’t think you should be treated unprofessional if you want to get off on time because it is a twelve hour shift and sometimes I don’t get a lot of breaks...” (FG9, paramedic student)

“You can be over meticulous and you can be, not over professional but over kind of thorough and a lot of people like that they can spend two hours on a scene and I think there’s again, there’s got to be a point where you’ve got to say we are actually just here to treat what we seen and take to hospital or leave at home but some people do spend a lot of time on scenes...” (FG9, paramedic student)

### **Keeping up-to-date**

#### **Professional behaviour**

“... if you see someone actually reading current research and saying to you, did you know that they are thinking about introducing naran intra-nasally or something and you’d be like, oh that’s very professional, they’re keeping up to with current evidence, that’s a really important part of it” (FG11, paramedic student)

“I did a couple of shifts where I spent a couple of weeks with an emergency care practitioner, he was always reading bits of research and things like that and then my practice placement educator, if there is something he’s not quite sure on, you know, he’ll go back to the station, look it up and print it off and then read it and seeing people do that, you know, they want their knowledge to be as high as possible to make their patient care as current as possible and relevant and seeing that is really good” (FG11, paramedic student)

“I think if they are keeping on top of their subject, you know, their clinical sort of excellence and they’ve read a paper and they’re bang up to date and they know that absolutely new sort of thinking of things... they are bang up to date and you think wow, he’s on top form, he knows what he is talking about, you know he’s keeping up to date and that’s what I would say as being professional” (FG2, paramedic student)

“Some of them, who make it their business and do access stuff and do look at journals and do keep up to date” (FG18, paramedic classroom educator)

## Attitudes and behaviours

### Professional behaviours

“...I think where you say, you know, if you say you are going to do something, then you do it, you don’t just not do it” (FG19, occupational therapy student)

“...putting in the extra work when you are not getting paid for it, just from my experience from my parents, the way they act is quite professional because they are always putting in extra work...” (FG10, paramedic student)

“Yeah, it’s also from a student perspective, although there’s so much studying that we have to do and there’s lots of reading its remembering to have a break yourself... but again it kind of links into it even though as a paramedic, a professional, you’re looking at it differently but yeah, it’s how you manage your time” (FG12, paramedic student)

“I was thinking you know sometimes like our students, some students will kind of wait at the clinic door, they are told they can’t go into a clinic unless a member of staff is present so they will have the uniform on, get themselves ready and they wait at the clinic door to kind of go in... and others are always late but the ones that are late are always late” (FG7, chiropody / podiatry classroom educator)

### Unprofessional behaviours

“...you find some people will just cruise along and not do a lot within the station which doesn’t help the environment within the station” (FG1, paramedic student)

“If people are turning up late for work what are they going to be like going on a home visit or seeing someone in their home that it’s not conveying a good image to other people going to meetings and case conferences, it needs to be on time” (FG13, occupational therapy placement educator)

“Coming in late, you know habitually being late, not just the one occasion where it’s been difficult [...] and it’s the taking responsibility for that lateness so it’s ok somebody being late, really sorry I’m late, well you don’t even get sorry you were late, ‘I’m late’, ‘why were you late?’, ‘Oh it was because of somebody else’, it’s that sort of thing, it’s everybody else’s fault, it’s never me” (FG6, occupational therapy classroom educator)

“Sitting yawning or not taking interest, not asking questions or reading up on things, not being prepared, not showing any enthusiasm, those sorts of things come through regularly and sometimes that’s because a student has gone thinking that they are going to be educated and not that they need to participate in their education by doing so...”  
(FG6, occupational therapy classroom educator)

“Talking in class when, and quite clearly it’s inappropriate to be talking about whatever it is they are talking about you know, whispery, jokey, messing around, not talking about what we are supposed to be talking about, you know, not showing the insight that they’re there for a reason, that’s one thing”  
(FG6, occupational therapy classroom educator)

“County basics like time keeping and one of the huge things that we have at the moment is like with mobile phones and things, isn’t it, you know, using them at inappropriate times” (FG13, occupational therapy placement educator)

“You get a lot of them who will sit there and be like another job and you just think well yes, that you are at work or you walk in and think oh they’ve said the vehicle is ok so I’m not going to check it, you know, just in case, you know, straight when you think they can’t be bothered” (FG3, paramedic student)

### **Ambiguous behaviours**

“We’ve all got different ideas about what’s acceptable where mobile phones are concerned... I like to be at work and focus at work and so for me I prefer to have text messages to look at when I come home if I know something’s happening then at lunchtime but I realise that people have different situations, ill children might need to get hold of them or someone’s ill and that’s different” (FG13, occupational therapy placement educator)

“...I think you can feel that you haven’t been professional because you haven’t had the time to be professional so you know you should have seen, I don’t know, ten people in the last week but you’ve only seen four of them because you’ve had to do other things as well and you feel unprofessional and you know that that’s what you should be doing but you haven’t got the time to do it, it’s not like you’ve purposely gone out of your way to be unprofessional but you just can’t” (FG13, occupational therapy placement educator)

## **Overall communication**

### **Professional behaviours**

“Communication, that’s one of my key things, behaviour and communication in what differentiates a professional and somebody who is behaving unprofessional and I think that goes through everything they do, not just their work, it’s their communication”  
(FG18, paramedic classroom educator)

### **Unprofessional behaviours**

“...You know having a student who was unable to communicate effectively with a patient and was quite patronising and derogatory in her manner towards the client...” (FG14, occupational therapy placement educator)

“Their attitude generally, you know, you can pick on, if you are a caring person, which obviously we are because we’re in this profession, you know straight away when somebody is talking harshly to an elderly lady or gentleman, they may have learning difficulties, they may have dementia, things like that, it still doesn’t give them the right to talk down to them and things like that and generally if you are with an attendant or colleague, you pick up on it straight away and it’s a case of pulling them to one side and having a word, you know” (FG1, paramedic student)



“...two students I’ve had issues with it’s been communication and that lack of being able to communicate with patients or have any idea about what’s going on around them. I had one student that just used to sit in groups and after the group would discuss how the group had been and she just couldn’t tell me anything about how the patients have been. I tried to see whether it was me that was intimidating her, trying to get her to work with assistants but she was just [not engaged]”  
(FG14, occupational therapy placement educator)

“Flirting with patients, it does happen, because they’re in your trust and it would be like if you have an inappropriate relationship with a patient, obviously it’s a massive breach of that trust” (FG17, chiropody / podiatry student)

“I mean sometimes it’s just an MDT meeting because we have big personal meetings but the patients aren’t there... because the patients aren’t there I think sometimes the professionals forget and sometimes it’s terminology, how they described patients and they think it’s safe because it’s a team that they know quite well but then they forget that they might have students in and new people who have come in, you know and sometimes after a meeting we have to say, oh that’s just how they are when actually they shouldn’t be saying it in the first place... you know it’s a sentence about a patient which is quite derogatory like about their size or something which isn’t really relevant to anything and that can be a quite public meeting sometimes as well”  
(FG8, occupational therapy placement educator)

### **Ambiguous behaviours**

“...regarding speaking to patients and things like that, someone’s standards might be slightly different to your standards so as you mentioned, there’s a grey area then so that may fall from your eyes as being slightly unprofessional, in their eyes, they’re not”  
(FG2, paramedic student)

“...you’ve got to be careful about imposing your standards upon other people, you can’t live in a place like this, it’s scruffy, it’s dirty, it’s this, if they’re happy and that’s their choice then making them feel comfortable with that... somebody who actually says no I’m going to put a call in to a social worker because this place is substandard for living, is that then being unprofessional even though they are doing it in their patients’ best interest?, it could be argued that it is and, equally the same, if that person walked out and said no, they’re happy with it, it’s their choice they’ve got capacity to make that choice and you walk away, somebody else might come in and think you’re actually being unprofessional by actually not taking any further action with it so it is subjective”  
(FG2, paramedic student)

## **Communication**

### **Professional behaviours**

“Yeah, being clear and concise with telling the patient clearly what you like think their need to like would be their weakness and asking them do they agree with it and then coming to like an agreement and negotiating goals and stuff and being clear about them”  
(FG19, occupational therapy student)

“I think it’s learning to speak, personally I think it’s learning to speak to them at their level, I mean if you go into little auntie Mary, it’s no good spouting off all clinical terms and conditions, if she’s got a bad chest, tell her she’s got a bad chest, you know, not that she could have possible pneumonia or something, speak to them in a language that they can understand” (FG3, paramedic student)

“...listening to them as well because if you’re not like paying attention you might miss something that they are saying, it could be something really important about like someone has had a fall in the morning and maybe it’s not a good idea to do that walking session with them today because they are a bit shook up so it’s like listening and like being constantly aware of what’s going on like around you because obviously things change on a minute to minute basis sometimes”

(FG19, occupational therapy student)

“...you have to write your notes so that anyone can understand them but even the patient because the patient is allowed access to the notes...” (FG19, occupational therapy student)

“It’s your body language as well, like the way you come across and be interested in the person and not like looking off over the other side of the room, you know, it’s making sure you are paying attention to the patient with all the communication, not just what you say, but obviously what you say is also important because obviously there’s the basic stuff like not swearing and things like that that could offend people” (FG19, occupational therapy student)

### **Unprofessional behaviours**

“Not giving people time, some people just need time to explain and just, if I want to be showing respect... if I’ve had an interaction and I’ve just thrown a lot of information at them I just want to take a step back and say right so how’s that been for you or have you got any questions on that and just give people a chance to take control again and say right actually this is what I want because it’s so easy for us as professionals to think right this is what we need to do rather than thinking about what do they want from us”

(FG13, occupational therapy placement educator)

“...You know having a student who was unable to communicate effectively with a patient and was quite patronising and derogatory in her manner towards the client...”

(FG14, occupational therapy placement educator)

“I’ll tell you one of the things I think, you see, I might sound really old fashioned now which is going to be quite funny but I don’t even know if it happens any more but when I was a student, our first contact with our educator was we had to write a letter, we had to write them a letter... to our educator saying this is who I am... and you know there’s nothing worse than receiving an unprofessional letter from somebody written on a scrap of paper that they’ve pulled out of a notebook somewhere, you know, that’s really, you know, that’s really unprofessional” (FG13, occupational therapy placement educator)

“it [written communication] needs to be polite and respectful and appropriate in any situation, to me, when I get the students that email me, all in small letters and it’s got like kisses at the end and things like that, to me that’s really unprofessional [...] I always give them a talk at the beginning of every year that I don’t want them to do that because if they have to be disciplined or anything, that’s me that’s going to have to do that and I don’t want them to put kisses on their emails and it’s not appropriate and they still do it and so the ones that don’t take that on and still behave in, you know, that communication really makes a difference to me to whether I view them as being professional or not...” (FG18, paramedic classroom educator)

“I was on a placement when a new student faxed in something and they’d done it in text speak, see you later, and that to me didn’t come across as professional, somebody giving a bad impression before you even saw them” (FG13, occupational therapy placement educator)

“I started getting them [letters of introduction] all by email rather than through the post and now and some of them became so informal they were, it was almost like ‘Hi [first name] and oh I’m coming on placement and can you tell me a bit about it [...] I’m sorry but I’m of an age where I don’t like to be called by my first name by somebody that I’ve never met. I wouldn’t call a consultant or a senior manager in this hospital by their first name if I didn’t already know them...” (FG8, occupational therapy placement educator)

### **Ambiguous behaviours**

“it’s a difficult one because you want to obviously have a lot of information and you read up about conditions etc and at the end of the day it’s about seeing the person and using your, utilising your knowledge, you know, a very individual way by getting to know a person for being a person and it’s quite hard sometimes to get that right and you think about, oh I know I might come across as quite patronising or using the right terminology and how you use everything you non-verbal communication and your verbal communication as well” (FG13, occupational therapy placement educator)

“...should we write [in a report for example] ... they [patients] use expletives or inappropriate language in the situation or should you just be really quite clear cut about the language that’s used and it all comes back down to risk and how specific you should be about the situations and let other professionals know what’s going on” (FG13 occupational therapy placement educator)

## **Respect for patients and colleagues**

### **Professional behaviours**

“...he’d never come back and talk about patients or anything, I don’t think that’s because he was quiet, I think that’s because he was professional” (FG11, paramedic students)

“Obviously not sort of talking about the people so that the people can hear and making sure doors are shut and just simple things like that” (FG13, occupational therapy placement educator)

“A. I think the biggest thing really is when you actually see somebody show respect for the patient because that kind of stands out...”

“B. Yeah, has the time of day for them, not trying to rush them in, rush them out, next one kind of thing.

“A. And it’s not just around the actual clinical care, it’s just respecting them as a person, kind of sits very head and shoulders above other things” (FG17, chiropody / podiatry students)

“I think it’s just the way they interacted with the clients, the rapport they had but how they had the respect of the team and how they integrated in the team and just the passion for the job and enthusiasm really and just, you know, you could tell they loved doing what they did really” (FG13, occupational therapy placement educator)

“I was kind of thinking of relating to colleagues in meetings and things I think you know giving everyone a chance to speak and valuing everyone’s opinion because I think in our team... they do value everyone’s opinion but I know I’ve been in situations before where it was the OT who we listened to what they’ve got to say, oh it’s just the physio and you know that’s not important kind of thing, so you know respecting everyone’s opinion” (FG13, occupational therapy placement educator)

“Well you know my team leader, he always asks your opinion of everything and he always appreciates anything you do for him, anything. He always thanks you for it and he always values your opinion and if he thinks your idea is better than his he’ll use your idea”  
(FG4, paramedic student)

## Treating people equally

### Professional behaviours

“...you’ve got to treat everyone equally, I mean say even if you go to someone who has just murdered someone else, you’ve still just got to treat them just as a person and don’t worry about any of the other things in their life”  
(FG10, paramedic student)

### Unprofessional behaviours

“I mean I’ve had, when I’ve been driving I’ve had my crew mate that has just had enough of the patient in the back has come and sat in the front with me on route to hospital... like if a patient stinks or something they’ll just come and sit in the front” (FG9, paramedic student)

“I get so embarrassed when I’m driving and you’ve got the attender and they’re not speaking and you’ve got to, I don’t understand if people don’t speak to patients, how do you find out anything if you don’t speak to them, it’s literally that is all we’re doing”  
(FG9, paramedic student)

### Ambiguous behaviours

“But it is quite hard when you’ve done a job where you’ve had a real abusive, you know, maybe kicked out and then you go to your next job and it’s the same and you go and you get the same again, it doesn’t happen all the time but it does happen where you’ve been Saturday night, Friday night, whatever, you’ve had a load of abuse and then you go to the next one and because you’ve had it 20 minutes, you go in with a professional [attitude] but then everybody does it, you do get a bit agitated” (FG3, paramedic student)

## Appearance

### Professional behaviours

“And its jewellery as well, we were talking about wearing jewellery like crosses and stuff, fair enough if that’s your faith but if you are meeting other clients, you’ve got to push your own judgements and morals aside and be more aware that that might offend someone of a different culture” (FG19, occupational therapy student)

“I tend to keep very plain what I do wear, just plain colours if I’m dressing in my own clothes and I don’t wear jewellery”  
(FG19, occupational therapy student)

“...being appropriately dressed, you can’t necessarily say smartly dressed because it’s not really appropriate to go to a sports session in your best finery or your heels or whatever, but yeah, you dress appropriate to what you are doing and where you are working”  
(FG19, occupational therapy student)

### Unprofessional behaviours

“Dressing appropriate to context, you know, if we are going to be doing certain activities in a classroom situation, moving and handling, things like that and people are, you know... wearing heels and false nails... low tops” (FG6 occupational therapy classroom educator)

“...you know when they [students] have slipped or they think they can get away with that bracelet in clinic or with hair coming round over the shoulder or any one of us would say no that’s not professional go and sort it out”  
(FG7, chiropody / podiatry classroom educator)

“There’s lots of rude things etc on those types of t-shirts and tops. Then I wouldn’t think that would be a professional thing to do even though it’s outside of your nine to five, Monday to Friday life” (FG6, occupational therapy classroom educator)

“...they’ve [students] got the knowledge but it’s when they do turn up in their jeans and their, you know, love bites on their necks which we just had fairly recently that you just think why do I have to start and explain to somebody why a love bite is not appropriate”  
(FG8, occupational therapy placement educator)

“If you walk in there [to a patient’s house] and you’re unshaven and your shirt’s hanging [out], your shirt looks like you’ve slept in it for a week... hands in pockets”  
(FG5, paramedic classroom educator)

### **Ambiguous behaviours**

“I suppose it’s the same about make-up, you know, should you have a little bit of make-up on but, you know, sort of being really heavily overdone and the kind of messages that gives”  
(FG13, occupational therapy placement educator)

## **Uniform**

### **Professional behaviours**

“I think like the old school ones seem to more, like better with the uniform... they always have the boots polished” (FG3, paramedic student)

“...I wouldn’t dream of now going into the NHS and turning up in a pair of jeans and a t-shirt and treat somebody, it’s just not something you would think of, even if I was stuck out in the wilds in the middle of nowhere, I would still turn up in a uniform because I would want people to see me as a professional”  
(FG15, chiropody / podiatry student)

“...uniform has to be clean, pressed, you know, hair tied back, no big chunky jewellery”  
(FG15, chiropody / podiatry student)

### **Unprofessional behaviours**

“I’ll give you an example, you know, we have this uniform now which we’ve had for two or three years, [there are] people on the road with the uniform they [have] had [for] five years, totally different... so I blame the management for letting that person wear the uniform, that’s an old uniform, they should be wearing this”  
(FG3, paramedic student)

“...you get people switching them [epaulettes]. I mean there is a person in management at a station who will wear the wrong epaulettes and they’re a manager, someone you look toward... she’s like not doing her job by not wearing her epaulettes because you can’t go to her as such because you think she is the same level as me, there’s no point talking to her... I think that’s wrong”  
(FG9, paramedic student)

### **Ambiguous behaviours**

“When you’re in your own time, it’s your own time, you know, you’re a different person then, you should set like when you go out to work, you should be, you know the professional paramedic that you are and that’s expected of you but when you’re not, you know, back into your what you feel [your private time] I don’t think you should go around in your uniform committing crime, that’s not what I’m on about” (FG10, paramedic student)

“If I was the type of person who didn’t shave and wore my shirt hanging out and slouched around all the time, I would have a different view, I would think that somebody who comes in with their polo shirt pressed and his trousers pressed and his shoes polished I would think a bit square, you know, but that’s, you know, whereas he might think that I was unprofessional so it’s very much where you start from really”  
(FG5, paramedic classroom educator)

## Public health

### Unprofessional behaviours

“Well I think grossly overweight don’t you. Paramedics especially. I think that’s extremely unprofessional because we are kind of promoting, well I think as self care professionals we are promoting healthy lifestyle and we turn up and they’re horrendously obese, you know, and the patient is just going to look at you and just go oh what on earth is that” (FG9, paramedic student)

“Well there’s people I work with and you know you do get terrible jobs like what we would call one under where someone’s trapped underneath a train and you do physically have to get under the train to treat them to find out what their problems are, to see if they’re conscious or to see if they’ve died already... they [overweight colleagues] wouldn’t physically fit down there who then you’re compromising the patient’s health in a way” (FG9, paramedic student)

### Communication in context

#### Ambiguous behaviours

“what I sort of struggled with is who makes that judgement because what’s inappropriate for one person is not inappropriate to another and an example of that, I’ve been to a patient’s house where someone has said to us I don’t like being called that... I don’t like being called darling and stuff like that so is that inappropriate behaviour or might someone, you know not mind being called that and in their age group they might think that is totally appropriate or in someone else’s age group it’s the patient that makes that decision for you” (FG2, paramedic student)

“[A] level 2 student introduced the patient to me by the patient’s first name, you know. Now I imagine it probably wasn’t, well I don’t know, but I but it may not have been the patient saying to the student call me Jane or you know, or call me Willie. It may have been the student saying to the patient do you mind if I call you Jane or Willie, you know and I personally don’t think that’s appropriate. If a patient says to the student, please call me Jane or Willie then that’s fine but I don’t think it’s right for the student to say to the patient do you mind if I call you such and such. But that’s what happens nowadays” (FG7, chiropody / podiatry classroom educator)

When you go to the GP’s surgery, you know, and you maybe see the practice nurse, you know, very often they’ll call you by your first name even though they haven’t asked. Now I know they probably see it as trying to be friendly and, you know, but it’s what you consider professional isn’t it whether you consider it acceptable or not” (FG7, chiropody / podiatry classroom educator)

“Sometimes you go into some patient’s house and you call them by their second name because you know if you call them by their first name you’re being too familiar and it’s unprofessional. You learn that very quickly” (FG4, paramedic student)

“But like with unprofessionalism, you know, like we said about joking, that is a, I’ve spoken to loads of paramedics and that is their way of coping, like making a really bad situation better because they are probably, I don’t know, the next day they are going to have to see the same thing again and if they didn’t joke about it, then it’s just going to drag them down but then there is times where you say it as well and who you say it to, like to work colleagues, it’s not as bad because they are probably going through the same emotion but to the family or to the patient, I think it can be quite unprofessional” (FG10, paramedic student)

“You drop your patient off at hospital, deliver your patient after a really bad complicated job or harrowing job and you come out and you crack on with the guys and chat about it even make jokes about it” (FG5, paramedic classroom educator)

“We have a very black sense of humour. You have to though because if you didn’t you’d end up killing yourself... an outsider looking in would think my God you’re joking. They really would... it’s a defence mechanism, it’s a coping strategy... if the public saw that they would say that would be very unprofessional” (FG4, paramedic student)

“...the occasional joke within the education setting is fine but you couldn’t continually do that because you would be undermining your professional appearance whereas in other situations you could be more relaxed perhaps” (FG6, occupational therapy classroom educator)

“It is difficult for us and it’s difficult for students because it can get confusing because we’ve got again a young client who works on black humour and you know jokes and some of that and it’s hard for, because sometimes you do joke with people and if you step back from and listen to it it’s not PC but it’s how they’re dealing with their injury...” (FG8, occupational therapy placement educator)

## Boundaries

### Professional behaviours

“...I mean you have different relationships with clients to one you have with a family member of a friend, it’s you know making sure you’re not disclosing too much, I behave different with my friends than I do when I’m in work so it’s setting that boundary and saying well this is, you know, this is appropriate, this isn’t, clients don’t need to know how old my children are or whether they go to school, you know, what my dog’s called” (FG8, occupational therapy placement educator)

“As a person I’m quite sort of, you know, I’m happy to give a lot of information, you know, maybe I shouldn’t say that, you know, but I’m sort of reigning in what I say and think it should become more, I think because I initially think nobody is going to do anything bad with it, with information that they might have, but you don’t know that so you have to protect yourself and your family, that sounds really sinister but you know...” (FG19, occupational therapy student)

### Ambiguous behaviours

“the people I was working with were seeking out communication in different ways shall I say and just trying to find those ways to build up a therapeutic relationship with someone and you wanted to get to know people sometimes you have to just try and see things from their point of view and then that kind of questions you know am I, you know, am I overstepping the mark here, particularly how I use like my sense of humour” (FG13, occupational therapy placement educator)

“I think I’ve put that about not being a friend to somebody and that’s a difficult boundary and it’s difficult for students to learn the difference because you’re being friendly with somebody and you’ve had a conversation but you’re not their friend as in that different level of kind of information” (FG8, occupational therapy placement educator)

“...because we work with a younger client group as well and we get to know them for quite a long period of time, but I think also years ago when you didn’t have mobile phones and you didn’t have email and the internet and Facebook. I think there is the boundaries again you didn’t give out our telephone number to anybody, you didn’t give out your home address but I think because people see Facebook as not being your personal details, but people see it as a detachment from their own... sometimes our

patients will give their Facebook information to students who then find it difficult to say I can’t take this” (FG8, occupational therapy placement educator)

## Accepting gifts

### Ambiguous behaviours

“There are rules governing things like patients giving you gifts but how, you know, how you deal with that, it’s like you’re not allowed to accept gifts from patients or you’re not allowed to do something which may be seen as leading to you treating somebody favourably than somebody else” (FG19, occupational therapy student)

“Yeah because it depends on the setting, like some you can do it where you accept it as a team gift, a gift to the team so then it’s not singling out anybody individually but it depends what it is as well to what the gift is and what rules are in different places” (FG19, occupational therapy student)

“I think it is one thing, you know, sort of a family giving the ward a box of chocolates or flowers whatever to say thank you and a card but if you are working in another setting where people might be considered quite vulnerable, for them to come along and give a gift, if they give you money or anything that you can see is putting them at a loss, it’s not a case of being able to accept it for the team, you have, you know, as much as they want to give it to you, they’re putting themselves in detriment to do it, you can’t accept it, you know, you just have to say that” (FG19, occupational therapy student)

“...when it’s appropriate just if somebody offers you, you know, a bag of boiled sweets to, oh thank you very much I’ll have one of those to where they’re actually giving you quite a personal gift and it’s not just like a box of sweets for the whole team when the person is discharged from your service. It’s how to deal with that” (FG8, occupational therapy placement educator)

“...there isn’t a notice up, there isn’t a clear sign in a department to say please don’t give these things and I think when patients come and they’ve thought about something they’ve wanted to buy you then you feel it’s a personal insult to them if you say no and it’s a really awkward situation and again it’s not always clear in departments anyway to say you can or you can’t isn’t it” (FG8, occupational therapy placement educator)

“We don’t know how many take money from patients and don’t tell. Not that we have a problem with that if a patient was to give a, if a patient wants to give a student a tip, they can. We don’t have any rule to stop it... it’s usually a couple of quid and a hairy humbug” (FG7, chiropody / podiatry classroom educator)

## Maintaining professionalism

### Ambiguous behaviours

“But it is quite hard when you’ve done a job where you’ve had a real abusive, you know, maybe kicked out and then you go to your next job and it’s the same and you go and you get the same again, it doesn’t happen all the time but it does happen where you’ve been Saturday night, Friday night, whatever, you’ve had a load of abuse and then you go to the next one and because you’ve had it 20 minutes, you go in with a professional [attitude] but then everybody does it, you do get a bit agitated” (FG3, paramedic student)

“We’re only human, you can’t be like happy and joking 24 hours a day, I mean you’re going to have bad days, we’re all human, we’ve all got things going on in our lives and there’s going to be times when you are with a patient and you are not going to be as professional as you would be if you were having a good day kind of thing, like you might rush a treatment or you might be ignoring them a little bit, not being as engaged in conversation with them, things like that” (FG14, occupational therapy placement educator)



“Twelve hours on the road and then ten minutes before you’re due to finish your mate’s not in to take you off and you get a late job. I think we’ve all been on a job where you can say someone’s took a shortcut” (FG4, paramedic student)

“It’s just human nature that though isn’t it. Because we’re human after all like aren’t we when it comes down to it. It doesn’t matter how professional you are we’re humans.” (FG4, paramedic student)

“We have to hand over that responsibility to educators in practice and in the past they haven’t always been clear as to whether to expect the student to follow what’s expected in the workplace or allow them to be a student with quite sloppy habits and we had to speak to some people, you know, they were saying things like, well, you know, I’ve passed so and so but I wouldn’t employ them and we’re having to say well actually you’re the gate keeper to the profession and there’s an expectation, why are you passing that person, we would like you to fail them if you are saying they are unprofessional” (FG6, occupational therapy classroom educator)

## Outside work

### Ambiguous behaviours

“If you bump into one of your patients... I think that might be different if you bump into a patient, you’d have to say ‘Oh hello’ and you would have to try and look sober and but apart from that, you don’t think about your job when you are out and about do you” (FG15, chiropody / podiatry student)

“I think patients need to understand as well that we’re not podiatrists 24/7, we do have other lives, I mean any professional, no matter what you are doing, you’re not 24/7, you’ve got a life” (FG15, chiropody / podiatry student)

“Well, physically assaulting people or things like that... I know that you are still bound by things from the HPC whilst you’re not at work but it’s I think that one’s a little bit even more of a dilemma because somebody could complain about you and really just have an attitude about you or an opinion about you and I do think staff need to be aware of that but where does it stop? If you went out to the local pub and you were walking home and you couldn’t walk in a straight line, is that unprofessional or is that just you being out socialising, you know, I just think there’s a bit of wave running grey line here now of where the line is drawn but yeah, I think the exceptional rules... if you have been assaulting somebody and have been accused and done for any sort of custodial sentence, yes, we wouldn’t want those people being paramedics” (FG5, paramedic classroom educator)

“I can understand that on social networking sites where you’ve got you in your uniform and then in the next photo it’s you drunk or in a fight or something, that’s when I think that doesn’t look good but if it’s just you, obviously not a picture of you in your uniform, I don’t see why that’s, I mean like I have a [relative] in the forces and on [their] social networking site, [they’ve] got [them] in uniform and when [they’ve] gone out and yet they’re very accepting of that but we’re not” (FG10, paramedic student)

“When I was at university Facebook was sort of flagged up as a big no no when we were on placements, we were told we weren’t allowed to even mention we’re on placement... there had been some incidents in the past where people had sort of mentioned educators or said or complained about what a horrible time they were having and it just obviously the message that gives for the people it comes across as very unprofessional...” (FG13, occupational therapy placement educator)

“It’s a minefield [social networking sites], it’s there, use it at your own discretion and it’s entirely up to you and be it on your head if you do something that you will later regret” (FG14, occupational therapy placement educator)

“I think it must be hard for them to flip that switch between I’m at Uni and I’m still a student OT but I’m not at Uni, I’m kind of in the work place and yeah my behaviour’s got to be different but how much different...” (FG8, occupational therapy placement educator)

“We have to hand over that responsibility to educators in practice and in the past they haven’t always been clear as to whether to expect the student to follow what’s expected in the workplace or allow them to be a student with quite sloppy habits and we had to speak to some people, you know, they were saying things like, well, you know, I’ve passed so and so but I wouldn’t employ them and we’re having to say well actually you’re the gate keeper to the profession and there’s an expectation, why are you passing that person, we would like you to fail them if you are saying they are unprofessional” (FG6, occupational therapy classroom educator)



Park House  
184 Kennington Park Road  
London SE11 4BU

tel +44 (0)20 7582 0866  
fax +44 (0)20 7820 9684  
[www.hpc-uk.org](http://www.hpc-uk.org)

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