
RESEARCH ARTICLE

Knowing about and Performing Professionalism: Developing Professionalism in Interprofessional Healthcare Education

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Abstract

Professionalism, and the ways in which it can be developed and maintained, has a high profile in today's health and social care climate. It is becoming increasingly important that higher education institutions develop ways of making teaching about the concept explicit; yet, teaching professionalism can be challenging for a number of reasons. Constructs of professionalism frequently represent character traits and attitudes rather than behaviours, which by definition makes them difficult to teach and potentially problematic to learn. Students of the School of Rehabilitation Sciences (RSC) within the University of East Anglia (UEA) have been using a Professionalism Charter since 2011. The purpose of the charter is to define the construct of professionalism for RSC students, to provide a tangible framework around which professionalism can be structured, to enable students to map changes in their professional attitudes, behaviours, knowledge and skills and to highlight areas for development. Evaluation of the charter has demonstrated that it is helpful in providing a reference point for best practice. Refinements are necessary, but the indications are that it has the potential to facilitate students' understanding of (knowing about) professionalism and provides them with opportunities to actively engage (perform) in practice.

Keywords: professionalism, charter, health and social care, education

Introduction

Healthcare practitioners are committed to behave in a professional manner expressed within codes of conduct and ethics, laws, guidelines and frameworks set out by the relevant professional and regulatory bodies. Furthermore, there is considerable UK legislation to regulate healthcare practitioners and ensure high-quality care for service users (Department of Health 1998, 2000, 2006a,b, 2007, 2009). In addition, the NHS Constitution (Department of Health 2012) sets out seven principles for the NHS underpinned by core values. One of these principles stipulates that 'the NHS aspires to highest standards of

excellence and professionalism' (Department of Health 2012, p3). There is no definition of professionalism supplied in this document but the tacit understanding is revealed in the ensuing statements, which stipulate that care should be of high quality, safe and effective, being delivered by staff who offer dignity and respect and whose education, training and development allow them to do so. Health and social care provision is reviewed by the Care Quality Commission (CQC) and their key findings continue to highlight that in some environments people may still be treated with lack of respect and that care has become 'task-based' (CQC 2012, p8). The report from the Commission on Improving Dignity in Care for Older People Commission on Improving Dignity in Care for Older People (CIDCOP) (2012) reinforces the idea that compassionate, sensitive and person-centred care is central to professionalism. CIDCOP also states that universities must satisfy themselves that applicants have both the academic qualifications and the compassionate values needed to provide dignified care. There is, therefore, a very clear mandate for higher education institutions to prepare students adequately to enable them to deliver these expectations and aspirations. Whilst it may seem a straightforward task to expect students to absorb attitudes that prioritise dignity, compassion and respect through a process of professionalisation, it is not quite as simple as first appears.

The primary note to make is that there is no universally accepted definition of professionalism. In western cultures it is regarded as a theoretical construct (van Mook *et al.* 2009b), which is subject to change and revision (Evetts 2003). Whilst there is a strand of opinion that views professionalism as an ideology serving political and market needs (Evetts 2003, Hodges *et al.* 2011), our focus here is on professionalism as a value system. Within this stream of thought, writers have commented on character traits or attributes and behaviours or acts (van Mook *et al.* 2009b) as well as the fiduciary relationships required of health practitioners (Howe *et al.* 2010). The Ottawa Consensus on medical professionalism (Hodges *et al.* 2011) concluded that the topic needs to be approached from a number of levels: the individual, inter-personal and societal/institutional. At the individual level it is the attributes (innate or learned) that are important. At the inter-personal level it is the behaviours in a particular context and within a particular relationship that are important. The societal/institutional level is more akin to professionalism as an ideology, which is not the focus of this article.

Among writers who take the value-based stance, there has been renewed interest in the idea that the concept of professionalism must be explicitly taught (Cruess & Cruess 1997, Cruess & Cruess 2006, van Mook *et al.* 2009c) and assessed (van Mook *et al.* 2009d). Many authors have identified the importance of formal educational curricula in developing professionalism in doctors (Gordon 2003, Hilton & Slotnick 2005, Shapiro *et al.* 2006, O'Sullivan & Toohey 2008, van Mook *et al.* 2009c). Evidence from these studies of doctors indicates that teaching professionalism is challenging. It is difficult to define and since it is often regarded as an abstract construct it is difficult to observe and, therefore, to assess (Cruess *et al.* 2004, O'Sullivan & Toohey 2008, van Mook *et al.* 2009a,b). Developing professionalism among allied health professionals has received rather less attention but where research has been carried out, the conclusions are similar (Kasar & Muscari 2000, Lindquist *et al.* 2006). Studies within the medical profession suggest that learning about professionalism requires long-term experience and reflection on the contexts in which behaviours and attitudes are demonstrated and the moral/ethical reasoning that motivates action (Gordon 2003, Hilton & Slotnick 2005, van Mook *et al.* 2009d).

The Health and Care Professions Council (HCPC), the governing body for 16 allied health professionals, has published a report on the first phase of a study which sought to develop an understanding of professionalism within HCPC regulated professions. The findings of this qualitative study resonate with the recommendations for medical professionalism in

that there is a suggestion that professionalism, in essence, should be regarded as a meta skill that draws heavily on the ability to make wise judgements in different contexts. The report authors recommend that further work be undertaken to develop professionalism as the manifestation of dynamic judgement (HCPC 2011).

An educational response

The School of Rehabilitation Sciences (RSC) at the University of East Anglia (UEA) has developed an educational response to the way that professionalism is handled within the curricula. The school has programmes for the professions of Occupational Therapy, Physiotherapy and Speech and Language Therapy. Commentators such as Jha *et al.* (2007) and van Mook *et al.* (2009c,d) have made recommendations which can be summarised as follows:

- There needs to be an explicit and generic definition of the concept of professionalism.
- Professionalism needs to be taught and assessed throughout the curriculum.
- Professionalism should be considered as a process rather than a fixed construct.
- Amendments are needed in the curricula that are designed to facilitate attitudinal and behavioural change.
- Professionalism needs to be taught and assessed in multiple ways.

Cruess & Cruess (2006) suggest that situated learning theory, using authentic practice-based activities, is the most appropriate way to develop professionalism in students. A balance should be provided between explicit teaching and experience to transform knowledge from the theoretical to the useable and useful (Cruess & Cruess 2006). This fits most closely with the view of professionalism as an interpersonal process (Hodges *et al.* 2011). This perspective draws on the idea that attributes and behaviours are important, but these may be dependent on the people, the situation and the context involved. It is therefore too complex a thing to measure professionalism by psychometric scales; rather, multiple methods of assessment are required including observation, mentoring and reflection, with more emphasis on formative than on summative learning (Hodges *et al.* 2011). Situated learning theory emphasises the importance of the environment in which learning occurs and the role models involved. The emphasis on context and situation within these two viewpoints, then, may take into account the effect of the hidden curriculum on professionalism, i.e. the organisational structure and cultures that may influence learning (Karnieli-Miller *et al.* 2010). For example, an organisation that places a heavy emphasis on high academic achievement may encourage students towards behaviours that enable them to pass assignments and ignore learning that is not assignment related. It also embraces the informal curriculum in which the interpersonal processes that occur between students and faculty, practice educators and patients provide students with tacit learning about professional working (Karnieli-Miller *et al.* 2010). Role models can be positive when they exemplify high professional ideals, for example, and the educational environment can be actively supportive by the extent to which it commits to professional learning in the timetable. The reverse may also occur where role models are poor and negative messages sent out by an educational institution (Cruess & Cruess 2006).

With this in mind we reviewed the ways in which learning about professionalism was embedded in the UEA curricula and identified four strands: specific teaching on professionalism, socialisation, clinical experience, and the assessment of professionalism. This exercise revealed a significant amount of teaching and assessment on the subject, but these were often indirect and might not be easily identified as such by students.

A UEA Charter

In 2002 the medical profession successfully introduced a Charter on Medical Professionalism prompting the generation of our own University of East Anglia Charter. The conceptual model we now have can be described as a web with the four previously noted strands linked by the Professionalism Charter. The Charter aims to:

- Define the construct of professionalism for RSC students.
- Provide a tangible framework around which professionalism can be structured.
- Enable students to map changes in their professional attitudes and behaviours.
- Highlight areas for development.

A preliminary Charter of Professionalism was generated using the principles from the Charter on Medical Professionalism (2002) and other related literature identified by using key authors on the topic (ABIM 1995, Kasar & Muscari 2000, Swick 2000, Evetts 2003, Cruess *et al.* 2004, Frank 2005, Hilton & Slotnich 2005, Royal College of Physicians 2005, Project Team Consilium Abeundi van Luijk SJe (2005), O'Sullivan & Toohey 2008, Blue *et al.* 2009, van Mook *et al.* 2009a,b,d). The characteristics of professionalism provided by these researchers were pooled and then analysed for commonality. Those characteristics that were repeated a number of times may be regarded as the consistently recognised knowledge, skills and behaviours through which people demonstrate their professionalism. Just as the medical profession has used a charter to highlight what professionalism should mean to doctors, so these characteristics were used to identify the concept for students at the School of Rehabilitation Sciences. The important elements of professionalism include values, attributes, behaviours, skills and knowledge. The Charter on Medical Professionalism (2002) refers to the components as 'responsibilities'. This seems an appropriate term since it reflects the personal accountability of individuals to embody them. At this stage, 20 such responsibilities have been identified (Table 1).

The UEA Charter has been written so that it complements and extends other related guidance on student conduct such as the *Guidance on conduct and ethics for students* (HCPC 2010). It also reflects the NHS values of respect and dignity, commitment to quality of care, compassion and striving for excellence (Department of Health 2012).

Students are expected to accumulate evidence of their growth in respect of each of the responsibilities within their continuing professional development portfolio. In accordance with situated learning theory, we provided details about the way in which UEA defines professionalism (the responsibilities). We then provided opportunities for students to perform professionalism and then to reflect on their experiences. These opportunities occur to a large extent within practice education, where students work under the supervision of a qualified practitioner. Students are expected to collect a mix of self-assessed and other objective evidence. This could be wide-ranging including a reflection about a patient/student interaction where compassion was particularly in play, an audit of record keeping or an observation, with feedback, of a clinical skill by the supervisor. We also wanted students to keep in mind that they should be practising professional skills during university-based activities and asked them to reflect on their feedback from assignments, their behaviour in the classroom or to engage in discussions with their advisor about pertinent topics, for example. In addition, students are encouraged to have regular voluntary meetings with their personal advisor during the academic year and one obligatory meeting at the end of each year. The purpose of this required professional development meeting is to review the student's progress in relation to the elements in the Professionalism Charter.

Table 1 AHP professionalism charter.

Derived from analysis of	Charter on Medical Professionalism (2002), American Board of Internal Medicine (ABIM) (1995), Kasar & Muscari (2000), Frank (2005), Royal College of Physicians (2005), Project Team Consilium Abeundi van Luijk SJe (2005)
Responsibility	Description
Honesty and Integrity	The ability to be fair, truthful to keep one's word and be straightforward
Empathy and Compassion	The ability to be sensitive and respond to the feelings and behaviours of others
Altruism and Respect for others	The ability to demonstrate a commitment to patients, the profession and society through ethical practice
Trustworthiness and Dependability	The capacity to demonstrate reliability and honouring commitments
Initiative	The capacity to create and initiate ideas
Judgement	The ability to make wise decisions
Confidentiality	Appropriate safeguarding of the disclosure of patients information
Maintain appropriate relationships with service users	The commitment to avoid inappropriate relationships with patients or their carers
Professional presentation	The ability to present oneself in a manner acceptable to clients, peers and colleagues
Co-operation	The ability to work effectively with others, honouring commitments and being loyal to decisions made
Organisation	The ability to systematically manage tasks, manage self and manage others
Responsibility	The commitment to having responsibility to society, to the profession and to self
Commitment to Improve	The ability and will to strive for excellence
Competence	Commitment to competence in technical knowledge and skills, ethical and legal obligations and communication skills
Effective verbal communication	The ability to share information with clarity and quality of content
Effective written communication	The ability to communicate information clearly and concisely in written form
Self-awareness	The ability to be insightful, particularly about the state of one's knowledge, skills and behaviours
Supervision	The ability to modify performance in response to meaningful feedback
Reflective practice	The ability to reflect on own behaviour and the underlying dynamics and to develop learning as a result
Clinical reasoning	The ability to analyse, synthesise and interpret information

The style of the meeting is one of mentorship, where personal advisors are expected to guide the student on their personal journey towards professionalism. The combination of experience, reflection and mentoring is considered essential in the development of the student's innate qualities and the acquisition of professional responsibilities that can be learned (Cruess & Cruess 2006, van Mook *et al.* 2009d, Hodges *et al.* 2011). Prior to the meeting the student should have reviewed the responsibilities and evidence that have been accumulated. They should have rated themselves on a 'red/amber/green' (RAG) scale that is relevant to the stage of education.

- **Red** = indicates an area that requires development.
- **Amber** = indicates that there is no or little evidence of meeting the responsibility but there is nothing to suggest that there is a problem.
- **Green** = indicates that there is sufficient evidence of achievement.

A final professionalism profile is agreed at the end of the meeting (see Figure 1).

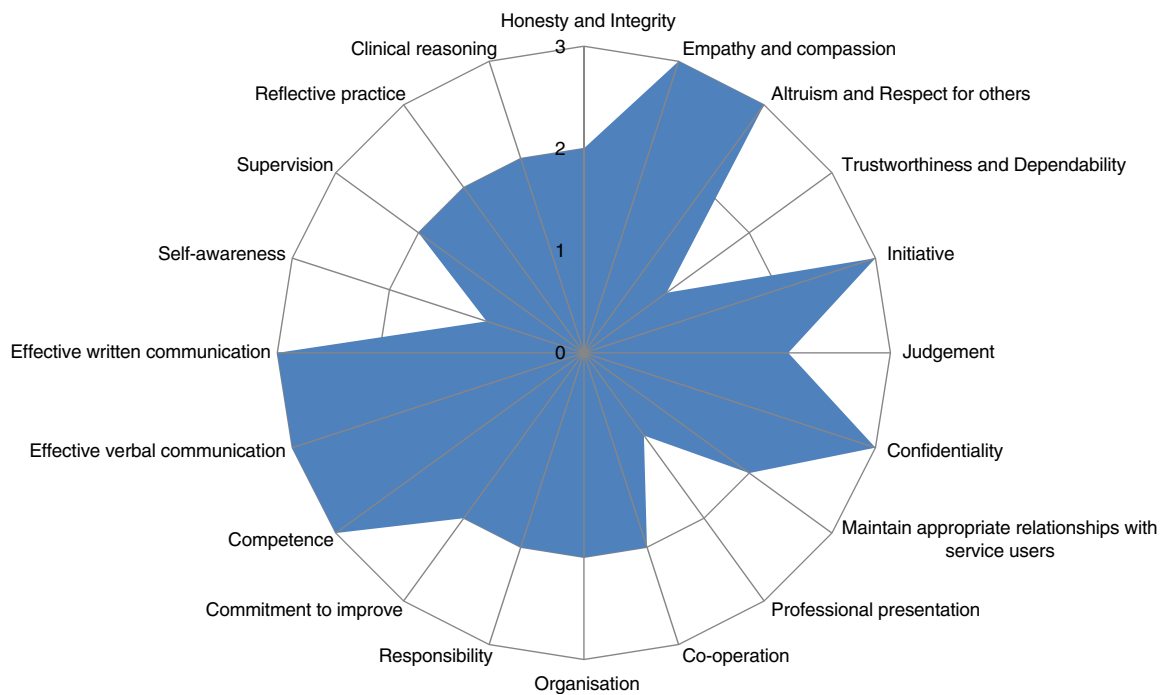


Figure 1 An example of a professionalism profile at the end of year 1.

Evaluation

Jha *et al.* (2007) reported that the evidence for how professionalism is promoted and measured in education is scant. We believe that evaluating the ways in which the innovation of the charter may monitor professionalism in students will add a valuable contribution to the evidence base. The charter was introduced to a cohort of BSc Occupational Therapy, Physiotherapy and Speech and Language Therapy students in 2011. The preliminary evaluation was undertaken as part of the usual quality monitoring systems at the UEA and ethical approval was not required. It took place at the end of one academic year and included:

- a student survey;
- faculty feedback via a workshop;
- exploratory statistical analysis of student professionalism profiles.

Student survey

The cohort of students was asked to comment on the usefulness of their professional development meeting and on their experience of using the Professionalism Charter. The responses indicated that 83% had found the meeting to be useful. The free text comments revealed that the meeting had helped them to develop their understanding of professionalism and ways in which to use reflective skills to tease out new insights.

Students appreciated having a system in place to document recognition of achievement and a structured way of plotting their academic journeys of learning and professionalism. In addition, they valued being able to plan ahead for the following year, with an advisor from the same professional background.

Faculty feedback

Faculty feedback was undertaken during a regular Advisor Workshop, where the aim is to monitor and review the UEA advisory processes. Approximately 23 members of faculty attended (82%). Faculty were asked to discuss how the Professional Development Meetings had gone in the academic year 2011–12 and to raise any issues about the Professionalism Charter. Responses were collected on a flip chart, collated and a summary of comments was sent to faculty for further consideration. There was unanimous agreement amongst attendees that the charter was a worthwhile initiative. The structure of the professional development meetings was regarded as being conducive to constructive dialogue, which was a good mechanism for developing the concept of professionalism. However, this type of meeting requires dedicated time and preparation from both parties. There was a realisation that the role of the advisor was to provide guidance on evidence being presented by the student to facilitate a discussion and assist the student in rating their performance. In effect, advisors need to fulfil the role of a critical friend.

Exploratory statistics

An overview of the RAG ratings across all professional groups showed that a sample of 64% (n = 53/83) of participants had completed the self-assessment and had had the discussion with their advisor by the point of evaluation: 64% (n = 21/33) Occupational Therapy (OT); 95% (n = 19/20) Physiotherapy (PT); and 43% (n = 13/30) Speech and Language Therapy (SLT). Using a comparison of total scores across the 20 professionalism domains, there were no significant differences between the professions (ANOVA $p = 0.446$). This indicates that at the end of Year 1 of training, the ratings achieved by each profession were similar and that the self-assessment was being interpreted in a relatively consistent manner. The requirement for the self-assessment to be discussed with an advisor is therefore an important part of the mechanism for completion and through which to address known limitations of self-assessment (Elnicki & Zalenski 2013). From a total possible score of 60, mean total scores (SD) recorded were 47.29 (± 5.87); 48.94 (± 9.94) and 45.08 (± 8.64) respectively for OT, PT and SLT. Charts of the individual responsibilities showed some interesting discrepancies. For example, no SLT or PT students achieved a green rating for the responsibility of clinical reasoning (Figure 2). One explanation might be that clinical reasoning is not made explicit in Year 1 for SLT students. However, it does form part of the curriculum content for PT and OT students and therefore no clear appreciation of a reason for such low scores is available. These discrepancies led to considerable discussion about how these elements had been rated.

For other responsibilities, such as competence in practice, it was clear that faculty had different ideas about what counted as evidence. Whilst we needed to have gone through this stage to reach our current stage of thinking, the following points emerged:

- It is almost impossible to interpret the reasons for the different levels recorded.
- We have a rating scale that is insufficiently sensitive.
- We have a rating scale that is unlikely to show progression or professional development.
- We need to evolve the process into something that will produce more meaningful results.

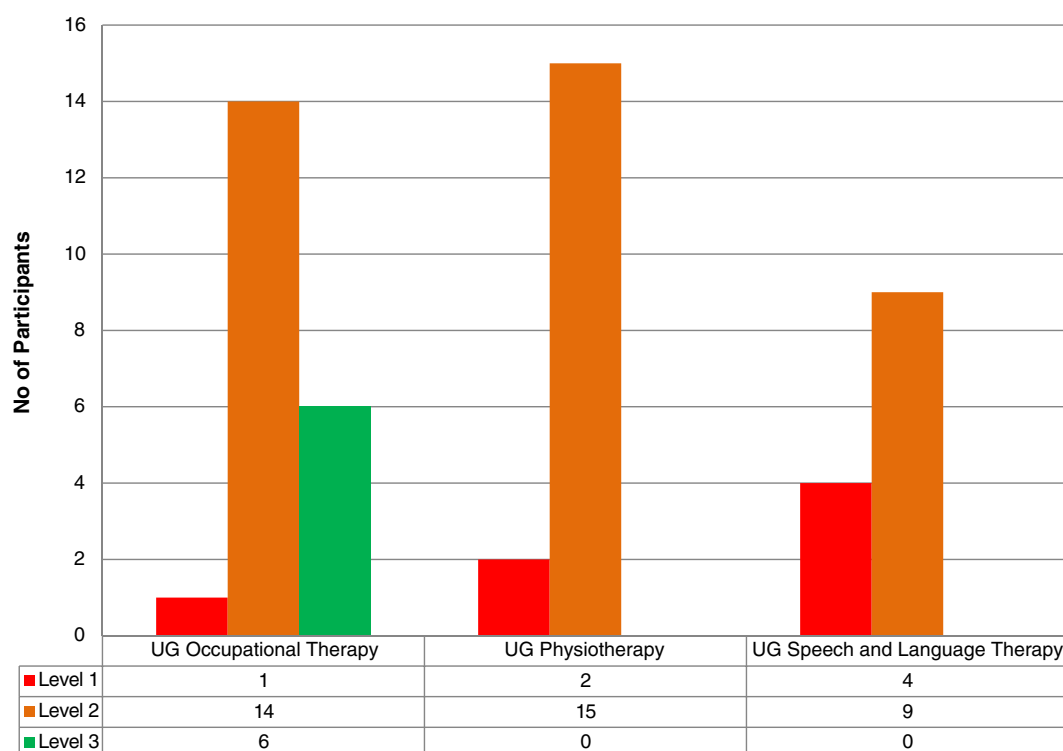


Figure 2 Clinical Reasoning ratings by profession.

The implications of the results of this analysis led us to consider how the Professionalism Charter should be developed.

Firstly, the professional development meeting builds on an established student–advisor relationship. However, we need to clarify and agree the role of the advisor in implementing the Charter and advisors need to be familiar with the mechanism. The essential point is that we are aiming to reach an agreement about the student's achievements, but it is primarily the student who is evaluating their own professionalism. The advisor can ask pertinent questions through which to promote the reflective process, so that the student is guided in developing the skill of linking their own evidence to each of the responsibilities to show levels of attainment.

Secondly, there should be more frequent opportunities to bring the Charter to the attention of students and, as a result, for them to monitor their progress during the academic year. We are planning to introduce café-style sessions at strategic points in the year where students can discuss informally, with peers and Faculty, their ideas about professionalism. We are also looking at ways to use university media sites such as Blackboard, Twitter, SMS texting or Facebook to prompt students to think about the topic. This is consistent with recent thinking expressed by professional bodies that we should engage in professional conversation to keep the concept alive (Fairbrother 2012b).

Thirdly, the Red, Amber, Green (RAG) rating needs to be modified. Initially, we tried to develop a more sensitive instrument that would show progression over the three-year course duration. However, it quickly became apparent that it would be difficult to show 'more' of what is essentially a value such as honesty or altruism. Some responsibilities such as clinical reasoning, written communication or competence, are skills that can be built upon, but most are things that we would expect to be maintained and used consistently in different situations rather than developed. This required a re-think about what we were trying to achieve and the terms used to convey this.

There have been multiple efforts to measure professionalism, including psychometric scales, checklists, objective structured clinical examination (OSCE), self-assessment, portfolios or reports completed by supervisors, but the reliability and validity of these methods are variable (van Mook *et al.* 2009b). Things like attitudinal scales can be useful, but someone with a poor attitude can perform professionally whilst someone with the 'right' attitude can (in a particular context) behave unprofessionally (van Mook *et al.* 2009d). The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report 2013) found that people who had been through professional education demonstrated failure to maintain their professionalism in a Trust where poor practice had become the norm. It is therefore important, if we are to have a mechanism through which professionalism can be evidenced, that we carefully consider and develop a practical and effective way of doing so.

The initial attempt at introducing the Professionalism Charter has raised a number of practical questions about how to define and measure a construct as varied and individual as professionalism. This does not mean that it is not possible, merely that, if it is attempted, it needs to be developed and evaluated carefully. van Mook *et al.* (2009b) used a framework proposed by Miller (1990) to show the importance of developing factual knowledge of a topic in the early years of medical education before demonstrating performance in daily practice. If this is to be applied to professionalism, it is necessary firstly to decide the criteria to be set for establishing the standards to be appraised (not assessed), so-called 'norm referencing' (van Mook *et al.* 2009b). This is what we believe we have done via the Charter. Appraisal then becomes a matter of requiring students to show that they can move from knowing about professionalism norms to performing them in practice. Multiple methods need to be employed. The process needs to happen throughout the student's education, with adequate opportunities for monitoring and guidance. Reflection and feedback are paramount. Having a charter and a system that necessitate that students produce evidence of their professionalism through a portfolio would fulfil these requirements. Further assessment of professionalism occurs at UEA through assignments specifically designed to test understanding of the concept. It also occurs in observations of professionalism during practice education. All of these methods, using different people to undertake the appraising, in different contexts, over a long period, help to triangulate the appraisal, making it more likely that the appraisal will be more accurate (reliable) and appropriate (valid) (van Mook *et al.* 2009b). Our task now has become clearer. We need a system that allows students to show their professionalism in the early years, through discussions and examples of how they may (or have) demonstrated a responsibility, which would then move on to more (in terms of quantity and variety) occasions where professionalism can be evidenced through tangible means. The RAG rating will be retained but we will provide more detailed guidance about the type and level of evidence that would be most helpful. We also need to take account of the situation and context in which professional acts take place, in addition to the learning climate and the relationships between student and faculty, student and health professional and student and patients. This will shed more light on the perceptions of professionalism held by organisations and the people within them, which are likely to influence our students (Hodges *et al.* 2011).

Conclusion

The Professionalism Charter is a promising instrument that has the potential to document students' professional performance, representing their own knowledge and experience of the concept. The unique quality of this tool is that it allows the individual to reflect on and choose their evidence, and make their own interpretations of how this corresponds to the specific responsibilities of the Charter. The role of the advisor is critical in assisting students to develop and internalise appropriate attitudes, knowledge and behaviours.

We have demonstrated that the Charter has inter-professional use and applicability in Occupational Therapy, Physiotherapy and Speech and Language Therapy programmes and have reason to suppose that it would be appropriate for other programmes of professional education. Furthermore, this model of mentoring students through their professional development resonates with clinical supervision that occurs in the workplace and so could easily translate into the schema of appraisal that is standard practice for practitioners.

The work continues. We are trying to refine the rating scales and the implementation and monitoring of the process of providing students with opportunities to experience and reflect upon their professionalism. We are currently undertaking another study to assess the extent to which the UEA interpretation of the meaning of professionalism harmonises with that of the Health and Care Professions Council and the early findings are promising. The Francis Report (2013) noted that healthcare professionals generally graduate with high professional ideals but when faced with a culture of poor practice these are difficult to maintain. We believe that usage of a Professionalism Charter by large numbers of people will help to build more resilient professionalism in the healthcare professionals of the future by providing an overt benchmark for people to gauge their level of performance.

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