Professionalism as explored through UK regulatory documentation

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Abstract

Professionalism is a complex phenomenon. Nevertheless, there are common influences when considering 'professionalism' that apply across professional groups regardless of individual beliefs, experiences and drivers. One of these influences are the requirements set out by regulatory bodies; these affect how professionalism is developed in learners and influence the behaviour of 'practitioners'.

The aim of this study was to conceptualise professionalism using regulator-produced documents that articulate professionalism requirements and subsequently inform curricula.

Qualitative methods were employed; their purpose being contextualisation, interpretation and understanding. Document and thematic analysis techniques, which were informed by the theoretical position of Pragmatism, were used to analyse the requirements for educational attainment of a range of professionals.

The analysis identified that professionalism has been conceptualised by each regulator as a multi-faceted phenomenon. There were however, elements of commonality in thematic content and in the way regulators have conceptualised professional attributes: Patient/service user focus; Regulatory focus; Practitioner focus. Document analysis permitted problematisation of working with different educational goal formats in relation to professionalism. This included challenges in determining attainment and the risk of losing sight of the complexity and richness of complex phenomena in mechanistic compartmentalisation.

Understanding themes identified from the documentation can inform the development of a framework that could be utilised to influence curriculum structure.

The challenges created for education providers by the current format of educational goals are most likely a reflection of the complex nature of professionalism, rather than the failure to conform to accepted educational formats.

A recommendation from the study would be adoption of a 'standards' format of educational goal, which may address the challenges that have been identified and be more appropriate for describing professionalism. This would however require wider collaboration in determining guidance for how providers may demonstrably satisfy quality assurance processes.

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Chapter 1. Introduction

1.1 Background

In the university environment, the study of medicine and dentistry is subject to external quality assurance by the relevant national regulator, in addition to academic regulation. This has led to an integral necessity for education providers to ensure their programmes deliver learning opportunities, teaching and assessment which satisfies dual requirements of the professional regulator and university progression (Pyle, 2012, Crain, 2008, Newble et al., 2005).

Demonstrable professionalism is an expectation of health care profession regulators for both those in training and registrants. There is an expectation from the public that the clinicians they see will demonstrate professionalism, both on an individual level, and in representing the profession as a whole. Individual practitioners have a personal responsibility to appreciate and uphold these expectations. Taking these aspects into account, 'professionalism' is justifiably a high priority for those involved in planning and delivery of undergraduate training on clinical courses.

Despite intense interest and investigation, challenges are apparent when considering the content and boundaries of professionalism. Education providers can face challenges when managing professionalism within the curriculum. Unlike a clinical skill, professionalism is not easily classified and a scale of objective requirements cannot be applied and translated to a grade. Likewise, unlike academic knowledge, a series of written papers cannot easily be devised to assess depth of understanding and practical application. On review of the literature in this area, what rapidly becomes apparent are the challenges associated with curriculum design and implementation of aspects associated with professionalism, in particular in the area of assessment.

1.2 Contextualisation of the synergistic nature of academia and policy

The approach adopted in this research has its foundation in the belief, held by the researcher and wider research team, that in order to further develop elements of the curriculum, including design of tools to confirm, record or demonstrate 'professionalism', first we must understand the profound complexities and challenges surrounding this phenomenon. This includes critical analysis of the resources, which are already available, and which influence our understanding of aspects of professionalism. Only following comprehensive

understanding of the phenomenon, together with an appreciation of the positive aspects and any difficulties presented by the currently available resources, should further attempts be made to design and deliver 'solutions'.

Further, academic enquiry, where investigation and reporting of findings follow a robust methodology and rigorous processes, should, we consider, be driving forward progress towards understanding the phenomena of professionalism. Future development of policy and regulation should be research informed, and strong collaborations between research in academia and regulators promoted (Bateman et al., 2019a).

1.3 Structure of this Thesis

By conceptualising professionalism from the perspective of an education provider, the intention with this research is to progress understanding in this area and provide recommendations to underpin future curriculum professionalism requirements. To that end, the starting point for this research was a narrative review, exploring professionalism in relation to clinical education described in the current literature, this is found in Chapter 2. There is a substantial breadth of published literature, so an appreciation of what was there aided the identification of areas warranting further focused consideration. This process highlighted challenges facing education providers, particularly in terms of assessment. However, rather than attempting to develop a new assessment, the focus of this research was to gain better understanding of the phenomenon of professionalism from the perspective of the education provider. The rationale was that greater understanding underpinned any future development in the area of education and development of the professional.

Refining the research question came next with consideration of the most appropriate methodology, presented in Chapter 3. This included the rationale for the conceptual approach and the specific methods employed. The pragmatic stance lead to an initial focus on policy and governance documents. Thematic analysis of the General Dental Council 'Standards for the Dental Team' (2013c) document demonstrated the complexity and diversity of what it is to be a 'professional' in the context of dentistry from its UK regulator. These findings are presented in Chapter 4. To build on this, and apply a specific education focus, a section of the General Dental Council 'Preparing for Practice: dental team learning outcomes for registration' (2015a) document was analysed. What became apparent during 'outcome' analysis was that the format used to express professionalism goals created challenges from an education provider perspective. This lead to further document analysis of the format used by the regulator to express professionalism goals. These findings are presented in Chapter 5.

In order to deliberate alternate formats of expressing ‘professionalism’ educational goals, and whether these present a more favourable or practicable approach for the end-user, consideration was given to professions outside of dentistry. The original scope was widened to analyse documents produced for education providers by four other professional regulators. These findings are presented in Chapter 6.

The focus of Chapter 7 is bringing together the research findings and presenting recommendations for regulators when preparing documents that contain professionalism requirements. Further interpretation of the findings then informed development of an idealised construct of professionalism, as implied within regulator documentation.

Chapter 2. Understanding professionalism through the Literature

In undertaking the following narrative review, the intention was to aid my understanding of the phenomena of professionalism in relation to its application in clinical education. A further aim was to gain insight in respect of the current approaches to representation of requirements in relation to professionalism, management of professionalism in the curriculum, and any challenges that had been identified.

In addition to appreciating the range of published literature related to professionalism, there was recognition that this study would be carried out through the lens of an educator. Once the research focus was refined to include how educational requirements in respect of professionalism were expressed, it was necessary to understand in wider terms, the way in which educational requirements and guidance are presented. In essence, what constitutes accepted convention and would be considered current good practice.

2.1 Professionalism

2.1.1 What is professionalism? A definition?

A simplistic definition of professionalism is found in many dictionaries and whilst accurate, provides little assistance in its practical application;

> *'Professional quality, character, or conduct; a professional system or method. In early use freq.: the characteristics of a particular profession; (now usually) the competence or skill expected of a professional.'* (Oxford English Dictionary)

This definition of professionalism, by relating it to the actions of a professional provides little guidance or support in actually defining what the concept includes. The original professions were law, medicine and the clergy; entry into a profession was defined by the mode of training and preparation which contributed to the candidate's knowledge acquisition and socialisation into that occupation (Eraut, 1994). There was a shift from a focus on socialisation, effectively an apprentice model, towards greater standardisation and regulation. Now, entry into these professions has become more formalised; there are specified pathways together with standardised processes. These structures and processes are frequently regulated at a national level, by national regulatory bodies.

2.1.2 Theoretical ideal or practical application

There has been a range of approaches within the medical education literature attempting a definition of professionalism, these are generally split between the development of a

theoretical construct of professionalism and development of a practical definition (van Mook et al., 2009). Unfortunately, some reports of a 'definition' are expressed as multiple paragraphs of broad desired outcomes or theoretical ideals, for example that reported by Swick (2000). One of the nine behaviours which Swick (2000) described as contributing to a definition of medical professionalism is reproduced below;

> *'Physicians adhere to high ethical and moral standards. The concept that professional work has a moral value compels the physician to behave ethically in his or her personal and professional life. Long embedded in the ethos of medicine are principles of beneficence and nonmaleficence.' (Swick, 2000 p. 614)*

Whilst this descriptor is likely to be considered accurate in a characterisation of what a professional will do, this approach does not assist in recognising professionalism or identifying how it could be assessed. Indeed, Ginsburg et al. (2004) observed that abstracted definitions are difficult to apply in every day settings, so there is no practical application. The lack of ability to predict professional behaviour has been linked to much published work considering professionalism as a set of 'virtues, values and characteristics' which are extremely difficult to observe or quantify (Stern et al., 2005).

2.1.3 The importance of context

Context is an important consideration when thinking about 'what is professionalism' (van Mook et al., 2009, Martimianakis et al., 2009). It can impact to such an extent that 'it depends on' becomes the answer to most scenarios. A specific scenario may change dramatically dependent on context: the specific-situational information, the institutional norms and values, other social pressures and influencing factors. In reality, statements about professionalism as applied to practice subtly shift from capturing an ideal state to something that can be managed and is considered reasonable. For example, the social pressure to act in a certain way has been described as an influencing factor in how students may behave at certain times (Rees and Knight, 2007), but does this mean that conforming to this equates to professionalism?

Concern has been expressed (Martimianakis et al., 2009) that the drive to 'define' professionalism has resulted in a narrowing and simplification of this complex area and that it is actually something which is '*socially constructed in interaction*' (Martimianakis et al., 2009 p.835) and cannot be viewed without considering the social, political and economic realities and priorities of each situation. As a set of values, behaviours and relationships, arguably, the best consensus on what constitutes professionalism, is a collection of

characteristics or common themes which recur whenever the topic is reviewed (Zijlstra-Shaw et al., 2012).

A conceptual model of dental professionalism has been developed by Zijlstra-Shaw et al. (2013). The authors developed this using semi-structured, open-ended interviews. They included both dentally qualified (dentist and dental care professionals) and lay participants, there was a range of dental experience represented including specialists, general practitioners and students. These research findings are consistent with the current literature in both dental and wider medical fields. The authors summarise professionalism as socially constructed, and that this construct is multifactorial and context dependent. The model contains tacit and overt aspects of professionalism, for example self-awareness and trustworthiness (tacit), responsibility and accountability (overt). How this understanding of professionalism can be translated into practical application, was piloted in a later evaluation of an assessment model which was developed and implemented for one cohort of students in one U.K dental school (Zijlstra-Shaw et al., 2017). Good internal reliability and validity were reported. Whether the findings of use of this model are generalisable to other settings and curricula is unknown.

2.1.4 No consensus agreement can be achieved

Recognising the challenges of forming a definition, less emphasis is now placed on research trying to formulate one unifying descriptor, and a move toward understanding what is needed within specific contexts. One approach has been to acknowledge that a definition is required, but that this only needs to be agreed within the institution or group who will be using it (Cruess, 2006). This level of specificity addresses the problem of setting boundaries for students and helps clarify 'levels' of expectations, whilst acknowledging that a consensus will not be possible. This approach of an institutionally agreed definition has been supported by O'Sullivan et al. (2012b) and included in the AMEE guide (O'Sullivan et al., 2012a) as a way of supporting professionalism integration into the curriculum.

2.1.5 Knowledge, Skill, Attitude or Behaviour?

Where professionalism sits in the knowledge, skills or attitudes debate is widely discussed in the literature. Kearney (2005) concluded that professionalism was an 'attitude' and considered the components as 'qualities' as opposed to 'responsibilities'. No definition of an attitude was provided in this paper, although reference was made to the fact that attitudes are ambiguous and complex. Professionalism has also been described as an 'action' rather than 'knowledge' (Wilkinson et al., 2009). Although at first glance these seem to be different

descriptors, they convey a comparative fundamental impression – that of doing what should be done because it is 'right', rather than, in the case of undergraduate students, because it is what is expected and what will gain the 'correct' assessment result.

The qualitative research conducted by Zijlstra-Shaw et al. (2013) resulted in four themes emerging. These were that i) Professionalism is a 'second order competence', ii) the expression of professionalism is dependent on context, iii) reflection is a necessary component, iv) professionalism encompasses both tacit i.e. 'used without conscious awareness' and overt personal characteristics (Zijlstra-Shaw et al., 2013). The first point raises challenges in terms of assessment, if professionalism is something that only occurs when doing something else (a first order competence), how do you separate the first action when it comes to assessment? Will the assessor be biased by the result and performance in the first order competence when it comes to assessing professionalism?

2.1.6 A static definition?

Whether the expectations of what defines professional behaviours or beliefs change over the course of an undergraduate programme has been another topic of much debate in the literature. The evolutionary journey of a student in different stages of 'professionalism' has been described by Monrouxe et al. (2011) as a transition from 'acting' to 'representing' and finally reaching the stage of 'becoming'. This paper and another by Hilton and Slotnick (2005) presented the concept of phronesis as applied to professionalism; practical wisdom. Hilton and Slotnick (2005) considered that professionalism was an acquired state, which takes a number of years to attain whilst developing required skills and knowledge and gaining experience, rather than a trait.

Some investigations have shown that the number of problems arising through unprofessional behaviour decrease as the student progresses through the course (Howe et al., 2010). This has been explained by a number of different possibilities, including 'proto-professionalism'; students' progress along the learning curve and come to better understand the institution and profession expectations, together with the higher stakes involved later in their student careers. Again, this highlights the importance of context and possibly the influence of regulation and assessment on the development and impact of professionalism. Another consideration is pseudo-professionalism; displaying behaviours not consistent with underlying attitudes, i.e. acting the part, however this is more difficult to maintain, particularly in unplanned or stressful situations (Howe et al., 2010).

The idea of developing a professional identity is another concept discussed (Hafferty, 2006, Martimianakis et al., 2009, van Mook et al., 2009). An identity characterises what a person does and the way in which they relate to others (Hilton and Slotnick, 2005). Hilton and Slotnick (2005) considered that development of identity is a product of two simultaneous processes: attainment and attrition. Whether or not this is the way an identity is developed, it does raise useful considerations when it comes to facilitating students in their development.

Professional identity is an area of growing interest in clinical education research. As with many of the other areas discussed in this section, a large proportion of the literature has a medical foundation. A simple Medline search (run on 15.03.19) for 'professional identity' and 'dental student' had 6 results, as opposed to 156 results when the word 'dental' was substituted by 'medical'. In their schematic representation of professional identity formation and socialisation, Cruess et al. (2015) discussed the dynamic nature and the different factors affecting identity formation in the sphere of medical education. There are individual, relational and collective aspects (Cruess et al., 2015, Vignoles et al., 2011). In medical education, many schools have adopted a 'White Coat Ceremony' to promote professionalism and professional identity formation (Swick et al., 1999, Irby and Hamstra, 2016). In the UK, at least one dental school has implemented a variation of this, a 'Dental Scrubs Ceremony' (Neville et al., 2018). In this iteration, in addition to the symbolic function, additional educational elements were incorporated with an aim to 'teach' elements of professionalism, these received a mixed response from student participants (Neville et al., 2018).

2.1.7 Has professionalism changed?

There have been many articles published in the clinical education literature on the teaching, development and assessment of professionalism, and a seemingly greater emphasis on aspects of 'soft skills' in the training environment (Gonzalez et al., 2013, Manogue et al., 2011, Hodges et al., 2011). There are also a number of articles in the UK dental press about the perceived changing skill set of today's new dental graduates (Cabot and Radford, 1999, Gilmour et al., 2018, Oxley et al., 2017).

With the increased level of interest, investigation and report of 'professionalism' in clinical education literature, one consideration is whether what is meant by 'professionalism' has changed over the decades. Are there 'new' or different expectations of new graduates in terms of professionalism that have changed over time? From a personal perspective and when talking with colleagues, in terms of the values associated with professionalism of new graduates we would argue 'no'. However, what has changed is the range of considerations

when professionalism is discussed, in part due to the social context and the move towards digital media. Social Media and digital professionalism is now a high priority in clinical education and use of social media amongst students is high (Kenny and Johnson, 2016). Students need to be aware of the potential consequences of digital media and be equipped to be able to manage this appropriately and be accountable for their actions (Ellaway et al., 2015). In addition, to this, social media is used as a teaching medium in many programmes, so appropriate engagement and awareness of digital identity is also important (Kind et al., 2014, Neville and Waylen, 2015). Regulatory bodies have produced guidance documents for social media use (General Medical Council, 2016a, General Dental Council, 2016a), as have indemnity providers, there is also inclusion of this area in regulated-produced student fitness to practise documents (General Dental Council, 2016c, General Dental Council, 2016b).

Further, in terms of the changing social context, there appears to have been an increase in reporting about litigation, the reported 'fear' culture and 'defensive dentistry' (Al Hassan, 2017). There is an increasing body of literature reporting the impact of anxiety, stress and burnout in the dental profession (Collin et al., 2019, Chipchase et al., 2017). When considering all of these aspects, it appears that whilst the expected values for new graduates in respect of professionalism have not changed, the climate they practice in may have.

2.1.8 Why do we need to teach, assess and understand professionalism?

Professionalism is not a fad concept which Universities have latched onto as the next great idea. It is a fundamental cornerstone for the role in which we train for, a requirement by the regulator and an expectation of the public. Unlike many undergraduate courses, the study of medicine and dentistry are subject to external regulation. The relationship between 'professionalism' and 'regulation' is a challenging one to define. 'Professionalism' is a requirement of our profession by the regulator, but the concept goes beyond simple regulatory requirement and encompasses an 'ethos' considered to be an expectation by the public and peers.

Regulatory Bodies

In medicine as within dentistry, there has been a move from implicit understanding to overt reference of the role and necessity of professionalism in the curriculum. Since the shift to outcome-based education (Oliver et al., 2008, Harden et al., 1999), there has been an emphasis on the outcomes that are achieved by the end of a programme of study, as opposed to the journey that has been travelled. This has been reinforced by the requirement of many external regulatory bodies for education providers to demonstrate attainment of specific

learning outcomes by assessment. This would imply that 'professionalism' can be classified in a similar way to other elements with learning outcomes, for example clinical skills and demonstrable leadership and management abilities. However, the question arises as to whether it is as simple as this would suggest.

Within UK undergraduate dental curricula, the publication of the General Dental Council document 'Preparing for Practice' (General Dental Council, 2012), placed additional emphasis on the importance of professionalism in the 'safe beginner' by making it one of the four domains to be achieved. This increased the explicit reference to a greater extent than the previous regulatory document 'The First Five Years' (General Dental Council, 2008). There is a requirement to demonstrate satisfactorily that all learning outcomes categorised as 'professionalism' have been achieved for the award of a dental degree and professional registration. The role of 'professionalism' is therefore a priority in terms of understanding the constituent elements and key to designing successful undergraduate courses and assessments. The requirement to teach, demonstrate and assess professionalism is in no way unique to dental programmes, similar challenges and requirements face undergraduate 'professional' courses: medical, nursing and midwifery programmes. National regulatory bodies outlining the requirements of a new graduate entering the profession, is mirrored in other countries (Australian Dental Council, 2016).

The General Medical Council (GMC) has advisory guidance in terms of professional behaviour and attitudes. Despite this being advisory rather than mandatory, there is specific reference to compliance in quality assurance reports of medical schools and the General Medical Council and Medical Schools Council (2009) have stated;

> *'... given that the GMC has to be satisfied that graduates applying for registration with a licence to practise are fit to practise, it would be surprising if a medical school thought it sensible to disregard this guidance.'(General Medical Council and Medical Schools Council, 2009)*

A practical list of expectations was published; this clarified what the Council would consider as unprofessional (Table 2.1).

Breach of confidentiality
Misleading patients about their care or treatment
Culpable involvement in a failure to obtain proper consent from a patient
Sexual, racial or other forms of harassment
Inappropriate examinations or failure to keep appropriate boundaries in behaviour
Persistent rudeness to patients, colleagues or others
Unlawful discrimination

Table 2.1 Unprofessional behaviour or attitudes (General Medical Council and Medical Schools Council, 2009)

This list is interesting on two specific counts, firstly that behaviour outside the workplace is not explicitly listed, and secondly that the list is rather extreme in level of behaviour or attitude that would be considered 'unprofessional'. This may be a reflection of the difficulty in 'quantifying' and gaining agreement on what is acceptable or not.

Once qualified, revalidation is now a reality for doctors in the UK and North America. Part of this includes explicit outcomes relating to professionalism. This requirement to achieve specific outcomes, like when considering undergraduate requirements, seems poorly aligned to the theory that professionalism is complex, context dependent and socially constructed.

Guidance by specialist bodies

Guidance produced by the American Dental Education Association (ADEA, 2009) provided six value-based statements for defining professionalism in dental education. The Association of Dental Education in Europe have similarly produced areas of competence for graduating dentists in respect to professionalism (McLoughlin et al., 2017). How professionalism can be integrated into the curriculum has also been the focus of articles by the Association of Medical Education in Europe (O'Sullivan et al., 2012a). These articles therefore make the assumptions that professionalism learning can be integrated into the curriculum and that assessment can be undertaken.

2.2 Assessment

Assessment is a means of determining how well a learner has achieved educational goals following a process of teaching or instruction (Reece and Walker, 2007). The General Dental Council in 'Standards for Education' define assessment as:

> *'the process or exercises which measure and record a student's progress towards achieving the learning outcomes necessary for completion of their programme and registration as a dental professional'* (General Dental Council, 2015d p.8)

The learning outcomes referred to in the above quotation are those in the 'Preparing for Practice: Dental team learning outcomes for registration' document (General Dental Council, 2015a). From a quality assurance viewpoint, assessment is therefore a way of demonstrating requirements have been attained. In terms of new clinical professionals, summative assessment has been described as a way of demonstrating competence to satisfy performance and competence requirements (Wass et al., 2001).

In designing any assessment the following criteria are considered: Reliability, Validity, Feasibility and Acceptability (van der Vleuten, 1996). As assessment is also widely recognised to drive future learning, the design of any assessment should therefore take this into consideration (van der Vleuten et al., 2010).

2.2.1 Why should we assess professionalism?

The need to assess 'professionalism' has been a key concept in the literature for many years. Investigations have shown occurrences of 'unprofessional' behaviour in both students (Howe et al., 2010) and qualified physicians are low (Papadakis et al., 2005). However, the potential consequences of not assessing professionalism and not taking action with students who show 'unprofessional' behaviour came to the forefront when Papadakis et al. (2005) published their findings of a retrospective study looking at those physicians who had had disciplinary action brought against them by medical boards. Their findings linked these physicians to previous unprofessional behaviour in medical school. This study was a wider scale of a previous study performed by Papadakis et al. (2004) and resulted in findings consistent with those previously reported. Although the validity of the extrapolation of these results has been questioned on occasion, Prasad (2011) wrote about the study design and subsequent ability to interpret predictiveness, it is highly likely that there is a link between an individual's behaviour as a student and their subsequent behaviour when qualified.

2.2.2 Assessing professionalism

Miller (1990) acknowledged that due to the complexity of professional services delivery by a physician, no single assessment method would be suitable. The framework for clinical assessment he proposed was a pyramid. The base of the pyramid, the 'knows' could be measured by objective tests, but on its own, knowledge is inadequate for a practising clinician. Knowing how to use that knowledge, which may include acquiring, interpreting and translating to have sufficient knowledge, skill or judgement for a particular function, is the next section on the pyramid (Miller, 1990). The top two sections of Miller's (1990)

pyramid contain the 'Shows How' and 'Does' stage of learning. It is these sections that will represent the behavioural aspect of professionalism, where the earlier 'Knows' and 'Knows How' represent the cognitive phase (Goldie, 2013). Within the assessment of professionalism, all levels should be considered and the tools used should be appropriate to the level of assessment on Miller's pyramid. It is also an opportunity to consider the educational goals that fall within the 'Affective domain' of Bloom's taxonomy. This taxonomy comprises three hierarchical models which permit classification of educational learning objectives. The Affective domain considers values and the perception of value issues, from initial awareness to analysis (Krathwohl et al., 1964).

The challenges of assessing professionalism are varied, but are widely acknowledged in the literature (Hodges et al., 2011). The lack of a definition has been a major cited factor (Zijlstra-Shaw et al., 2012), as has the concept of whether professionalism is a behaviour, or an attitude (Aguilar et al., 2011). An attitude is '*a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour'* (Eagly and Chaken, 1993 p.1). The response is a behaviour which has both direction (favour/disfavour) and an intensity. Aguilar et al. (2011) discuss the challenges of assessing attitudes, behaviours and values. In their paper, they stressed their belief that a consistency was required between those professional attitudes taught in the curriculum and those that are assessed. Ginsburg et al. (2004) highlighted that the legitimacy of an approach of assessment, reliant on observable behaviours, is dependent on two critical assumptions. The first is that assessors have a common set of standards for what constitutes 'professional' behaviour. The second is that a student's behaviour is an index of willingness/ability to adhere to these standards. van Mook et al. (2009) argue that if we only assess professional behaviour, this inadequately and inappropriately represents the wider concept of 'professionalism'. This is in support of many other authors where there is a concern that demonstrating an outward appearance of professional behaviour will allow graduation, but may not take unprofessional attitudes into consideration. This is highlighted in the 'Inner Values' versus 'Outer Conduct' debate (O'Sullivan et al., 2012b, van Mook et al., 2009).

Given the complexity of 'professionalism' and the uncertainty of interpretation and assessment, there has been a shift in recent years toward concentrating on the demonstrated behaviours that can be assigned as professional traits. The Conscientiousness Index (McLachlan et al., 2009) was developed eleven years ago for use in medical education. This Index focuses on a scalar measure of traits linked to conscientiousness in students, which was validated by the judgment of their clinical teachers. There is evidence to suggest that lack of

conscientiousness can be related to unprofessional behaviour in later medical practice (Stern et al., 2005).

2.2.3 Different methods of assessment

There appears to be a consensus that individual episodes of assessment are inadequate when assessing aspects of professionalism or professional competence with a suggestion that a longitudinal approach should be considered (Goldie, 2013, Hodges et al., 2011, van der Vleuten and Schuwirth, 2005, Zijlstra-Shaw et al., 2012). O'Sullivan et al. (2012b) also emphasised the importance of triangulating findings and using multiple assessment tools prior to making a judgment.

Objectivity in an assessment of professionalism has come under significant scrutiny. Attribution bias (Stern and Papadakis, 2006) has been described as '*the tendency to generalise observed behaviours to all contexts*' (Goldie, 2013 p.e955), which could be taken to mean the same standard to be expected in different contexts, or that prior knowledge of a student and their actions may bias the assessment of the specific occurrence. This would be significant because the importance of context is widely acknowledged as a fundamental factor is determining how professionalism is considered (Zijlstra-Shaw et al., 2013, Martimianakis et al., 2009, van Mook et al., 2009).

In determining how to reduce subjectivity in the arena of judgements of professionalism, the question of whether to ask assessors to use norm or criteria reference arises. The difficulty with norm referencing is that the lack of consensus on definition and even the range of acceptability or the interpretation relevant to context means that there is too much variability between assessor scores and therefore criterion referencing would be indicated as preferable (Goldie, 2013). The difficulty, however with criteria referencing is that setting the 'standard' to be achieved often results in a low threshold, which is not discriminatory between individuals.

2.2.4 Methods which have been used to assess professionalism

In a review of studies published between 1982 and 2002 with instruments reported to measure professionalism, Veloski et al. (2005) found that three quarters of the assessments looked at individual elements of professionalism, with only a small proportion looking at this phenomena as a whole.

Taylor and Grey (2015) reported their experiences in considering Critical Incident Reporting in terms of professional behaviours in a UK Dental School. Their findings indicated a low

incidence of unprofessional behaviour among the student cohort, but most commonly reported unprofessional behaviours were related to a lack of conscientiousness (Taylor and Grey, 2015).

In terms of conscientiousness, McLachlan et al. (2009) highlighted that examples of conscientious behaviour can be quantified, making it a more transparent measure of assessment. The authors did, however, question whether part of the validity of the measure they had used was that it was retrospective, with the participants being unaware that the variable was being used as a predictive element of professionalism. The authors questioned whether behaviour would change if students were aware of their 'data' being used in this way. This then brings into play the consideration of whether firstly, professionalism is seen as a behaviour or an attitude, and secondly, does it matter if someone is merely 'acting' professionally as long as they actually do it? In the majority of circumstances this position would probably result in a satisfactory outcome, however where it becomes a risky strategy for the instances where people do not know they are being 'watched' and there is a reliance on them doing the 'right thing' anyway. The majority of this work concentrates on pre-clinical students, but Kelly et al. (2012) applied the conscientiousness index to a cohort of clinical students.

In their retrospective cohort study, Stern et al. (2005) attempted to establish outcome measures for professional behaviour and then to identify predictors of these outcomes in a US medical school. Like other investigators, they concluded that information contained within the admissions applications was not predictive of future professional behaviour as a medical student. This conclusion is unsurprising as the content of such applications is heavily influenced by expected inclusions, may have significant contributions from educational institutions, and be significantly influenced by the widely available media on 'how to get into medical or dental school'. What Stern et al. (2005) did find was that predictors of professionalism existed where students had opportunities to demonstrate conscientious behaviour or humility in assessment. The former strengthens the weight of evidence supporting the assessment of conscientiousness in the debate of how to assess professionalism and the latter raises the interesting question of self-deprecation being linked to humility and how this may then be linked to professionalism.

Peer assessment has been considered as a method to assess professionalism and has been found to be acceptable in the formative arena. There has been concern, however, that there is reluctance to 'rate' one another, particularly in a negative respect, when this peer assessment becomes summative (Goldie, 2013, Finn et al., 2009, Arnold, 2002).

Schubert et al. (2008) reported their experience with preparing single best answer, multiple choice situational judgement tests. A relevant observation they made was that one of the challenges of a 'best answer' format within the realm of professionalism, was getting a consensus on the 'correct' answer. They found gathering responses from a group of 'experts' was not straightforward and to get universal agreement (which they considered was needed to make the assessment legally defensible), required compromise and production of a low-level standard of question. This links with the findings of a low threshold by Goldie (2013). The use of situational judgement tests (SJT) has also been reported (Goss et al., 2017), both as a tool for teaching and assessment. The authors identified that the reliability of their SJT was lower than what may be expected for a summative assessment. However, they felt that this was a reasonable finding due to the nature of professionalism, previous work on the reliability of SJTs, and the alternate options available for professionalism assessment (Goss et al., 2017).

The use of objective structured clinical examination (OSCE) to assess professionalism has been reported (Mazor et al., 2007) and 360 degree multi-source feedback may be a way forward in triangulating opinion (Papadakis et al., 2005). OSCEs assess at the level of 'shows how' on Miller's pyramid, albeit in a simulated environment (Khan et al., 2013). The relatively short, discrete stations of an OSCE could necessitate assessment of an aspect of professional behaviour, without accounting for the complexity of the phenomena as a whole. Challenges arising from the use of standardised patient scenarios as a method for assessing professionalism were discussed by Prislin et al. (2001), particularly relating to validity.

2.2.5 What can we assess? Does this reflect professionalism?

Any tool developed should be reviewed in terms of 'whether the assessment represents professionalism'; is it on its own an acceptable measure of professionalism, or is it an acceptable contributor to a broader/longitudinal measure of professionalism. An example of this would be the validated tools for assessing conscientiousness, which have been considered from a faculty and student perspective (McLachlan et al., 2009, Kelly et al., 2012). If this tool reached the point of wide acceptance in its ability to validly and reliably assess and 'quantify' conscientiousness, would we be content to accept this tool as representing a measure of 'professionalism' – would this satisfy faculty, students, the regulator and the public?

It is also worth considering that if a longitudinal set of assessments are planned, these should be considered as a whole, to balance representation of the various component parts of professionalism.

2.3 Stakeholders

2.3.1 Students

The student perspective provides a different lens placed on both the role of professionalism and how the student is placed on the 'professionalism pedestal' throughout their undergraduate career. Some studies have reported that students feel there should be an element of leniency with regard to the professionalism expectations placed on them (Finn et al., 2010) which is proportionate to age and experience. This approach is echoed in Cox and Jones (2012) where an interesting viewpoint is expressed –is it fair to the students to assess an 'item' if it has not been taught?

Addressing the first point, that of leniency in regard to the expectations placed on students, there is little evidence to either support or refute this position. From a legal perspective in terms of negligence, the standard of care expected by a junior doctor is no different of that expected of a more experienced and senior colleague. The Court of Appeal has rejected arguments (1986) that inexperience is a defence and '*the law requires all medical staff.....to meet the standard of competence and experience society expects from those filling such demanding posts*' (Brazier and Cave, 2007 p.161). This is an important point, although not directly transferable as junior doctors are registered with a governing body unlike a student. Dental students are not qualified or registered and will always be working under supervision. The GMC and the GDC do however regulate the education providers and require student Fitness to Practise arrangements to be in place (General Dental Council, 2010, General Medical Council and Medical Schools Council, 2009). Therefore, like qualified registrants, there is certainly a consideration of whether all clinical students should have the same 'level' of professionalism expected of them at any stage of being a clinical student. How this may be applied for pre-clinical students is also a consideration.

The second comment regarding 'fairness' in assessing something if it has not been taught opens a range of avenues of questions, perspectives and challenges. Not least, the question of can professionalism be 'taught' and whether there is a degree of expectation and self-awareness expected from students, which potentially cannot be taught, but can be developed. We can certainly ensure that students are aware of the professional expectations that are placed on them, and these could be assessed.

2.3.2 Clinical Educators

Aside from the lack of an agreed definition, and whether or not we are actually assessing attitudes or observable behaviours, one of the primary issues in assessing professionalism is the reliance on the judgement of those assessing the students. There are many facets to the issue of judgement, many of which have been recognised and reported in the literature. Recognition is an important first step in devising a solution which still appears to be a reasonable distance away. Aside from the challenges of having a different understanding of what is actually included or expected within 'professionalism' by students and staff, an interesting concern raised by Ma et al. (2013) is that of students and assessors having different interpretations of the same language, and that the interpretation is also altered by the context in which it is used. A differing perception of importance placed on the various elements of professionalism by students and faculty is a reasonable and fully understandable observation, the influence of context has already been described as a significant factor in any action of or judgement on professionalism.

There are a number of potential barriers that have been reported to accurate reporting of unprofessional behaviour of students by teachers, as well as methods to try and address these (Howe et al., 2010). Teachers wishing to increase popularity, or who adopt a 'quid pro quo' attitude in the assessment of their student with the hope that the student report on their course or teaching may be assessed in a positive light, or victimisation of students they may not like, has been cited as an unethical practice of teachers (Bandaranayake, 2011). In more general assessment terms when considering potential assessor bias, it has been suggested by van der Vleuten et al. (2010) that where assessors have an ongoing interaction with the learner, there is a propensity to rate positively. This may potentially be the result of intending to preserve the relationship with the learner or avoid the additional 'work' which a negative report may lead to (van der Vleuten et al., 2010). Awareness of this potential influence could be important in planning assessment in settings like longitudinal clinical attachments / placements.

2.3.3 The Regulator

The regulators of doctors and dentists in the UK, the GMC and the GDC respectively, have a role of investigating allegations of practitioners being unfit to practise. The GMC document 'The meaning of Fitness to Practise' (General Medical Council, 2014) explains which types of conduct can be referred to a fitness to practise investigation. In 2018, the GMC received 8573 enquiries about doctors (General Medical Council, 2019), these were both from the public and public organisations.

For students, *'a student's fitness to practise is called into question when their behaviour or health raises a serious or persistent cause for concern about their ability to continue on a medical course, or to practise as a doctor after graduation.*'(General Medical Council and Medical Schools Council, 2009 p.28). Each university must have a student fitness to practise policy to ensure that students on a health care course leading to registration with a registrant body are 'fit to practise'.

From a regulator's perspective, contributing to the upstream 'prevention' agenda, starting with registrants who have a solid foundation and ethos which supports continuing attributes of a professional, has importance. A 2019 GDC report 'Moving Upstream' (General Dental Council, 2019c) follows on from the 2017 'Shifting the Balance' report (General Dental Council, 2017) and includes elements of focus on 'promoting professionalism', 'Dental education: delivering safe, well rounded professionals into practice and 'Ending the 'climate of fear'; the student engagement programme' (General Dental Council, 2019c).

2.3.4 The Public

Despite much in the literature on the teaching and assessment of professionalism from an educator and student perspective, there is minimal on the patient perspective.

Professionalism of staff has been identified as a contributing factor when the public make judgements of the quality of the dental service they receive (Tickle et al., 2015).

Wider patient and public consultation is now integral to both educational developments by providers and regulatory policy and decision making. The Department of Health document 'Liberating the NHS: No decision about me, without me – Government response to the consultation' (Department of Health, 2012) has undoubtedly influenced the direction of travel. In articulating the need for society as a whole to be instrumental in influencing change, this document reduces the significance of the role of the 'expert'. The involvement of patients and the wider public in the quality assurance of dental education programmes is now expected and required by not only the regulators (General Dental Council, 2015d) but also Higher Education Institutions. Public input is now contributing to all stages of programme delivery and development, from admissions to assessment (Bateman et al., 2019b, Gharib et al., 2017).

2.4 Can professionalism be taught?

The traditional concept of 'teaching' is of a 'specialist' delivering a lecture on a topic, providing the key concepts and definitions and facilitating further development. However for

'professionalism', the dimensions added with the complexity, behavioural and attitudinal aspects, mean additional challenges.

2.4.1 Methods suggested

A debate in the literature exists surrounding the issue of which comes first – teaching or assessment. Can we assess something that has not been formally taught? (Cox and Jones, 2012), and even a suggestion that we cannot expect students to demonstrate professionalism consistently unless it can be reliably and validly assessed (Tsugawa et al., 2009). Walton et al. (2013) considered that pre-clinical students struggled with patient empathy, suggesting that they were unable to relate to a patient perspective. However, they did advocate starting professionalism education at the very beginning of the course. The paper however was unable to provide strong justification for this conclusion.

A range of methods have been suggested by which to 'teach' or develop professionalism with students, these include; experiential learning and role-modelling (Cruess, 2006, Finn et al., 2010, Glicken and Merenstein, 2007), promotion of the use of reflective portfolios or incident reflection (Field et al., 2010, Hodges et al., 2009, O'Sullivan et al., 2012b) and formative feedback (Cruess, 2006). By considering the methods of 'teaching' that have been described, the question is raised of whether we are 'teaching' our students or whether we are providing them with the skills and environment with which they are able to learn. It is also worth considering if there are different perceptions of this question based on societal-cultural norms and expectations. In respect to role-modelling, it is arguable that this is a learning opportunity; just because a student sees how a teacher acts does not mean they have interpreted anything from it or indeed will do anything different. Stern and Papadakis (2006) concluded that in order to 'teach', role-modelling must be combined with reflection. This is probably a fair approach and would be consistent with many of the learning theories currently supported which included experiential learning and reflection (Cox, 1993). This highlights the relevance of the question asked by Cruess (2006) of whether we should be evaluating what is 'taught'? Or what has been learned?

In terms of conscientiousness, the initial conclusions from reviewing results of the Conscientiousness Index (Finn et al., 2009) were that in a small number of students, there was a slight increase in the level of conscientiousness demonstrated; this was attributed to teaching. However, when the Conscientiousness Index was applied to a larger sample of students within the same environment, the evidence was not significant and indicated conscientiousness to be a stable trait, therefore not influenced by teaching (Chaytor et al.,

2012). This returns to the question of whether 'professionalism' is something ingrained in people's understanding, being an example of tacit knowledge, understanding and attitude, or whether it is a concept described and learnt from the literature.

2.4.2 The 'informal' and the 'hidden' curriculum

Hafferty (1998) described the informal curriculum as '*an unscripted, predominately ad hoc, and highly interpersonal form of teaching that takes place among and between faculty and students*' (Hafferty, 1998 p.404). An example of this could be the use of Parables, where short stories are used to illustrate principles. Parables are a way in which professionalism has been 'taught', these are a good method and often effective, however they are difficult to build into a formal curriculum (Stern and Papadakis, 2006). Much has been made of the place of professionalism in the 'hidden curriculum'; that which is not explicitly shared but implicitly expected. There is also a difference in what is 'taught', the formal curriculum, and what is covered and experienced in the informal curriculum (Cruess, 2006).

Investigators have suggested that a 'core group' of faculty should take responsibility for teaching professionalism (Tsugawa et al., 2009). However, this would seem to imply that professionalism is an independent entity which is in contrast to many other author's opinions that professionalism is integral to much of what is done within the undergraduate curriculum and should not easily be separated (Zijlstra-Shaw et al., 2013). Not only is it not easily separated, but arguably it should not be separated, as that would perhaps result in students compartmentalising behaviours to certain environments. Professionalism should be embedded into practice and be an ethos, not an additional activity. The challenges that arise if a small group are 'nominated' to 'teach' professionalism is that this is not the way students should view professionalism. Tsugawa et al. (2009) suggested rewarding staff who act professionally. This would appear to be in direct conflict to the altruistic nature often expressed as one of the fundamental components of professionalism. 'Unprofessional' behaviour by members of faculty would be inappropriate and the same standards of professionalism from institution leaders and teachers should be expected (Stern and Papadakis, 2006). The hidden curriculum, described as a '*set of influences that function at the level of organisational structure and culture*' (Hafferty, 1998 p.404) is further considered by Hawick et al. (2017) where convincing leadership in professionalism curricula is a contextual factor that could enable or inhibit successful translation.

2.5 The source and challenges of the literature

It is worth considering the influence of the source and type of the literature contributing to this review, and the current understanding within the medical education field of professionalism. A significant proportion of the literature is from North America and the UK. The conclusions, instruments and socially accepted ideas therefore need consideration when assessing transferability and appropriateness. There is recognition that what is appropriate, or considered appropriate, in terms of professionalism in much of the literature has an Anglo-Saxon origin and may be neither accepted, or appropriate, in other countries (Hodges et al., 2011). Even between the UK and North America the emphasis is subtly different with greater inclusion of ethics and jurisprudence in writing from the UK and commercialism being a factor in American pieces (Zijlstra-Shaw et al., 2012). This may now begin to change as we perhaps move away from dentistry in the public sector.

It is also worth acknowledging that the current position and expectations of professionalism can vary within the medical communities of different countries. Tsugawa et al. (2009) highlighted that within the study setting they were investigating (Tokyo, Japan) both their findings and those of others suggested that the level of professional relationships were not equal to those in other countries. The shift in patient-physician relationship and recognition of patient autonomy is discussed by Park et al. (2017). They conducted thematic analysis of professionalism essays written by first year medical students in South Korea and identified respect for patients and physician accountability as the two core aspects of professionalism. They also concluded that culture context-specific elements should be considered in curricula development (Park et al., 2017).

The clinical background of the author or the profession involved in the 'investigations' reported is also worth acknowledging. Much of the literature and research comes from a 'medical education' background, with a smaller contribution from specific dental education contexts. It is not always easy, nor perhaps necessary to identify the setting if the work is a commentary and clinical education journals will publish work from a variety of contexts, there are however 'profession specific' journals. The question of whether work from a medical education training context is transferable in terms of the findings, or whether there are nuances specific to the 'dental education' arena is worth considering. The context and range of activities undertaken by undergraduate medical and dental students does differ; dental students carry out much more intervention treatments and directly manage patients.

However, as with the debate of whether professionalism has changed, the values applied to the roles students undertake are unlikely to be different.

An even greater consideration is the type of literature and evidence currently available. A search of relevant sources found that a high proportion of papers were essentially opinion pieces. This does not mean that they are not valuable, and certainly without them the literature in this area would be sparse, but a few well positioned authors have shaped the current direction of opinion and do not always draw on evidence which is supported by empirical data.

2.6 Terminology and educational considerations

When considering the way in which professionalism requirements and guidance are delivered and the manner in which they are presented, it is valuable to take a step back and consider the various traditional formats generally used in education. There is variability with how educational goals are expressed within learning programmes and this can introduce additional challenges.

In essence, educational goals encompass how stakeholders advise what should be, or has been, achieved prior, during or following a period of study. The stakeholders in terms of education will include students, those with responsibility within an academic institution (teachers, programme leaders, assessment leads), and bodies involved with quality assurance. In the clinical education arena, there are still the traditional terms for educational achievement including aims, objectives and learning outcomes, but there are also more situation-based goals, referred to as to competencies and Entrustable Professional Activities (EPAs) (ten Cate, 2005, ten Cate et al., 2015). The different terminologies and the fact that they often get used inappropriately, interchangeably or possibly both, create both confusion, frustration and challenges for the stakeholders involved with their use (Bateman et al., 2017a, Bateman et al., 2018a, Bateman et al., 2019c). These terms all mean different things and therefore have different inherent implications.

In terms of educational goals, professionalism, or professional attributes, is often a domain included in curricula and requirements from regulatory or guidance bodies (General Dental Council, 2015a, ADEA, 2013, Australian Dental Council, 2016).

2.6.1 Learning outcomes

Learning outcomes are education goals which are '*focused on the endpoint of study, stating explicitly what the participant will be able to do on successful completion*' (Bateman et al., 2017a p.855). The use of learning outcomes in clinical education has been prominent for over twenty years (Spady and Marshall, 1991). Learning outcomes have the potential to support the planning, design, delivery and assessment of a curriculum (Harden et al., 1999, Spady and Marshall, 1991). There is a subtle, but distinct difference between learning outcomes and learning objectives, the latter focus on intended education purpose and offer direction from the perspective of an education provider. Features that characterise an 'outcome', and support education development for the stakeholders using them, are:

- Tangible endpoints, i.e. practical descriptors, not theoretical ideals
- Indication of scope
- Direction on how to assess

Learning outcome taxonomies

Multiple taxonomies have been developed in relation to learning outcomes, those most widely considered in the clinical education literature are:

- Bloom's Taxonomy (Cognitive, Affective and Psychomotor domains) (Bloom, 1956, Krathwohl et al., 1964)
- Structure of Observed Learning Outcomes (SOLO) (Biggs and Collis, 1982)
- Fink (Fink, 2003)

Bloom's Taxonomy

This taxonomy comprises three hierarchical models which permit classification of educational learning objectives. The three models are cognitive (knowledge-based), affective (attitudes, emotions, feelings) and psychomotor (skills-based). The original taxonomy developed by Bloom was based on the Cognitive domain (Bloom, 1956), subsequently the original work on the cognitive domain has been modified and added to. One such modification by Anderson et al. (2001) included modifying the wording of the levels to make them 'active' i.e. the 'knowledge' level became 'remembering', 'comprehension' became 'understanding'. This potentially addresses issues with the learning 'objective' terminology in Bloom's taxonomy, making the context more outcome focused. This revision also reversed the order of the final two levels, so that 'Evaluating' now precedes 'Creating'.

Structure of Observed Learning Outcomes (SOLO)

SOLO (Biggs and Collis, 1982) is based on the 'level' of understanding. Like Bloom, it is a hierarchical structure, and it includes a quantitative phase of understanding (amount of detail increasing) and progresses to a qualitative phase of understanding (including structural and relational aspects). The taxonomy is an alternative to Bloom's Cognitive domain. Demonstrating development and progression of understanding of a concept longitudinally through a curriculum has been described as a spiral curriculum (Harden and Stamper, 1999). The use of the SOLO taxonomy has been proposed as a useable way of applying a learning spiral and promoting and developing a deeper understanding in dental education (Lucander et al., 2010).

Fink

Fink (2003) provides a non-hierarchical approach which encompasses different elements of a learning experience from foundation knowledge through to becoming a self-directed learner, 'learning to learn'. There is an interactive nature to what ultimately becomes 'significant learning'. The elements of Fink's taxonomy are relational, rather than hierarchical and include: Foundational knowledge; Application; Integration; Human dimension; Caring; Learning how to learn. Understanding and remembering ideas and information would be a 'Foundational knowledge' element and may require the learner to 'compare', 'identify' or 'define'. Learning about establishing effective working relationships with others or aspects of managing yourself may be a 'Human dimension' element and verbs may therefore include 'advocate', 'promote', 'respond'.

Taxonomy challenges

In terms of how outcomes could be considered with respect to a particular learning outcome taxonomy, a number of challenges exist, related to specific taxonomy application.

Hierarchical taxonomies could be applied at different stages during a programme when demonstrating the way concepts are developed and in charting knowledge progression, i.e. in Year 1 a certain expectation is set, which will then be developed further by the time the student progresses to Year 3. However, in terms of the outcomes required at the end of a professional programme, challenges arise in application and indeed utility if all required levels are similar. For example, in the UK undergraduate dental degree, the level of all outcomes is described as that of the 'safe-beginner' (General Dental Council, 2015a). At the exit point of a programme there is not a range of levels or progression required.

In respect of Bloom's taxonomy, identifying 'assessment opportunities' in the psychomotor domain for outcomes is relatively straightforward with obvious tools apparent. However, actual assignment to a 'level' within the psychomotor domain can be challenging. Whilst greater detail and arguably utility has been added to Bloom's psychomotor domain by Dave (1970), at the point of exit, at the level of 'Safe Beginner' it could be argued that the student should have achieved the level of 'Precision' at the very least, whilst 'Articulation' or 'Naturalisation' may be required. It is also sometimes difficult to separate out clinical tasks from the inherent cognitive element required to implement a practical task.

Outcomes in the cognitive domain provide more obvious opportunities for clarity in terms of expectations and assessment than the psychomotor domain and the affective domain. Biggs and Tang (2011) highlighted the dichotomy between what is needed for students to succeed in professional life, and the method by which students are taught and assessed. So from a practical and pragmatic approach to curriculum delivery, do we teach and assess what we 'need' to teach or what we 'can' teach? Related to this, when preparing learning outcomes, are these written to address what we 'want' from our new graduates, or what is potentially achievable to assess?

Biggs and Tang (2011) recommend that in designing degree programmes, deciding on the type of knowledge required should be the starting point. The merit of this approach is arguable, but the relevant observation is that many degree programmes have a curriculum that is already well established and only modified when required. The 'luxury' of designing a curriculum from scratch is rarely a reality, primarily due to resource constraints and logistics. There are examples in dentistry where curriculum 'revolution' has occurred, notably to align 'themes' of learning longitudinally throughout a programme (Ryder et al., 2008, Manogue and Brown, 2007). However, in many other cases an evolution has occurred to anticipate or react to changes in focus and the scope of tangible requirements which have inevitably changed over the decades (Bateman et al., 2017b).

Determinants of a curriculum are complex and multi-factorial, there is an element of influence of a regulator's requirements (Pyle, 2012, Crain, 2008), this often presents as programmes adapting to demonstrate alignment and compliance with new or updated regulatory requirements. However, whether a regulator's requirements would be the starting point for design of a brand new curriculum is debatable.

2.6.2 Knowledge on professional courses

Students on a professional course will, in general, go on to practice in a professional capacity in the 'real world', therefore they should be prepared in a way which will allow them to function in that environment. Graduating students need to be equipped to manage the challenges of practice and situations that will arise once they graduate from the learning environment and become independent practitioners.

The different ways of expressing knowledge, and their function, have been described in the literature. 'Declarative knowledge' (Biggs and Tang, 2011) is outlined as 'knowing about' or 'knowing what'. This type of propositional knowledge can be readily accessed, verified and is therefore consistent and has also been previously described as 'University knowledge' (Leinhardt et al., 1995). Whilst declarative knowledge provides a good foundation and is knowledge that students will need to develop, it could be considered as a 'stepping stone' to the next phase of development. In practical application of degree programme planning and assessment, we may assess it in specified examinations within programmes that may fit at the end of years, but perhaps these indicate a transition phase of learning and evaluation. This will to some degree be a process of confirming that information has been delivered and retained by the student. This would translate to the lower end of a hierarchy in terms of understanding, such as 'knowledge' or 'comprehension' in Bloom's cognitive domain (Bloom, 1956) which may include verbs such as list, outline, discuss, or the SOLO taxonomy (Biggs and Collis, 1982) quantitative phase where recall, identify and classify are examples of the verbs used.

For students to apply, synthesise and critique their understanding, to the point where they are able to manage situations that they will be exposed to as dental professionals they will need 'Professional knowledge' (Leinhardt et al., 1995, Maudsley and Strivens, 2000). This is also the level at which they should therefore be examined in the 'Finals' dental degree examination to attain the regulator's requirement of being the 'Safe Beginner' (General Dental Council, 2015a). Raising the level of knowledge to a point which permits application and adaptation, is the concept of 'Functioning knowledge' (Biggs and Tang, 2011). This type of knowledge relies on *experience* being fundamental to development. What makes the 'professional' is their choices, resulting in actions made following '*an informed decision to do it this way and not that way'* (Biggs and Tang, 2011 p.161). Translating this, it may be seen as a level of understanding at the higher end of outcome taxonomies, for example the 'evaluation' level in Bloom's cognitive domain (Bloom, 1956) which includes verbs such as

appraise and justify, or the SOLO taxonomy (Biggs and Collis, 1982) qualitative phase where within the 'extended abstract' examples of verbs include theorise and reflect.

Teaching delivery differs from degree programme to degree programme and also within programmes themselves. So-called 'traditional' programmes start with developing declarative knowledge and then seek to convert this to the applied professional requirements, i.e. learn the foundation principles, then have opportunities to apply these (Manogue et al., 2011). Programmes adopting a Problem Based Learning (PBL) approach seek to ground professional knowledge from the initial stages of learning (Bassir et al., 2014, Fincham and Shuler, 2001). From personal experience and discussions with colleagues, whichever approach is taken, those working closely with undergraduate students often see a progression. The student moves from 'going through the motions', albeit they may possibly be performing a task 'correctly', to applying their understanding and appreciating *why* they are doing something and the value of that process. This is the transformation of when 'core' knowledge is surpassed by 'threshold' concepts (Biggs and Tang, 2011, Meyer and Land, 2005). The transformative change in thinking associated with threshold concepts and how this may inform clinical education has been discussed in both medical and dental literature (Neve et al., 2016, Kinchin et al., 2011), and the potential integration with reflective practice has been explored (Hyde et al., 2018).

The nature of the learning environment within the undergraduate dental programme is indicative of the type of knowledge sought to impart, and the understanding level required of students by curriculum designers. In moving away from a didactic lecture-based class held in a large lecture theatre, to a clinical environment, which is dynamic and individual to a particular situation (patient), the opportunity to impart higher-level knowledge and therefore opportunities to demonstrate understanding are greater. The impact and benefit of this situational knowledge, anchoring learning to authentic tasks and workplace participatory learning are well established in the literature (Billett, 2004, Honebein et al., 1993, Lave and Wenger, 1991, Savery and Duffy, 1995).

2.7 Summary

A consensus on a definition of professionalism is unlikely to be achieved which is universally supported across professions, continents and groups of stakeholders. This does not however change the requirement for professionalism to be demonstrated and the increasing pressure on providers of undergraduate medical and dental education to prove 'competence' or attainment to external regulators and the public. On consideration, a universally agreed definition is

unlikely to be achieved because there is such an influence of context meaning that a simplistic definition would be both inaccurate and inappropriate. However, to continue with curriculum development in professionalism (learning and teaching), set expectations of students and a plan for implementation of assessments, some direction is required in terms of content. If shared understanding can be achieved by those involved in the planning, delivery and receipt of a programme, this should suffice and enable programme development. From the literature, achieving agreement of an institutionally accepted descriptor may be the most appropriate way forward.

There is no currently universally recognised and accepted tool for assessment of professionalism, although many have been suggested, piloted and validated to varying degrees. Accepting the lack of definition, it would appear that key to increasing reliability and validity of assessment tools is understanding the potential bias and confounding factors which may influence judgements of professionalism. Do we need to discriminate between levels of professionalism; is obtaining a higher 'professionalism score' than a colleague to be coveted in the same way as obtaining a higher grade in an OSCE, or is it acceptable, and indeed preferable to have a dichotomous divide of 'professional' or 'not professional'? This comes back to 'what are we trying to achieve by assessing professionalism?' To address this question, a greater understanding of professionalism is required.

Understanding different methods of expressing educational attainment is important to appraise current requirements facing education providers. It also permits consideration of format recommendations for future education requirements.

In terms of UK dental education providers, there are governance and quality assurance processes already in place by law from the national dental regulator, the General Dental Council. This would suggest that there is already the foundation of a shared resource, which could potentially indicate the 'content' of an understanding of professionalism, and from which further local detail could be developed. The next chapter considers my approach to further understand professionalism from a dental education provider perspective. Whilst appreciating the complexity of the phenomenon and the different ways to approach investigation, an intention to develop practical recommendations has led to adoption of a pragmatic approach in this research.

Chapter 3. Conceptual Approach and Methodology

Consideration of the literature in the previous chapter indicated the challenges in conceptualising and integrating attainment of 'professionalism' into education programmes. To underpin further development in this area, there was an indication that more detailed study was needed to gain a deeper understanding of this complex phenomenon. Refining the research focus was the next stage, together with development of a coherent strategy which would address the aims of the research in an educationally sound and rigorous way. Consideration of the methodology is presented in this chapter, together with the rationale for the conceptual approach and the specific methods employed. The objectives of the chapter are:

- To consider the conceptual approach to this study.
- To refine the research focus.
- To consider the methodology available to address the study aims.
- Following on from determination of methodology, to consider specific methods available and their detail.
- To consider how to address elements of rigour necessary to underpin this study.
- To consider the ethical issues involved and the balance and dynamic of both academic and professional integrity.

3.1 Overarching conceptual approach in relation to the phenomenon from the literature

The research design has been approached from a viewpoint of an educator, who monitors and assesses student dental health care professionals as they strive to develop against a set of professional requirements. As an educator involved in the delivery of an accredited professional programme, we are charged with designing and implementing robust curricula that 'gate keep' entry into the profession. Part of the requirements relate to demonstration of professionalism. Ultimately, through this study, the aim was to develop and facilitate robust and tangible recommendations on how 'professionalism' is managed by education providers. Therefore, adopting a pluralist epistemological position on the judgement of professionalism, the analytical position of this study was informed by Pragmatism (Biesta and Burbules, 2003).

Acknowledging and appreciating that there are multiple factors influencing both individual and societal perspectives of professionalism, there are elements of influence that are common

across professionals. One of these being the expectations articulated by the regulators of that group. These dictate how 'professionalism' is interpreted and influence how people 'act'. Regardless of individual beliefs, experiences, drivers and influencing factors, the requirements of the regulator of the professional body with which they are registered will have an influence. This is because if they do not deliver to those requirements their professional livelihood is at risk. Similarly, regulatory requirements affect education providers who design, implement and deliver programmes of study that lead to a registerable qualification with that given body.

3.1.1 Pragmatism

Biesta and Burbules (2003) outline the historical origins of Pragmatism and identified its founders as Charles Sanders Peirce (a natural scientist and philosopher), William James (a psychologist and philosopher) and John Dewey (a psychologist, philosopher and educationalist). They go on to stress the importance of recognising that there is not one 'pragmatism', there were differences in the ideas and approaches for each of these founders, and between them, they engaged with a wide range of philosophical topics (Biesta and Burbules, 2003). Dewey's focus on philosophy *in action* was a fundamental aspect of pragmatism and commentators have proposed that it is this that makes it an attractive proposal for those in roles where a practical approach is often taken, for example educators (Biesta and Burbules, 2003). Similarly, the argument was reportedly made by Peirce, that to attribute meaning, knowledge must be able to be applied to action (Biesta and Burbules, 2003 p.6).

Dewey's experienced reality approach, with reality only being revealed as a result of activities (Biesta and Burbules, 2003) has been referred to as *transactional realism* (Sleeper, 1986) and the way in which interactions between individuals lead to transformation of the worlds of both individuals, so there is a shared 'world' as *practical inter-subjectivity* (Biesta, 1994). In doing this, a combination of constructivism and realism has been permitted. The mode of experience that supports action was the way in which Dewey characterised 'knowing' (Biesta and Burbules, 2003). Judging knowledge by its consequences in action is the approach to test knowledge in pragmatism and how the knowledge functions in serving the purpose of those using it (Cornish and Gillespie, 2009).

In considering the cycle of knowledge guiding action, which then has feedback into knowledge construction, Cornish and Gillespie (2009) determines that for pragmatists, '*the only sensible yardstick by which to judge a piece of knowledge is whether that knowledge is useful for a given interest'* (Cornish and Gillespie, 2009 p.802). Following an action focussed

process, Cornish and Gillespie (2009) concludes that health researchers adopting a pragmatic approach would '*prioritize on the creation and evaluation of workable and useful intervention programmes'* (Cornish and Gillespie, 2009 p.807). This had resonance when planning the current research in an attempt to have tangible recommendations which could have an impact for education providers. In the context of this study, the lens of an education provider has been used. The requirements of regulatory bodies were therefore evaluated according to their applicability and the consequences of applying them within an undergraduate context.

3.2 Refining the research focus

In considering the 'purpose' of educational research, Biesta and Burbules (2003) describe how Dewey's approach rejected the idea that research should be only about finding more efficient ways to deliver educational goals, but that in addition, inquiry into the goals themselves should be integral:

> *'The point of doing educational research is not only to find out what might be possible or achievable, but also to deal with the question of whether what is possible and achievable is* ***desirable*** *- and more specifically whether it is desirable from an educational point of view.'(Biesta and Burbules, 2003 p.109)*

This was considered important in designing this research, so two main foci were identified:

1. What guidance was provided in terms of professionalism for undergraduate education providers and how were requirements articulated;
2. Consideration of format and whether it is 'desirable' in achieving the ultimate aim of promoting 'professionalism'?

This meant critically reviewing regulator-produced requirements and determining their utility, whilst also considering their influence in relation to promotion of professionalism.

> *'….Dewey told educational researchers – and educators – not to let themselves be maneuvered into the role of educational technician; they are not simply adjudicating matters of educational means, while the question of educational ends are decided for them elsewhere.' (Biesta and Burbules, 2003 p.109)*

To expand further on this, Yardley (2000) argues that the impact and utility of a piece of research is its decisive criterion. How to determine 'usefulness' is difficult, but in the context of this study, the ability to identify what is currently in place, any challenges with the current approach and the ability to deliver recommendations could be considered as a demonstration of utility.

The literature describes multiple attempts at 'defining' professionalism and approaches for 'assessment' of professionalism. These have been of limited practical value and success and in this study an approach was taken to step-back and attempt to conceptualise professionalism initially. To do this, conceptualising professionalism from the perspective of an education provider on the basis of regulator requirements was considered a pragmatic approach.

The General Dental Council, like other regulators of clinical professions, set out their requirements for both registrants and education providers in a series of documents. Analysis of these documents therefore would provide conceptualisation of what the regulator outlines as encompassed by 'professionalism'.

3.3 The aim of this research

The aim of this investigation was therefore to conceptualise professionalism from the perspective of an education provider. This would include development of a construct containing the various influential elements determined by professional regulatory bodies.

3.4 Methodology

Following consideration of the literature, it became clear that challenges remain in terms of conceptualising and integrating attainment of 'professionalism' into education programmes. The lack of a broadly accepted consensus in the current literature for working with the concept of 'professionalism' prompted a need to go back a stage, and indicated that more detailed study was needed to gain a deeper understanding of this complex phenomenon. In essence, to understand why a consensus was so difficult to reach. To do this, a quantitative approach did not seem appropriate, as adoption of research methods which have a basis in a positivist paradigm (Cleland, 2015) and consider objective precision (Carson, 2001) didn't seem to fit with the complexity associated with professionalism as found in the literature. Attempts to work with tangible measures and aspects which can be measured have been reported in the literature along with the challenges and shortfalls of such an approach (Schubert et al., 2008, Stern et al., 2005). Thomas and Magilvy (2011) suggested a greater depth of understanding of phenomena is important and in this research that was considered important. There are assumptions that have been made about the complex phenomenon of professionalism, one of which is that there are many variables, which are complex and intertwined. The purpose of this research was one of contextualisation, interpretation and understanding, through the lens of an educator, adopting a pragmatic approach. This indicated the necessity of qualitative research methods, as opposed to a hypothesis being

present and the purpose of the research to be prediction and explanation, which would have supported the use of quantitative research methods (Cleland, 2015).

The influence of the researcher on their work is a consideration in qualitative research. In order to address this it was important to recognise the preconceptions and these are discussed more fully later in this chapter. In adopting pragmatism as a conceptual approach, by design, a focus is being placed on certain aspects of the phenomena, whilst other areas will not be identified (Bordage, 2009). Alternative frameworks to investigate the phenomenon could have been applied, for example social research theory to emphasise interactions between students and their clinical teachers, or behaviourism to focus on practice and performance (Bordage, 2009). These would have continued to indicate a qualitative approach, but with use of different methods.

Data in this study included:

- Governance document(s) which contributed to informing professional standards expected of those teaching and assessing the students;
- Curricular requirements of education providers in terms of 'professionalism'.

An overview of the investigation is shown in Figure 3.1.

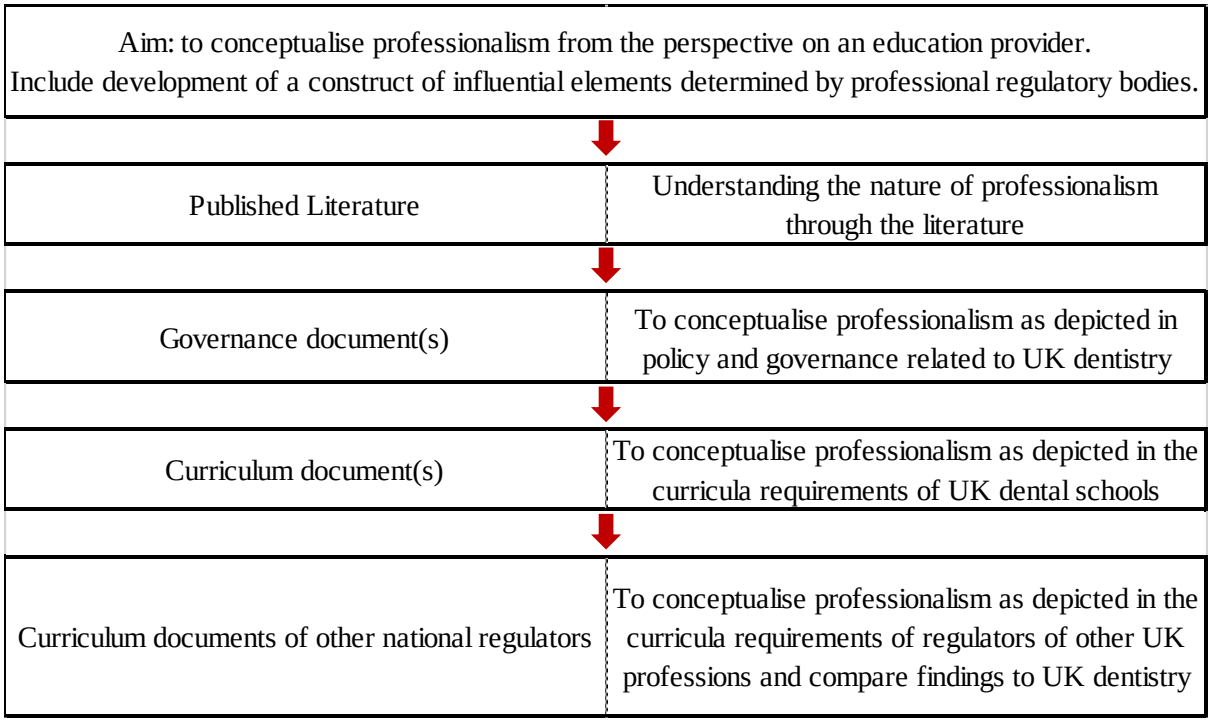

Figure 3.1 Investigation stages overview

3.5 Research Methods

In terms of the specific qualitative methods to be employed in this study, considering the nature of the data, document analysis and thematic analysis were selected.

3.5.1 Document analysis

The document analysis undertaken followed conventions outlined by Rapley (2017).

Documents in social research can be viewed in different ways; either as a resource or as a topic (Silverman, 2011, Prior, 2008). Have (2004) used the term 'natural documents' to describe those documents which have not been produced for the purpose of research, but have been '*produced as part of current societal processes'* (Have, 2004 p.90). This would be a way of describing the regulator-produced documentation identified for analysis in this investigation. In terms of production purposes, he suggests that there is often a specific purpose, which is '*often to 'fix' aspects of current events and actions for future inspection'* (Have, 2004 p.90). An advantage of this form of data is that the actual data has not had researcher influence. This lack of bias from the data collection process has been referred to as 'non-reactivity' (Appleton and Cowley, 1997). However, in terms of trying to understand and interpret the document, the researchers' own frame of reference will be an influencing factor (Have, 2004).

The use of documentary analysis as a method to analyse clinical guidelines has been reported in the literature (Appleton and Cowley, 1997, Drennan et al., 2012) as has use with curriculum documentation (Momeni et al., 2008, Roskell, 2013) and organizational policies and procedures (Paul and Hill, 2013). There was some cross-over in terms of the analysis that was undertaken with thematic analysis of the documents in some of the studies mentioned. In this investigation, the term 'document analysis' has been used when the focus has been on the construction of sections of the document, i.e. the style used to write statements and the complexity of the statement construction. Using a document to investigate a phenomena has a potential disadvantage, in that it is unknown to what extent the document influences practice. For example, a document's existence may have little impact on the profession for whom it was designed or applied to, or many in the profession may be unaware of it. Research in the literature on analysis of clinical guidelines, commented that although there was ratification of documents by senior staff, the effect on professional practice was unknown (Drennan et al., 2012). This factor was considered when documents were being selected for inclusion in this study.

The advantages and disadvantages of documentary research (Appleton and Cowley, 1997, Bowen, 2009, Mason, 2002, Denscombe, 2010) have been described and are summarised in Table 3.1, together with a response to each point in respect of this investigation.

Advantages of document analysis	Consideration in this research
Information already exists	Considering the phenomena and how it was applied in a specific context in the most robust and efficient manner. Documents produced by national regulators exist and education providers are required to work with them. The collection process was therefore non-reactive.
Can be collected from different time periods	This could be considered in terms of historical development. Not the focus of this investigation, however social context at the time of production was considered in the discussion.
Inexpensive Easy to analyse data	Little additional 'resource' required. Document analysis and thematic analysis techniques were available.
Can utilise quantitative and qualitative analysis	Could look at quantitative elements (emphasis or the way in which statements are constructed) and/or thematic approach.
Disadvantages of document analysis (robustness of data source)	**Consideration in this research**
Information may be incomplete Data is restricted to what is already present	Not a problem in this investigation as the content of the document is the focus – any 'apparent gaps' are a reflection on the conceptualisation, not the available 'data'.
Representativeness needs careful consideration	Careful consideration and awareness of the researcher's reflexivity was needed to ensure rigorous analysis.
Access to content may be limited or restricted	Documents selected in this investigation were freely available, and in the public domain.
Data may not be generalisable to all populations	No – but pragmatic approach– it is generalisable to UK dentists and cross-profession comparison was possible.
Data may be dated	Current documentation was used, acknowledgement that a number documents were currently under review.

Table 3.1 Summary of advantages and disadvantages of using document analysis

3.5.2 Thematic Analysis

The thematic analysis undertaken followed conventions outlined by Braun and Clarke (2006), with the purpose of identifying and reporting patterns within the data. This analysis method had the intention of providing a '*rich and detailed, yet complex, account of the data'* (Braun and Clarke, 2006 p.78) which was appropriate to represent the complexity of the phenomena.

3.5.3 Approach taken in this study

Figure 3.2 outlines the analysis process undertaken with regulator produced documents.

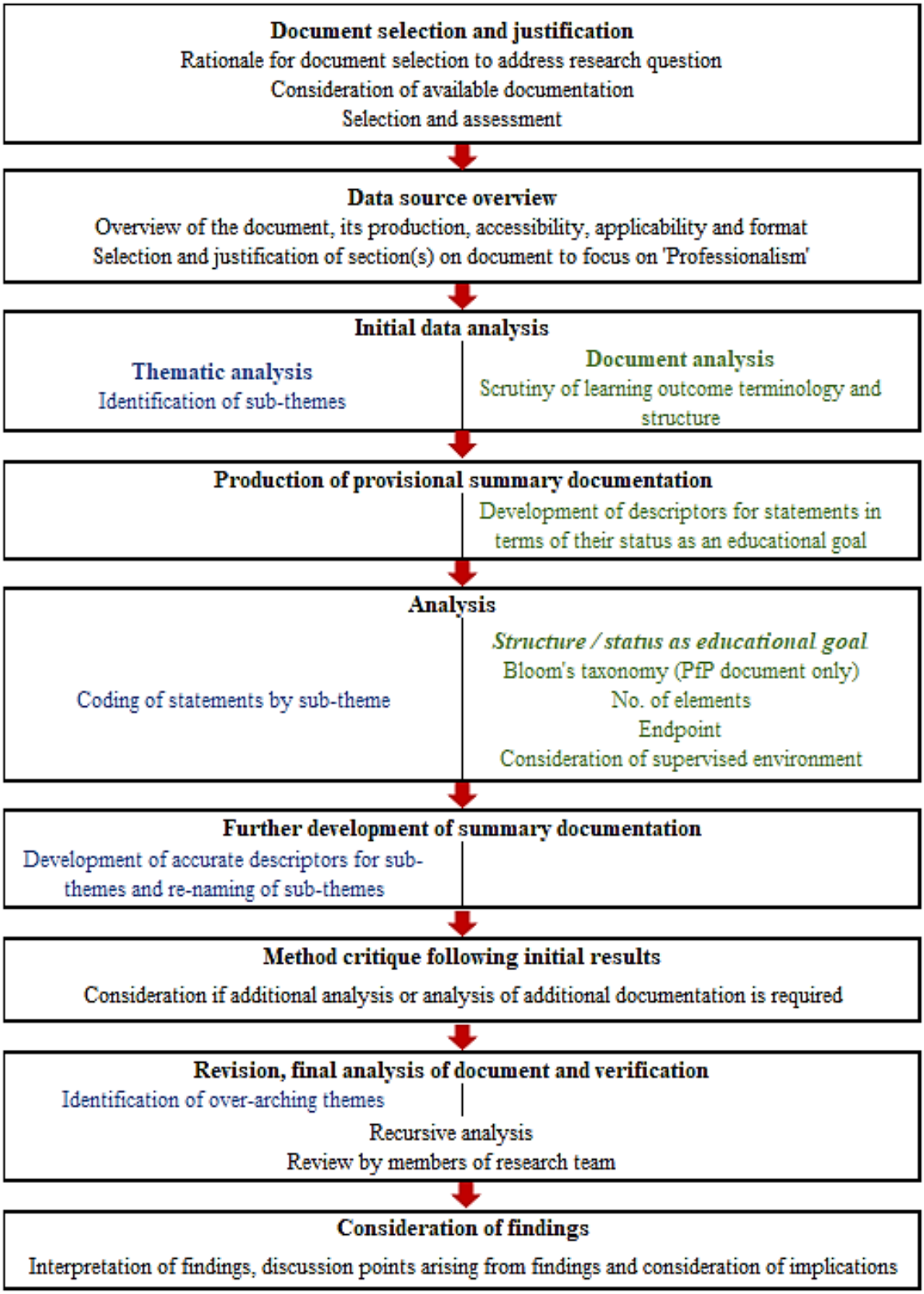

Figure 3.2 Method in analysis of regulator-produced documentation

In this research, documents were the 'resource' in terms of their content, i.e. what was 'in' the document, and how is the resource was used for a specific purpose. These data have been 'read' interpretively, with interpretation made of the content, rather than adopting a purely literal observation of layout and design elements (Mason, 2002). An 'archaeological' approach was not adopted, this would have focussed on how the content of the document came into being, i.e. the previous iterations, the social climate at the time of production, as a result or what had been done in another arena. However, in the discussion sections of this research, timing of document production and social context has been considered as a result of the analysis findings.

Document selection and justification

This included outlining the rationale for document selection and how document analysis would address the aims and objectives of the specific phase of the study. Potential documents were identified and a summary made of how they would fit the selection rationale. This included whether the document described a requirement of registration imposed by a national regulator, and evidence from surveys detailing the 'awareness' that a group had of the specific document.

Data source and overview of the document

This included consideration of the representativeness of the document and whether it required consideration in a particular context, or could be reviewed in a stand-alone context. It was important to acknowledge that when looking at 'dental' documents, the researcher had an insight into and was knowledgeable about the local conventions and 'stylization' of the document and the context in which it is applied (Have, 2004). A similar level of insight into the other professions included in this study was not present, this could have had a possible adverse effect on the interpretive meaning of those document's content. In responding to this, discussions were had with people whose background was not dentistry, to explore their insights in the interpretation of certain document sections being analysed.

Credibility consideration included; the purpose the document was written for, the authorship of the document and its origins (Denscombe, 2010). Initial content review considered which sections (all or part) of the document to analyse and of the rationale for this selection. A brief summary of history of the document was included (when it was produced, whether previous iterations existed), its accessibility (how/where to access and whether there were any restrictions on access) and an overview of the document format and layout. Brief information on the body producing the document and information outlining to whom it was applicable (i.e.

specific registrant groups and / or education providers for use with pre-qualification students) was also stated.

Initial data analysis

This included consideration of the type of analysis (document and/or thematic analysis) that would be appropriate for each document to maximise the potential data analysis.

For each document, a spreadsheet was established using Excel to capture the data, followed by initial data sorting. Dependant on the document type, either one or two databases were created, their purpose being:

- Thematic analysis: Identification of 'sub-themes' and coding of statements
- Document analysis: Scrutiny of learning outcome terminology and structure

All documents were subject to thematic analysis, which initially involved identification of and coding statements by 'sub-theme'. A variety of terminology has been used in the literature to describe this stage of coding. For the purpose of this research I used the term 'sub-themes', these were headings which briefly encompassed aspects identified by the researcher which embrace an element of commonality identified within practice.

Sub-theme identification was data driven (Fereday and Muir-Cochrane, 2006) rather than a theoretical or deductive approach (Braun and Clarke, 2006) which would have used pre-determined themes from the professionalism literature (Figure 3.3). The rationale was to consider the inferred nature of professionalism from each document independently, rather than have influence from other perspectives or documents. Knowing which sub-themes were identified in previous documents could have influenced the researcher, and potentially the truly inductive nature of the approach, but awareness of this potential was considered appropriate in terms of management. Sub-themes were identified until they were exhaustive, in that all of the data within a document (or selected section of a document) could be placed in a sub-theme (Merriam, 2014).

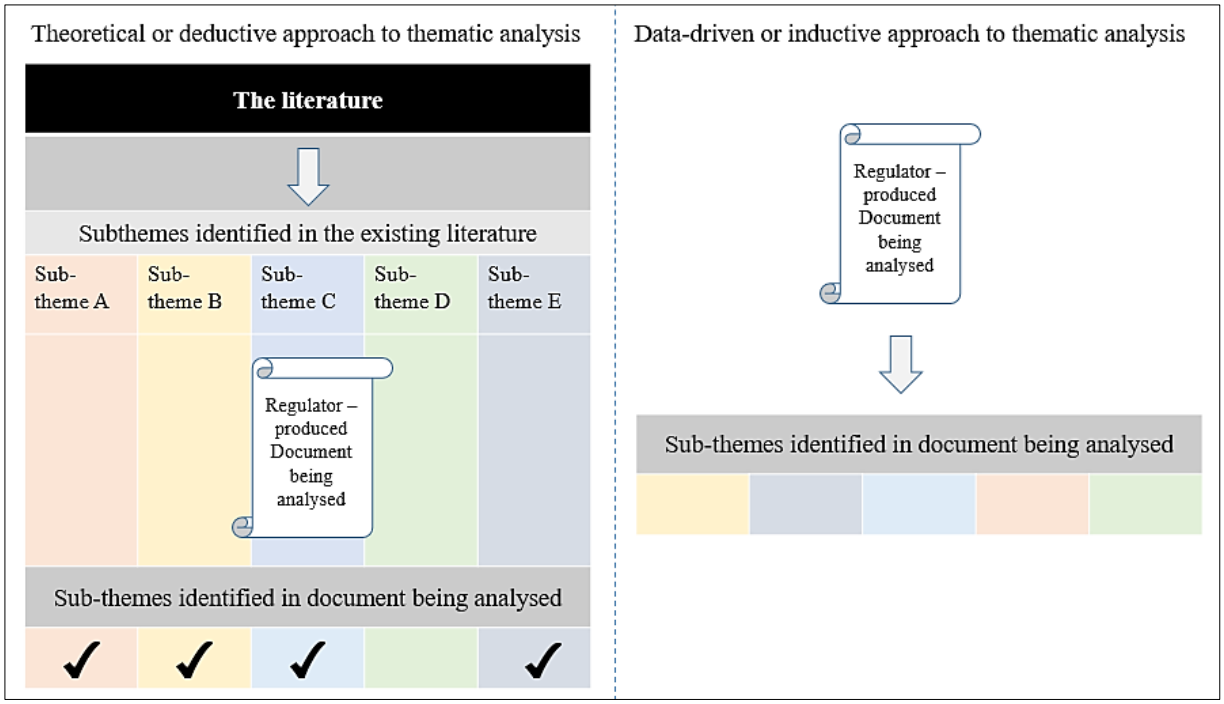

Figure 3.3 Approach of sub-theme identification in thematic analysis

Production of provisional summary documentation

In terms of the scrutiny of 'learning outcome' terminology, challenges were identified after initial analysis of the data concerned with the use of the term 'learning outcome'. Firstly this included the criteria which required satisfying to conform to a consistent allocation to being defined as a 'learning outcome', and secondly what other educational goals were available if the statement was considered not to be an 'outcome'. The literature demonstrates inconsistencies in how education goals are defined and therefore a risk was identified in consistent data management which would be transparent to external review.

The criteria used in determination of a 'functional' learning outcome were therefore determined. The range of educational goals that statements could be classified as were also listed, together with a definition of what they would involve in this study (Table 3.2).

Principle	An approach that should be applied to activities undertaken as a professional.
Standard	An approach that should be applied to all activities undertaken as a professional. Provides an indication of the appropriate level which is expected to demonstrate achievement.
Objective	An expression of the intended educational purpose from the perspective of the educator. The delivery and direction has been outlined.
Outcome with feasibility challenges	Where the statement contains the characteristics of a learning outcome, but in terms of practical application, challenges arise: Technically defines an endpoint and has an action verb to describe the level of this expectation, but with current available assessment tools not possible to assess attainment of this outcome.
Functional Outcome	Endpoint defined and a tangible means of assessment is available to determine attainment.

Table 3.2 Descriptors developed in this study for identification of educational goal 'style'

Analysis

In terms of data management, manual sorting and processing were undertaken. The use of data management software was considered, for example use of NVivo, but not adopted as little benefit was seen in using this tool. The quantity of data in this investigation was manageable using a manual system and data management software would still require description and analysis of the data as this is not the purpose of this software (Cleland, 2015).

For thematic analysis, the data in the documents were then coded by the sub-themes that had been identified. Modifications in sub-themes (i.e. addition, removal or amalgamation of sub-themes) was undertaken as required.

Figure 3.4 shows the stages in the document analysis (education provider documents only).

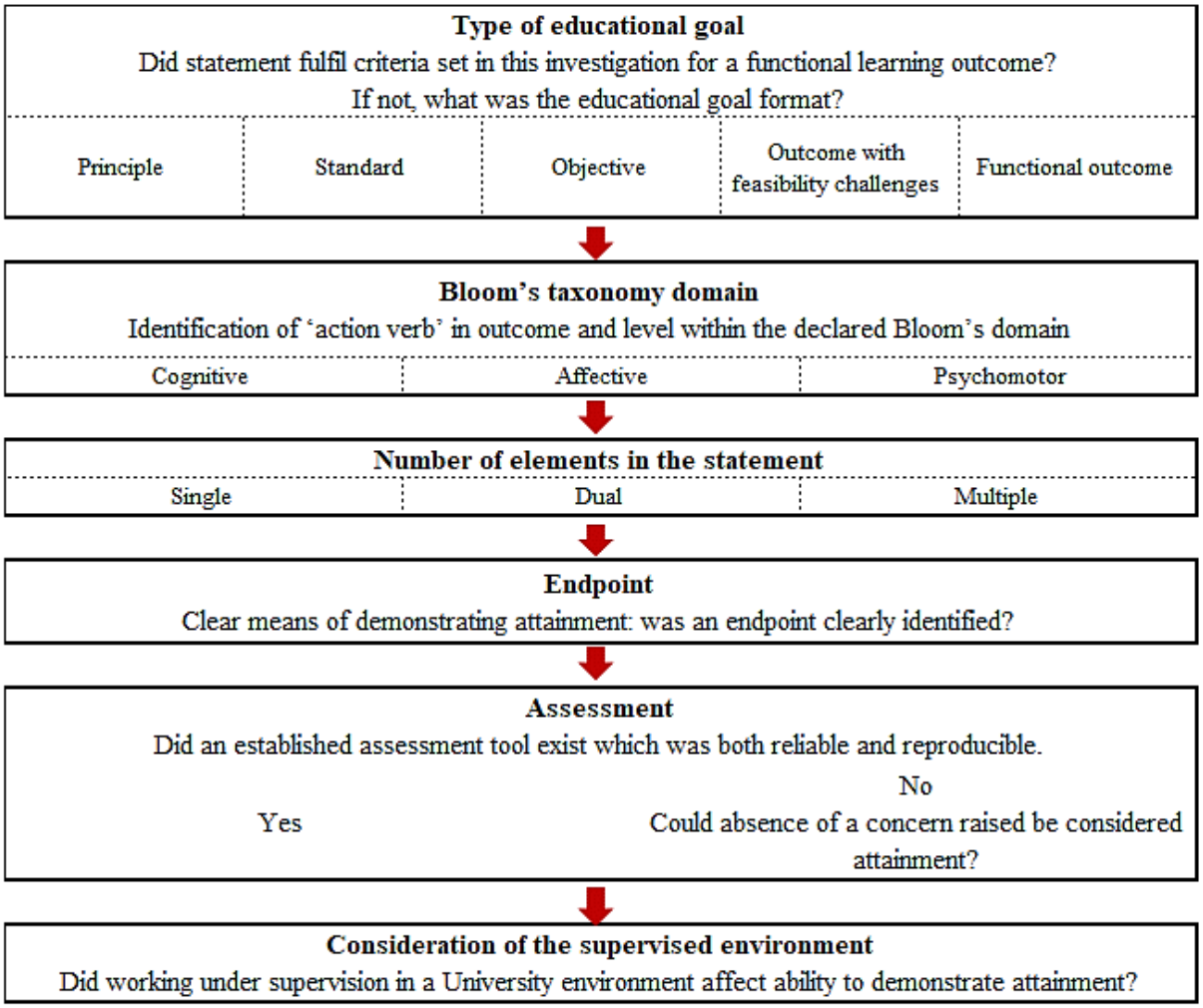

Figure 3.4 Document analysis stages

Further development of summary documentation

A descriptor for each sub-theme was developed. The intention of these short paragraphs was to encompass the content of the sub-theme, and to permit other researchers to follow the method used in this study to code the data. They also would allow comparison of sub-themes to future documents. Sub-themes descriptors were developed by reading the statements included in the sub-theme, writing an encompassing descriptor and then re-reading each statement and considering whether it was appropriately represented by the descriptor. Braun and Clarke (2006) describe an important feature for themes is that they are '*internally consistent, coherent and distinctive'* (Braun and Clarke, 2006 p.96). At this stage, the name of the sub-theme was also reviewed to consider whether it was appropriately representative, and if not it was modified. For sub-themes identified in analysis of earlier documents, the previously developed descriptor was reviewed to consider whether it appropriately included relevant areas from the document currently being analysed. Descriptors were then revised as appropriate. Sub-themes also required refinement so that there was no overlap between them

(Merriam, 2014). As with aspects of the document analysis, reading of the data was interpretive, with the researcher having a role in what they believe the data represents (Varpio et al., 2017). Merriam (2014) discusses the importance of being *sensitive* when naming elements within the research, in this research this included naming sub-themes in a way that accurately reflected the data they contain and a sense of their nature could be inferred by some-one reading the heading. Maintaining conceptual congruence (Merriam, 2014) when identifying sub-themes involved ensuring a similar level of abstraction was achieved. The language used in reporting the findings of this research and the approach of ensuring analytic rigour were based on the problematizing of thematic analysis, presented in the literature by Varpio et al. (2017). This included reference to 'identification', as opposed to 'emergence' of themes and the role of crystallisation (Richardson and St Pierre, 2005) as opposed to 'triangulation' which would align with a more positivist approach.

Taking an overview of the findings from each thematic analysis and comparing and contrasting these findings, it was important to consider potential reasons behind what Seale (2004) includes as 'deviant cases'. In this research, this was taken to mean examples of outlying results or 'sub-themes' and consider the possible explanations for their presence.

Method critique following initial results

Being receptive to the potential need to modify the study design based on the findings that were being identified was also necessary in this study (Cleland, 2015). It was necessary to expand the original document selection due to the findings and questions arising that arose during analysis. An example of this was I had initially planned to analyse the 'professionalism' domain of the GDC 'Preparing for Practice' in isolation. The rationale behind this was to address the aim of conceptualising how the regulator portrayed the concept of 'professionalism' within the undergraduate reference document. However, with challenges arising when considering the content of the outcomes in the professionalism domain, one further avenue of investigation was whether these challenges were specific to demonstrating attainment of professionalism outcomes, or whether within the document they were universal. Therefore, my initial approach was modified, to include analysis of the design and terminology of the outcomes in the 'Clinical', 'Communication' and 'Leadership and Management' domain, to permit comparison in style between domains.

Revision, final analysis of document and verification

The results of the mapping were reviewed in a verification process. This involved revisiting findings (recursive analysis) to confirm sorting and allocations. This also involved engagement with the wider research team to crystallise these aspects.

Further consideration and identification of overarching themes within each document. An overarching theme was considered as encompassing subjects identified in sub-themes.

Consideration of findings

Consideration was given to the narrative of each overarching theme, and the implications both individually and in how overarching themes interact and relate to each other.

3.6 Assurance of analytic rigour

A number of elements were considered and put in place to support the rigour of the analytic process. This included **recursive analysis** (Whittemore et al., 2001, Ely et al., 1997) which was incorporated in both analytic and interpretive modes. Returning to analytic choices, for example decisions on style of writing of statements or coding during thematic analysis was incorporated both at the stage of initial analysis, and at later stages, for example after analysis of other documents to consider if a consistent approach had been applied which would enhance ability to draw comparisons across documents. In terms of interpretative processes, the period of investigation of this research was a number of years, over which time the researcher developed further understanding of various elements either directly or tangentially related to the research topic. The advantages and disadvantages of this approach were considered and to disregard additional insight gained to inform interpretation did not seem pragmatic when considering the purpose of the inquiry – to move forward the way in which education providers work with 'professionalism' in the curriculum.

A **methodical systematic procedure** was adopted for data handling, interpretation and analysis (Malterud, 2001), ensured a consistent approach was applied to each document and thematic analysis. **Memoing** (Jamieson, 2016), the process of recording decision reasoning and my thoughts when analysing data in my research diaries to record analytical choices. Use of meticulous process records, recording procedures and being explicit about the decisions and judgements made, together with the reasoning behind decisions, permitted future review or audit of processes (Mays and Pope, 1995). All of the above would support judgements of dependability (Lincoln and Guba, 1985) of the research. In addition to demonstrating process transparency, I found memoing invaluable when reviewing the decisions that had been made a

period of time after the initial decisions. As noted in the section on recursive analysis, my own understanding and perspective altered during the investigative process. Therefore having records of my thought process and rationale at initial analysis was helpful in considering what may have changed or why I may have a different interpretation after a period of time.

Transparency of coding was another aspect in terms of rigour of analytic processes (Yardley, 2000). Clarity of characteristics for each theme or educational descriptor were necessary so that other researchers could follow the method used in this study. One of the challenges I encountered relatively early on in the research process when reviewing the education literature was both the lack of consistency, and ambiguity, of the terminology used to describe educational goals (Bateman et al., 2017a). Descriptors were therefore developed as part of the analytic process.

In terms of **reflexivity** (Malterud, 2001, Varpio et al., 2017, Ramani et al., 2018) at the beginning of the study (and throughout the process) it was important to consider the position of myself as the researcher (as well as the surrounding research/supervisory team) and the relationship that may have on interactions in the research. How meaning is both constructed and imposed during the research process can be affected by the researcher's position (Varpio et al., 2017). The lead researcher (HB) and two members of the research/supervisory team (JE and GM) were dentally qualified and registered with the General Dental Council. In that capacity, as registrants they were aware of the GDC produced documents and specifically were bound by 'Standards for the Dental Team' (General Dental Council, 2013c) in terms of professional conduct. In this investigation both I, as lead analyst, and another member of the research team (JE) had had extensive involvement with working with one of the primary documents in the research – the GDC 'Preparing for Practice' document and it's earlier iteration (General Dental Council, 2015a, General Dental Council, 2012). HB / JE have had responsibility (for over 7 years) in their institution for mapping the School of Dental Science's curriculum to the GDC curriculum outcomes in Preparing for Practice. They also contributed to assessment blue-printing in the School to ensure demonstration of graduate attainment of the GDC outcomes. During the time spent on the process of mapping and blue-printing, they had encountered challenges in the mapping process and had found it necessary to make decisions and assumptions on how a determination of attainment could be consistently and transparently applied. There was therefore a preconception that there were challenges associated with the format of presentation of the outcomes, but the underpinning details of the challenges were not known. By acknowledging these preconceptions (Tracy, 2013, Ramani et al., 2018), I aimed to overcome any bias in the analysis (Malterud, 2001).

Alongside transparency of the position of the researcher and awareness and consideration of any influences this may have, there was acknowledgement that researcher interpretation is an integral factor in qualitative analysis where a conceptual approach other than positivism is applied (Varpio et al., 2017).

In addition to experiences of curriculum mapping and blue-printing, three members of the research team (HB, JE, GM) were clinical teachers, supervising undergraduate dental students in the clinical environment, giving feedback and undertaking assessment, including judgement of student professionalism. They also all have experience in the practicalities of designing and implementing assessments for the undergraduate curriculum. The remaining member of the research/supervisory team (JS) has a background in social science, and has worked extensively within education research and quality assurance. This element of making clear the relationships that exist with the research will support confirmability of the research (Mann and MacLeod, 2015).

Peer review (Jamieson, 2016) was incorporated in the analysis in the form of the members of the research team not involved in the initial analysis (JE, GM, JS) reviewing the 'education goal' description and the thematic coding of statements within the documents. This enabled **crystallisation** (Richardson and St Pierre, 2005) of the approach rationale and corroboration when justifying the assignment made in the analysis. When there was disagreement between researchers in allocation, the group reviewed the rationale, descriptors and their application, before agreeing on a consensus. Following this remaining outcomes were re-reviewed to ensure any modifications in application were applied consistently.

On a wider 'investigation' level, peer review in the form of the PhD review panel and peer review of abstract and manuscript submissions to peer-reviewed conferences and a journal, together with presentation at conferences contributed to confirmation of credibility (Bateman et al., 2018a, Bateman et al., 2018b, Bateman et al., 2018e, Bateman et al., 2018c, Bateman et al., 2019c). Credibility as a measure of qualitative rigour was proposed by Lincoln and Guba (1985) and further in Guba and Lincoln (1994). In this investigation the element of peer review has been interpreted as contributory to credibility in assessing whether accepted practices have been used to carry out the research and whether the findings appear reasonable to an audience of peers in the clinical education arena (Cleland, 2015).

In terms of **saturation**, we acknowledge that this is difficult to achieve within the context of a single document and there is a limit to the identification and interpretation which can be achieved. Varpio et al. (2017), in their work reflecting on the challenges of the expected use

of specific terms in qualitative research in response in quantitative expectations, have suggested that in terms of 'saturation' the data should be sufficient to allow transferability, together with its ability to answer the research question (Varpio et al., 2017). Following that rationale, in terms of **transferability** (Lincoln and Guba, 1985), this study considered whether the findings would be useful in another, similar context (Cleland, 2015). Question sessions following conference presentations provide an indication of resonance (Tracy, 2013), in terms of whether the reason for investigation and the findings are those with which others working in similar fields of clinical education can understand and identify with.

The integral place of 'professionalism' is similar in many clinical professions, and the way that professional regulators have specified requirements for both qualified and training registrants has similarities across professions. This would suggest that analysis of the way professionalism has been both conceptualised and portrayed / delivered would have transferability outside of dentistry and across other health professions. Transferability beyond a UK setting is less certain for certain aspects of the study. The thematic analysis was based on UK documents and whilst there are likely to be similarities in the way professionalism is conceptualised in other countries, there is evidence in the literature to suggest that the regional context may have an effect. The way in which educational goals have, and potentially could in future be used, would be transferable across an international context as the literature suggests that a similar range of approaches is adopted across a number of countries.

In terms of authenticity (Mann and MacLeod, 2015), this study aimed to include ontological authenticity through increasing awareness of the challenges associated with the phenomena of professionalism, and educative authenticity by providing a framework of understanding of approaches which have been tried and how to use the information generated from these. With this there is potential for catalytic and tactical authenticity by providing guidance on how approaches could be altered which may inspire change through empowering stakeholders (Mann and MacLeod, 2015).

3.7 Ethics and academic integrity

For many research studies, consideration of ethics primarily centres on the well-being and treatment of the participants. In this research there were no 'participants' and the focus was analysis of published documentation. The project team formed the opinion that the nature of the data and the investigation did not require formal ethical approval. The data (documents produced by various UK healthcare regulatory bodies) were in the public domain and freely available and accessible, further, all were widely used by the registrants of each body. An

internal University PhD review panel, one member of which was a former chair of an NHS ethical review panel, reviewed the project. Documentary analysis of clinical policies and guidance of aspects of nursing services was reported in 2012, with the comment that '*the study was reviewed by the NHS research ethics service, which determined that the service evaluation did not require NHS local ethic committee review'* (Drennan et al., 2012 p.341).

Despite documents being less problematic as a source of data in terms of bias in collection, analysing the data does require further consideration, the ethics and credibility of the researcher is in part a consideration (Merriam, 2014). It was acknowledged that the dental members of the project team are registrants of the General Dental Council and are required to comply with many of the documents under analysis, both in terms of personal actions and planning and delivery of education programmes. Mauthner (2002) highlights that it is also important to consider a wider view, that of the potential political impacts and any power relationships affected. In the case of this research, this included ensuring the integrity of the profession was not undermined and that the trust in and legitimacy of both the profession and the regulator were not compromised. That was not about getting the 'approval' of the regulator, as that in itself would be unethical and potentially compromise academic integrity, but in ensuring that the investigation and reporting of findings was an academic enquiry with robust methodology and rigorous procedures.

At stages throughout the research all of the above were revisited for consideration by the research team to assure themselves of the appropriateness of approach.

The next chapter will present the findings of the initial focus for this study, which was analysis and interpretation of the content of policy and governance documents.

Chapter 4. Understanding professionalism through policy and governance documents

After outlining the pragmatic approach adopted to develop a deeper understanding of professionalism in the previous chapter, the initial focus was policy and governance documents related to dentistry (in the UK). This chapter describes the rationale for document selection and the findings of thematic analysis applied to a regulator document intended for qualified dental professionals: Standards for the Dental Team (General Dental Council, 2013c). The objectives of the chapter are:

- To identify and consider document(s) which contribute to the policy and governance of professionalism with specific reference to dentistry in the UK.
- To undertake an analysis of the content of the document(s) identified as influencing professionalism and determine the key themes outlined.
- To consider the emphasis of the themes identified, with a view to identifying the actual messages conveyed.
- To consider the implications for educational and clinical practice from these findings.

4.1 Policy and governance document selection and justification

This phase of the study required identification of appropriate document(s) which described the conduct requirements and professional approach expectations of UK based dental professionals.

As the national regulatory body, GDC-produced documentation was the focus and 'Standards for the Dental Team' (General Dental Council, 2013c) was considered the primary published source of information for dental professionals in the UK in respect of generic requirements concerning conduct, performance and ethics. On the GDC website 'Standards for the Dental Team' is described as setting out the '*standards of conduct, performance and ethics that govern you as a dental professional'* (General Dental Council, 2019d).

When 'Standards for the Dental Team' was introduced, the GDC commissioned an independent research agency, Enventure Research, to survey registrants about their awareness and usage of the new standards. The dataset and report produced by Enventure Research is available on the GDC website (Enventure Research, 2014b, Enventure Research, 2014a). This online survey was sent via email in March-April 2014 and received responses from 843

GDC registrants, approximately 25% of total registrants at that time. There was a representative make-up of respondents by dental professional role, reflecting the GDC registers at that time. Key report findings included that all respondents '*were aware that the GDC sets standards that all registrants must abide by'* (Enventure Research, 2014b p.4) and 93% were aware of the new 'Standards for the Dental Team' which had come into effect (Enventure Research, 2014b).

The report findings demonstrate two important factors of relevance in this research. Firstly, that UK registered dental professionals are aware of the regulatory role of the GDC as their governing body and how this role is pursued by production of standards, that they as registrants must abide by. Secondly, the awareness of this specific GDC document within the UK dental professional group, which reinforces its influence and therefore appropriateness for selection in this research.

Establishing this consciousness was important, as the content of a document will only be influential if people are aware of it. Ensuring visibility of the 'Standards for the Dental Team' content was a regulator priority, not only to registrant groups, but also the public. The document re-iterates that one of the new requirements in the document is for those managing a team to display, in an area visible to patients, information stating that they are regulated by the GDC, together with the nine principles contained in the document (General Dental Council, 2013c).

In terms of the response rate for this survey, non-response can be a problem with online surveys (Vannette et al., 2018). There is also the possibility that survey respondents potentially represented those who were more engaged with GDC activities and therefore there may have been selection bias in the form of response bias.

4.1.1 Other documents considered for analysis to achieve the phase aim

As 'Standards for the Dental Team' was produced by the UK dental regulator, and there was prominent awareness and visibility (Enventure Research, 2014b), the content was considered in this research both relevant and influential. There were other documents produced by the regulator, analysis of which would add to conceptualising the regulator's portrayal and expectations of Professionalism. This would include GDC documents and guidance provided which related to Fitness to Practise (General Dental Council, 2019a). However, these are applicable if concerns are raised about a practitioner's fitness to practise, so will only be directly applicable to a smaller cohort. The profession generally, although aware of the

existence of that information, would be less familiar with the detailed content, and it would therefore be less influential to practice.

Information was also available from indemnity companies and the national dental trade union body, the British Dental Association, but again these are recommendations, and not universally visible or given consideration by all registrants.

4.2 Methodology

The method adopted was document and thematic analysis (see Methodology chapter for rationale and consideration of rigour), with 'Standards for the Dental Team' (General Dental Council, 2013c) as the resource.

4.2.1 Standards for the dental team

'Standards for the Dental Team' (General Dental Council, 2013c) was implemented on 30 September 2013 and replaced 'Standards for Dental Professionals' (General Dental Council, 2005) which had been in effect from 2005 to 2013. Both documents were associated with supplementary guidance documents. Figure 4.1 depicts a timeline of GDC documents produced outlining standards requirements, and associated supplemental guidance documents.

GDC Document	Supplementary/supporting GDC guidance documents
Standards for Dental Professionals Applicable to: All registrant groups Effective 2005 – 2013 (General Dental Council, 2005)	Principles of Patient Consent (published May 2005) Principles of Patient Confidentiality (May 2005) Principles of Dental Team Working (Jan 2006) Principles of Complaints Handling (May 2006) Principles of Raising Concerns (May 2006)
⇩	
Standards for the Dental Team Applicable to: All registrant groups Effective from 30th September 2013 (General Dental Council, 2013c)	Guidance on advertising Guidance on child protection and vulnerable adults Guidance on commissioning and manufacturing dental appliances Guidance on indemnity Guidance on prescribing medicines Guidance on reporting criminal proceedings Guidance on using social media

Figure 4.1 Development of Standards document produced by GDC

The earlier, 'Standards for Dental Professionals' document contained six 'Principles of Practice in Dentistry', this increased to nine principles in the new document. 'Standards for the Dental Team' came into effect on the same date as the GDC's Scope of Practice document (General Dental Council, 2013b), which described what different registrant categories are trained and competent to do.

Document description

'Standards for the Dental Team' (General Dental Council, 2013c) was available to access without financial charge on the GDC website (www.gdc-uk.org > Information, standards and guidance > Standards and guidance > Standards for the dental team) and was downloadable in a pdf format. In printed form the document was an A5 paper sized booklet with 98 pages. When initially published, a hard copy was sent to the registered address of each GDC registrant. It was applicable (as a whole, rather than allocated individual sections) to all registrant groups: dentists; dental therapists; dental hygienists; dental nurses; orthodontic therapists; clinical dental technicians; dental technicians.

The document contained nine principles, each principle had three sections, with multiple statements in each section:

Principle	**Patient Expectations – 'what patients can expect'**
	Standards – 'what registrants must do to ensure patient expectations are met'
	Guidance – 'how registrants meet the standards'

Statement distribution within the Standards document is shown in Table 4.1.

Principle	No. of statements		
	Patient Expectations	Standards	Guidance
Put patients' interests first	9	9	29
Communicate effectively with patients	5	4	19
Obtain valid consent	1	3	16
Maintain and protect patients' information	4	5	25
Have a clear and effective complaints procedure	1	3	19
Work with colleagues on a way that is in patients' best interests	2	6	31
Maintain, develop and work within your professional knowledge and skills	2	5	7
Raise concerns if patients are at risk	2	5	16
Make sure your personal behaviour maintains patients' confidence in you and the dental profession	3	4	12

Table 4.1 Distribution of statements by Principle in Standards for the Dental Team

Selection for analysis

Options for data selection in terms of sections to analyse included whether to focus on specific sections (i.e. 'Patient Expectations', 'Standards' and/or 'Guidance'), or to consider the entirety of content. To be fully representative of the nature of professionalism inferred by

the document, all sections were included. In addition, identification of which statements contained 'Must' and / or 'Should' as part of their wording was recorded.

4.3 Findings

4.3.1 Thematic analysis

Sub-themes in 'Standards for the Dental Team'

Fourteen sub-themes were initially identified, this was revised to twelve after review (Figure 4.2).

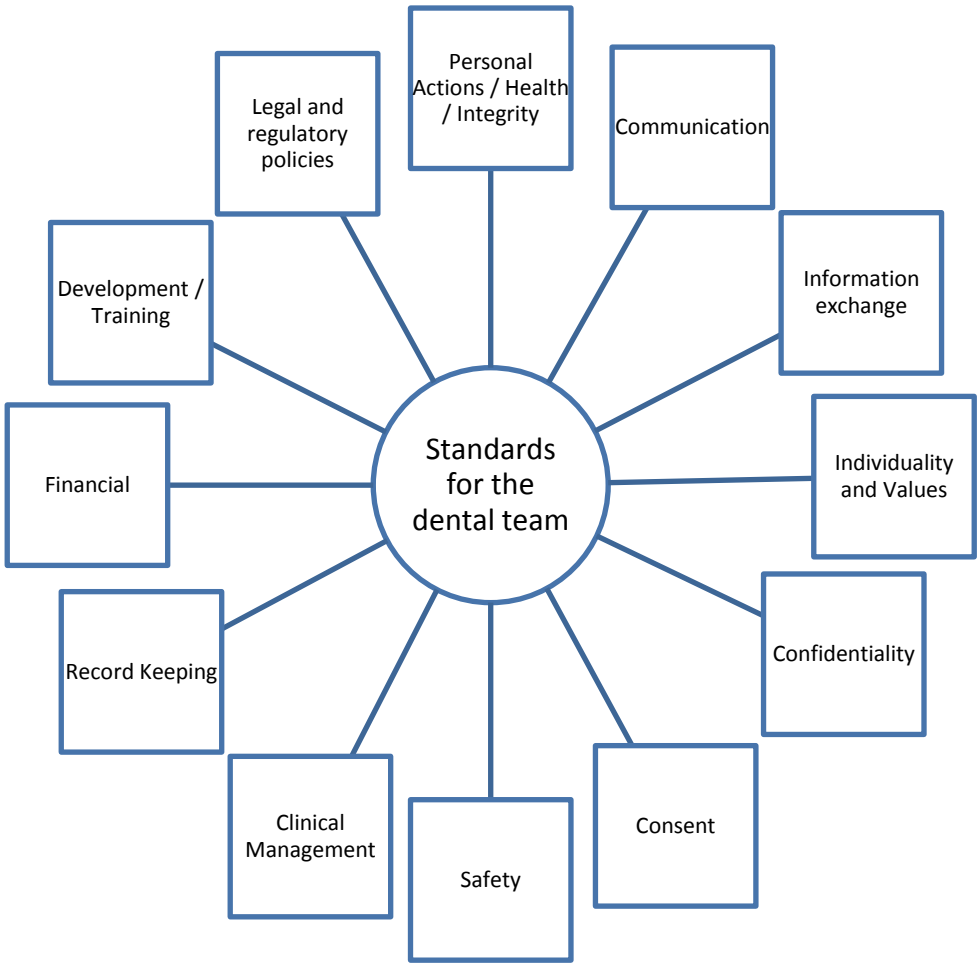

Figure 4.2 Sub-themes identified in 'Standards for the dental team'(General Dental Council, 2013c)

An example of how mapping of each statement by sub-theme was recorded, is in Appendix A. One excel worksheet was created for each of the nine Principles. Analysis of statements by sub-theme is shown in Table 4.2.

Principle / Topic	1 Put patients' interests first			2 Communicate effectively with patients			3 Obtain valid consent			4 Maintain and protect patients' information			5 Have a clear & effective complaints procedure			6 Work with colleagues in a way that is in the patients' best interests			7 Maintain, develop & work within your prof. knowledge & skills			8 Raise concerns if patients are at risk			9 Make sure your personal behaviour maintains patients' confidence….		
Communication	1	2	7	4	3	18	1	1	8			2	1	1	6		1	7									
Information Exchange	1		5	3	2	13		1	5			7			5	1	1	6						1			
Individuality and Values	4	3	8	1	2	2		1	5																		
Confidentiality										1	1	15			1									1			
Consent				2	1	2	1	3	14			5															
Safety	2	1	6									2					1	7			1	2	3	6		1	1
Clinical Management	1		4														2	4		2	2						
Record Keeping						3			7	2	2	14			1			2		1							
Financial	2	2	6	1	1	5		1	2			1			1												
Development / Training			3												3			5	1	1	3		1	1			
Protocol		1	1											1	6			3			1		1	3			
Personal actions / Health / Integrity	2	3	12			1												3	1		2	1	1	3	1	3	12

Pt Expectations Standards Guidance

Table 4.2 Sub-themes in 'Standards for the Dental Team' together with their distribution

Figure 4.3 show sub-theme distribution by statement type (Patient expectations, Standards or Guidance).

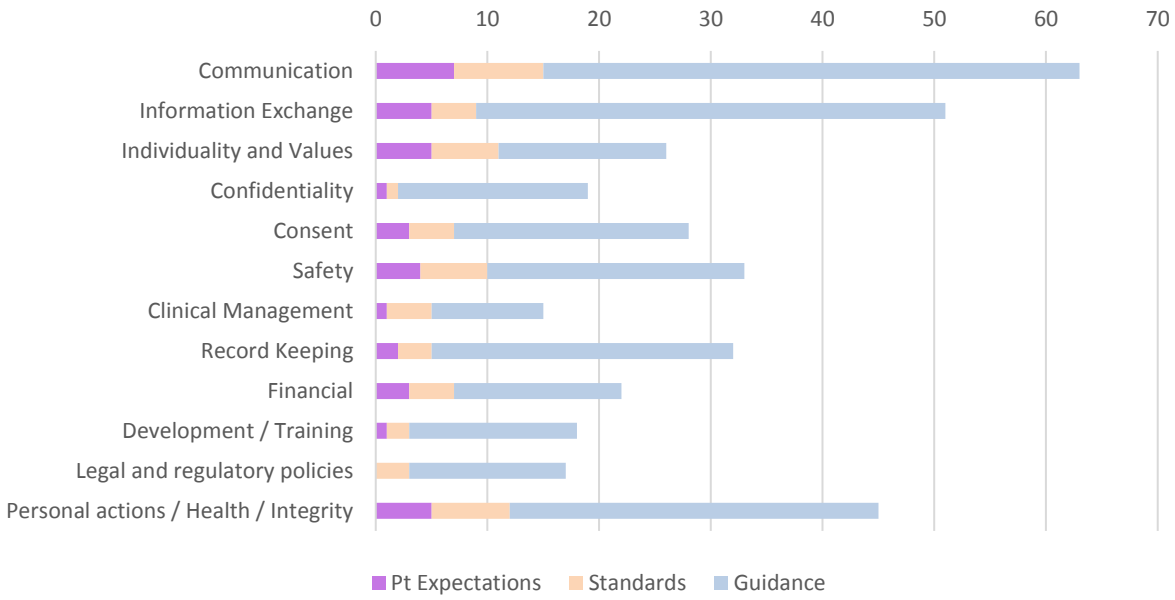

Figure 4.3 Distribution of sub-themes in Standards by type and number of statements

Themes featuring in 'Standards for the Dental Team'

Each sub-theme had a descriptor developed to reflect content. The next stage of analysis was consideration of overarching themes (Table 4.3).

Sub-theme	Descriptor	Overarching theme
Communication	Appropriate, effective communication incorporating verbal, non-verbal and written communication incl. literature and websites. Listening (two-way exchange) and discussions. Emphasis on effective delivery of information to facilitate understanding, not just delivery. Clear, non-misleading information delivery allowing patients time to consider information communicated. Clear, comprehensive communication with colleagues.	Patient
Information Exchange	Sufficient and accurate information transfer to patients and colleagues in a format that is effective, be that verbal or written. What do patients want / need to know. E.g. who they are being treated by, GDC info, prices, complaints, aspects of their treatment and what to do if things go wrong. The giving and receipt of information includes that to other parties.	Patient Regulatory
Individuality	Aspects involved in providing tailored dental care, taking account of individual needs / wishes and requirements. Individual, patient-centred approach. Includes aspects of disability and culture. Health and personal belief/values - equality. Tailored information delivery and exchange.	Patient Regulatory
Confidentiality	Use patients' information (variety of formats) appropriately, store securely, only disseminate when/where appropriate with appropriate permissions / justification. Ensure all those you are working with do this too. Staff concerns must also be maintained as confidential when appropriate.	Patient Regulatory
Consent	Provide sufficient information (options, implications, risks, benefits, outcomes) in a way patient can understand so they are fully informed, allow time and opportunity for questions, to make informed judgements about the care they receive. Ensure this has been received before commencing treatment. Consent also required for transfer of personal information.	Patient Regulatory
Safety	Care delivered should be tailored to patient's needs taking into account their health and well-being. Staff should have appropriate knowledge and skills for tasks they perform and be in a 'fit' state to do these. The environment should be clean and safe, following all applicable legislation and sufficient / appropriately trained staff present. Concerns should be raised and appropriate action taken if concerns about personal or patient safety (internal to dental environment or external elements). Appropriate medical emergency preparation and training should be undertaken and incidents should be recorded and reported as necessary. Personal safety considered and appropriate management undertaken (immunisations etc.).	Patient Regulatory Practitioner
Clinical management	Appropriate care for patients needs to be delivered with regard to the patients' best interests, and with consideration of managing pain and anxiety. Delegation and referral must be managed appropriately and be in the patients best interests. The person delivering the care must have appropriate training / competence. Due regard must be taken for the scope of practice and skill set of those referring / delegating / being delegated to.	Patient Regulatory

Record Keeping	Written treatment plan incl. proposed treatment and costs completed /updated as required. Decision making and justifications documented, with patient discussions. Written consent documented where necessary, otherwise documenting ongoing discussions and consent, including understanding. Patient records must be up to date, contemporaneous, complete, accurate and legible. Records for each visit must be complete and comprehensive. 'Records' encompass notes, radiographs, consent forms, photos, models, Px etc. Must follow appropriate national advice and legislation for retaining, storing, disposing or sharing pt. records. Referrals recorded.	Patient Regulatory
Financial	Patients' interests must be placed before financial gain. Dental professionals must have appropriate indemnity and insurance. They should not accept gifts/payment etc. if doing so could or appear to affect their professional judgement. Pricing info must be clear. Patients can be charged to access their records, within specified limits. There must be arrangements for compensation / redress if a patient suffers harm, this may include correcting work at own expense. Patients must be fully informed about their treatment proposed costs, this must be updated as required. Patients must be fully informed of arrangements and options in terms of NHS / private care.	Patient Regulatory
Development or training	Find out about, be aware of relevant legislation / laws / regulations. Understand roles and responsibilities. Update and develop knowledge and skills throughout working life. Identify areas where improvement needed. Only do tasks / Rx trained / competent in - training should be 'appropriate'. As a registrant - responsible for ensuring those you are responsible for (non-reg) are appropriately trained / competent. Specific areas of development mentioned include CPR / complaints. Embed training culture into practice. As a team encourage, support and facilitate CPD, proper induction / performance management and opportunities to learn and develop.	Practitioner Regulatory
Legal and regulatory policies	Specific 'protocols' in place, specific to area worked in, for procedures related to complaints, safeguarding, compensation, medical emergencies. Guidance of procedures that is clear and includes where appropriate timescales. Emphasises people (staff and or patients) should be aware of protocols and procedures and be able to follow and understand them. Knowledge and following of evidence and best practice.	Regulatory
Personal actions, Health, or Integrity	Honesty, integrity, putting patient's interests first and before financial gain. Actions must reflect well on you as an individual and the wider profession. Interactions with others (staff internal, staff external i.e. referrals etc., patients) must be appropriately undertaken. Formal relationship / dealings with the regulatory body and complying with requirements and responsibilities associated with registration. Acting within / abiding by laws / regulations.	Practitioner Regulatory

Table 4.3 Thematic findings within Standards for the Dental Team

Table 4.4 shows the overarching themes identified in 'Standards for the Dental Team', together with their descriptors.

Category	Descriptor
Patient	Direct relevance to the patient; how they will be kept safe, be respected, be appropriately informed about their care and experience a high standard of care provision.
Regulatory	Focus on the expectations, legal requirements, standards or guidance which exists from a variety of sources (regulator, and national regulation) with which compliance is required for individuals acting in the 'professional' role.
Practitioner	Focus on the practitioner as an individual; their continuing ability to perform their role effectively and safely. Their taking responsibility for their going fitness to practise.

Table 4.4 Overarching theme descriptors for 'Standards for the Dental Team'

4.3.2 Distribution of 'Must' and 'Should'

Statements in the 'Guidance' sections of each Principle could be characterised as either 'Must', 'Should' or 'Both' based on their content and explicit inclusion of 'must' and/or 'should' in the statement. The proportions of these groups were calculated and visually represented in 100% stacked column charts by 'Principle' (Figure 4.4) and by sub-theme (Figure 4.5)

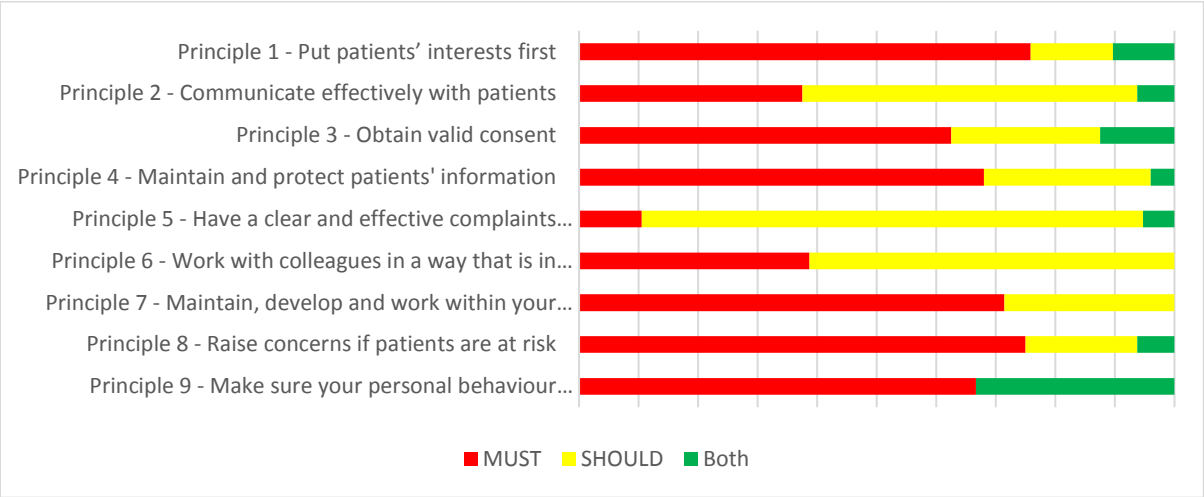

Figure 4.4 Proportion of statements containing 'Must', 'Should' or 'Both' by Principle

Figure 4.5 Proportion of statements containing 'MUST', 'SHOULD' or 'Both' by sub-theme

Sub-themes by predominate 'Must' or 'Should' category are shown in Table 4.5

Greater Proportion MUST	Greater Proportion SHOULD	Proportions approx. EQUAL
Individuality and Values	Communication	Information Exchange
Confidentiality	Legal and regulatory policies	Clinical Management
Consent		Development or Training
Safety		
Record Keeping		
Financial		
Personal actions/Health/Integrity		

Table 4.5 Sub-themes by predominate 'Must' or 'Should' category

4.4 Discussion

4.4.1 Relationship of sub-themes with the principles in the document

There were some clear parallels between the twelve sub-themes identified in this research and the nine principles within Standards. Figure 4.6 illustrates where there were transparent and directly comparable links in terms of content and perception to the published Principles.

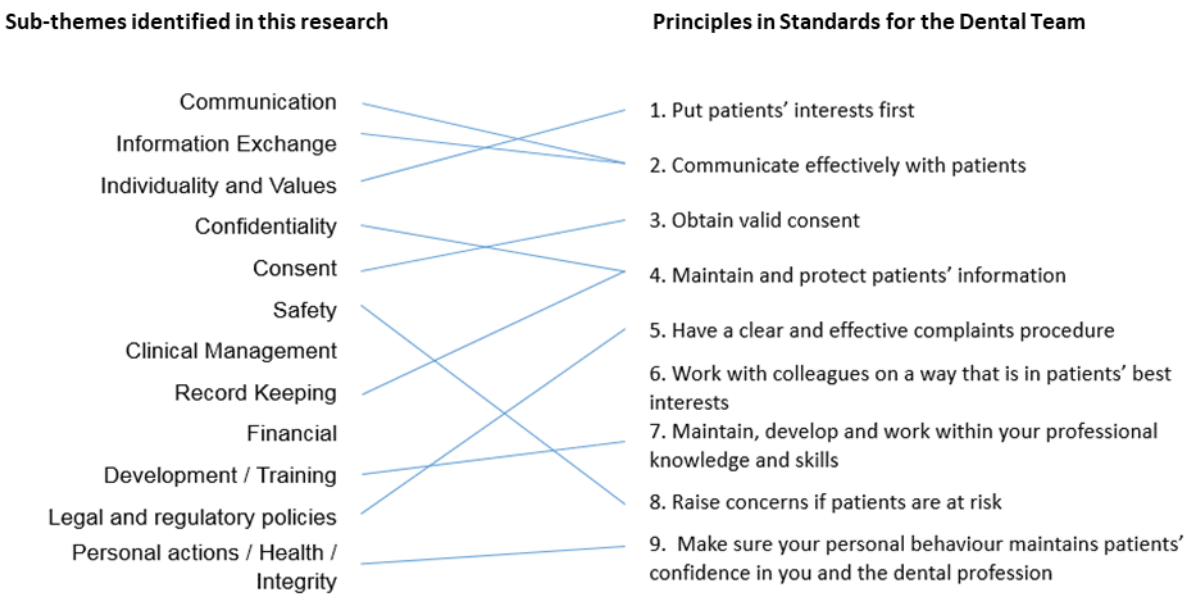

Figure 4.6 Links between identified sub-themes and Principles in Standards for the Dental Team

In terms of aspects associated with Principle 2: *Communicate effectively with patients*, two compelling sub-themes were identified, these were where an observer would likely infer a link: 'communication' and 'information exchange'. Although these two sub-themes are integral to each other when done well, the two are separate considerations, one being the actual information transferred, the other being the method of communication used, tailored to the individual to ensure comprehension.

Whilst the 'Communication' sub-theme linked to Principle 2: *Communicate effectively with patients*, during analysis it was noted that the sub-theme scope differed from that of Principle 2. The GDC principle focused on communication with patients, whereas the sub-theme (identified from the Standards document as a whole) extended to include communication between dental professional colleagues, wider health professionals and the regulator. This could be considered as an illustration that although key principles can be written and considered independently, in reality they interact and overlap as a group of Principles. Only when considered as a whole, rather than in isolation, does the 'richness' and intricate nature of a complex phenomenon such as professionalism become apparent. It may also be a reflection that the primary focus for the GDC is 'protecting patients' and therefore the focus of the principles. There are elements of communication with colleagues, but this is in Principle 6: *Work with colleagues in a way that is in the patients' best interests* and again the underlying focus of this Principle is the patient.

Other sub-themes did not appear to have direct correlation with a specific Principle, but were implied in the way the Principle would be achieved, or in part contribute. For example:

'Individuality and Values' linked to Principle 1: *Put patients' interests first* and Principle 2: *Communicate effectively with patients*. 'Safety' appeared in Principle 1: *Put patients' interests first*. An example of a partial correlation between the sub-theme of 'Protocol' and Principle 5: *Have a clear and effective complaints policy*, where the Principle reflects one element of the larger scope of the sub-theme.

The way in which parallels can be drawn also highlighted that there was specific (rather than a more generic) focus on some areas in the GDC guidance, for example complaints handling. These areas of specific focus could represent areas which have been problematic in the past or the cause of high profile cases. Complaints handling has become a high profile topic over the last decade with an emphasis on articles in the dental press, advice booklets and workshop provision by indemnity providers and the trade union organisation and further guidance being issued by the regulator (General Dental Council, 2019b). With indemnity declaration now a requirement as part of the GDC annual renewal of registration process, and indemnity costs rising, appropriate complaints management has a high profile. Similarly, looking back at some of the higher profile clinical 'scandals' of the last few decades, for example the Mid-Staffordshire NHS Foundation Trust Public Enquiry (Francis, 2013) some of the key points to come out of these are the appropriate sharing of information, working together in the best interests of the patient, raising concerns and the need to have effective complaints handling.

There were also sub-themes identified in the document analysis which have no obvious direct comparator with the Principles, an example is the topic of 'Financial'. However, when looking at the Standards document as a whole, ensuring financial information is communicated to patients and understood during the consent process is included.

In terms of considering the emphasis of the sub-themes, 'Communication' featured most prominently, i.e. within the analysis, it had the greatest number of statements mapped to it. This correlates to the prominence of Principle 2: *Communicate effectively with patients* in the Standards booklet, which had the highest number of associated statements. This suggests that when reading the document, a registrant may infer from the relatively high proportion of statements, that it is one of the more prominent considerations and may therefore infer importance of this area. The next sub-theme most highly weighted was 'Information exchange'.

The sub-themes with lowest coverage within my analysis were 'Clinical management' and 'Legal and Regulatory Policies'. In terms of 'Clinical Management', these focused on planning and delivery of treatment, rather than treatment procedure specifics. These findings

appear, to this researcher from their perspective as a registrant and educator, appropriate when considering the nature of these two areas. The specific detail of 'appropriate' clinical care/treatment may change over time with the evidence base and understanding of best practice. Similarly, protocols and policies will be updated, based on current legislation and best-practice guidelines. It is therefore not the purpose of this type of document to itemise all specific details, as it would become almost immediately out-dated and inaccurate. Instead, to signpost and provide a 'standard' in the way in which registrants should approach care delivery.

Challenges separating integrally linked elements

As a practicing clinician, it is often difficult to separate some important practice matters. In reality they are often integrally linked, and possibly dependant on each other. This was the case with the sub-theme 'Consent', where it was particularly difficult to consider the elements of 'consent' separately from 'communication' and 'information exchange'. This also reflects the way in which professionalism has been described in the literature, as both a meta-skill and second order competence, where it becomes evident when other actions are being undertaken (Zijlstra-Shaw et al., 2012, O'Sullivan et al., 2012b).

4.4.2 What 'Must' or 'Should' findings may infer about 'Professionalism'

There are challenges with outlining precise requirements for some of the sub-themes identified, this may explain why there was a predominance of 'should' statements. For example, both 'Information Exchange' and 'Clinical Management' will be dependent on a number of context dependent factors. It could therefore be argued that there can be no rules which may be implied by a 'must' prefix. That would seem reasonable, however, the same may be thought of 'Individuality and Values' and 'Communication', however they have a predominated and equal 'Must/Should' assignment respectively.

Whether there is importance in the distinction between 'must' and 'should' and whether in practise it makes a difference is debatable. A tentative suggestion is that there may be relevance if there was a challenge to a registrant that they were not considered acting in accordance with the Standards. There, the distinction between should and must may be argued that 'should' is a recommendation rather than a requirement.

Use of language such as 'must' and 'should' in relation to their role in documents which are 'Standards' or 'Guidance' was discussed in the Inquiry into the performance of the College of Dental Surgeons of British Columbia (Cayton, 2018).

4.4.3 Scope of applicability

'Standards for the Dental Team' is applicable to all registered dentists and dental care professionals in the United Kingdom, and having an overarching document could be considered beneficial. Arguably the 'Principles' are relevant to all registrants groups with only the way in which they apply differing. However, inherent challenges should be acknowledged when a universal document is intended for different groups, each of whom have different roles within a profession. The document is applicable to dentists, dental therapists, dental hygienists, dental nurses, orthodontic therapists, clinical dental technicians and dental technicians. In terms of actual direct applicability, although the descriptors of each Principle at face value appear to be appropriate for each registrant group, the statements contained within each principle are not. This means that very little of the document will be directly applicable for registrant groups other than dentists, with appreciably less direct relevance for some groups, for example dental technicians who may have little direct patient contact. Arguably, the impact of this may be that less regard is taken of parts of the document by groups of registrants for whom many sections are not applicable. However, in reality it is likely that this would not be the case, and the nine Principles are likely to be the primary focus; whilst some of the follow-up statements are not applicable, the focus would be on the over-riding Principles. This then raises the question of how beneficial it is to have further detail/guidance statements and whether by their inclusion they focus on specific elements and potentially risk detracting from the over-riding principles.

Publication timing of the document

It is unknown, and outside the scope of this research to investigate or make any supposition, as to what extent, if any, events in the healthcare arena affected the development of the Standards document. It is however reasonable to be aware of the social context and climate in terms of health and dentistry at the time it was produced.

In the same year (2013) the GDC removed barriers to Direct Access to some dental care professionals, meaning that some groups of dental professionals can now see patients directly, without a prescription from a dentist (General Dental Council). The GDC website makes explicit reference to the fact that this was after consideration of impact on patient safety. The Scope of Practice document was also published (General Dental Council, 2013b).

In the broader health arena, a number of high profile documents were published in the year, preceding the publication of 'Standards for the Dental Team'. One of these was 'Liberating the NHS: No decision about me without me' (Department of Health, 2012) which highlighted

the need for a culture of change in the NHS to ensure patient involvement. Another publication was 'The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' (Francis, 2013) which had as one of its essential aims of ensuring shared cultures of putting patients interests first.

4.4.4 Implications from the findings for training

Undergraduate

The analysis of 'Standards for the Dental Team' identified that the 'Clinical Management' sub-theme had relatively little prominence, if based on the number of mapped statements. This however echoes the presentation of learning outcomes in other documents produced by the regulator, one example being 'Preparing for Practice' (General Dental Council, 2015a). 'Preparing for Practice' (General Dental Council, 2015a) outlines requirements of undergraduate dental curricula and the minimum standard a student needs to attain in order to permit graduation. The term 'the safe beginner' is used to describe a dentist with appropriate knowledge and skills to become registered with the GDC and practice independently. Preparing for Practice has four domains of learning outcomes, of which the clinical domain represents one. The Venn diagram on page nine of Preparing for Practice (General Dental Council, 2015a) depicts four overlapping domains (Clinical, Communication, Professionalism, Leadership and Management), suggesting the actual delivery of clinical dentistry is only one element within a whole range of processes and requirements, and there are 'other' equally important aspects. At first glance it may be considered inappropriate that the actual 'doing' part of dentistry has such a small input to the whole, but on further reflection, this makes sense and echoes actual patient interactions and associated management.

Postgraduate

This would be indicative of the scope of the dental foundation training curriculum, and the availability and coverage of the continuing professional development courses. The Dental Foundation Training Curriculum (COPDEND, 2015) is presented as a competency framework under the same four domains as the undergraduate curriculum in Preparing for Practice (General Dental Council, 2015a). The Committee of Postgraduate Dental Deans (COPDEND) document also explicitly references the GDC's Standards for the Dental Team.

In terms of development of professionals, the implementation of the latest continuing professional development scheme in 2018 (Enhanced CPD) has introduced transparency in

the links to specific areas of development with the requirement to articulate specific development outcomes (these are labelled A-D and can be found in full on the GDC website). In a brief summary of what type of CPD may fall into each outcome:

A Communication skills, Raising Concern, Complaints handling, Consent

B Management and Leadership

C Cross infection control, Medical Emergency training, maintenance and development of clinical skills and knowledge

D Legal and ethical issue awareness

'Standards for the Dental Team' is specifically mentioned in terms of considerations when planning CPD activity (General Dental Council, 2018a).

4.5 Critique of methodology applied

The analysis of this document was one of the earliest in the research process. During these initial stages, quantitative analysis was more familiar than the methods and principles of qualitative analysis. It is therefore arguable whether, if this section of the investigation had been completed later in the research process, I would have included breakdown of the sub-themes numerically. I would however argue that the inclusion of this analysis is relevant as the number of times a sub-theme is apparent, whilst possibly not denoting theme importance, reflects the 'flavour' of the document that may be gained by the reader (dental professional).

An analysis of whether 'Standards' document statements were describing a 'behaviour' or an 'action' was initially planned. This was not subsequently implemented, due to feasibility and consistency of attribution. The distinction between the two became indeterminable in many cases, so I determined the resulting data would be not be beneficial in the analysis as a behaviour can characterise the way in which an action is done.

4.6 Summary

In the UK, 'Standards for the Dental Team' is the primary focus for policy and governance requirements of professionalism in dentistry. The document outlines principles, standards and guidance that either 'must' or in some cases 'should' be demonstrated by registrants. Failure to adhere to the document content would pose a risk to GDC registration. The population of dental professionals to which the document applies appears to be aware of its existence and purpose.

During the analysis of the document, there were a number of sub-level themes identified; these encompassed a wide range of attributes. The sub-themes characterise important, but distinctive, parts of a larger concept ('the professional') and these sub-level themes had resonance with those described in the published literature.

The Principles in 'Standards for the Dental Team' when taken as a whole, do appear to provide a good overarching view of the qualities and considerations associated with professionalism. However, it became apparent that when considered in isolation, there was a loss of the richness and encompassing nature apparently inherent in professionalism. This possibly reflects the complexity of the phenomenon and the difficulty in representing it.

This thematic analysis has demonstrated the complexity and diversity of what it is to be a 'professional' in the context of dentistry from the perspective of the UK regulator documentation. This adds to the evidence that simple uni-dimensional consideration of learning, teaching and assessment of 'professionalism' is inappropriate when it is considered against the expectations on those once they are qualified.

To further investigate regulatory requirements, this time with a specific education focus, the next chapter contains my findings following analysis of regulator-produced curriculum documentation.

Chapter 5. Understanding professionalism through the prescribed curriculum documentation

The previous chapter described the findings of thematic analysis applied to a regulator document intended for qualified dental professionals. In demonstrating the complexity and diversity associated with being a 'professional' it raised additional challenges about how professionalism could be managed within the undergraduate curriculum. To build on the specific focus from the perspective of an education provider, this chapter aims to conceptualise professionalism as depicted in the curricula requirements of UK dental schools. What became apparent during the analysis was that the format used to express professionalism goals by the regulator also warranted further exploration. This was because the format itself presented additional challenges to education providers. The objectives of the chapter are:

- To identify and consider the documents which contribute to the curricula requirements of professionalism with specific reference to dental undergraduate students in the UK.
- To undertake an analysis of the content of the document(s) identified which contribute to professionalism curricula and determine the key themes outlined.
- To consider the emphasis of these themes in comparison to other key domains in the document(s) with a view to identifying the actual messages conveyed.
- To consider the implications for providers of undergraduate education and how they may impact on educational practice.

5.1 Curriculum documentation document selection and justification

The General Dental Council (GDC) as the professional regulator of the dental profession in the UK, has responsibility for the quality assurance of UK training programmes which lead to inclusion on the dental registers. To this end, they publish documents, for both primary registration and specialty education, which outline requirements of curricular content and assessment and set educational standards. They also hold responsibility for the processes of programme validation to satisfy regulatory requirements, which includes demonstration of compliance with and attainment of the content of these documents. GDC produced documents were therefore the focus when identifying documents for this phase of the study (Table 5.1).

Document	Year of Publication
Standards for Education: Standards and requirements for providers	(General Dental Council, 2015d)
Preparing for Practice: Dental team learning outcomes for registration (2015 revised edition)	(General Dental Council, 2015a)
Student professionalism and fitness to practise Standards for the dental team: Guidance for students	(General Dental Council, 2016c)
Student Professionalism and Fitness to Practise Standards for the dental team: Guidance for providers	(General Dental Council, 2016b)

Table 5.1 Documentation produced by the UK regulator (GDC) specifically connected to undergraduate education

A key document identified was 'Standards for Education' (General Dental Council, 2015d). That document outlines 21 requirements for providers of UK dental GDC accredited training programmes. This document highlights three areas (Standards) required of providers of dental training programmes, these are: patient protection; quality evaluation and review; student assessment. The Standards for Education document does not have a specific focus on professionalism, it does not use the term 'professionalism', but it does set out the regulator's expectations in terms of learning outcomes attainment. Requirement 9 includes ensuring that the curriculum maps to the latest GDC outcomes and Requirement 10 requires that any serious threat to students achieving the learning outcomes are addressed and the GDC notified. In terms of assessment, Standard 3 requires that student assessment be appropriate to demonstrate learning outcome attainment (General Dental Council, 2015d). The outcomes which are referred to are those detailed in the GDC document 'Preparing for Practice' (General Dental Council, 2015a). 'Preparing for Practice: Dental team learning outcomes for registration' has Professionalism as one of its four domains under which learning outcomes are listed. 'Preparing for Practice' describes what a new dental graduate will 'look like', described as the 'safe beginner'. This document was therefore considered the primary appropriate source to determine curricular requirements.

5.1.1 Preparing for Practice

The original 'Preparing for Practice' document was introduced in 2011/12 (General Dental Council, 2012) and replaced 'The First Five Years' (General Dental Council, 2008). This earlier document outlined only the dentist's curriculum whilst 'Developing the Dental Team' (General Dental Council, 2009) defined the curricula for all members of the Dental Care Professional team. A timeline of GDC documents produced outlining training requirements is shown in Figure 5.1.

The GDC stated on the previous version of their website that there were a specific set of aims that they wished to address by moving to the new 'Preparing for Practice' document. These included: increasing patient focus; meeting current and future oral health needs; inclusion of the full range of skills, knowledge and behaviours needed for working in dental practice; a consistent approach for all registrant categories in one document; and flexibility for training providers. The last two points potentially raise questions as to whether a consistent approach is achievable, whilst allowing flexibility for training providers. This may be recognition that a common approach of training and assessment is not present nationally, even for those in the same registration category (e.g. when students start clinical work, the format and timing of the final examination), so this should be recognised and accommodated in regulatory requirements.

The 2011/12 Preparing for Practice (General Dental Council, 2012) was revised in 2015 (General Dental Council, 2015a). The revised version updates links to other GDC documents, which had become out of date, a number of learning outcomes were modified and a small number of new outcomes were added. Within the professionalism domain, six outcomes had subtle wording changes and a new outcome was added with a focus on 'duty of candour' (GDC Preparing for Practice learning outcome 7.4). The new outcome was likely a direct result of the legal duty requirement introduced for both National Health Service and independent healthcare providers (Care Quality Commission, 2015).

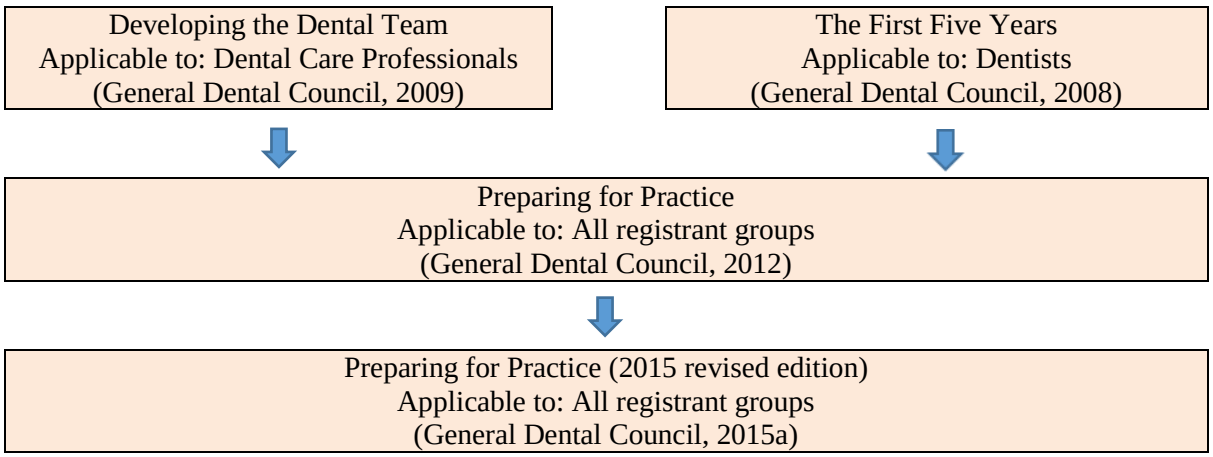

Figure 5.1 Timeline of General Dental Council documents produced outlining training requirements

5.1.2 Other documents considered to achieve the phase aim

Whilst the GDC document 'Preparing for Practice' was the most obvious document when considering influences on the UK undergraduate dental curriculum, others were considered.

The ‘Profile and competences for the European dentist – update 2009’ document (Cowpe et al., 2010) was developed and published by the Association of Dental Education in Europe and was an update to the previous document published in 2005 (Plasschaert et al., 2005). This document, developed by a taskforce comprising of dental educators across Europe sought to identify and describe the key parts of good practice desired in a graduating dentist. The document lists a series of competences, displayed by domains and each domain has ‘major’ competence(s) with supporting competences. The first domain listed is ‘Professionalism’ with 2 ‘major’ competences listed; ‘professional attitude and behaviour’ and ‘ethics and jurisprudence’. Adherence to the content of this document is expected by education providers, but not specifically assessed or regulated. It is likely that awareness of its existence will not be universal amongst a large number of staff on UK dental programmes. The contents therefore, whilst familiar in that they draw from best and evidence-based practice, would not be a primary guiding source for clinical teachers/assessors making a judgement of professionalism in undergraduate students. In this document professionalism is described by ‘competences’ rather than ‘learning outcomes’. Since undertaking the research in this phase another iteration of this Association of Dental Education in Europe document has been published: The Graduating European Dentist: A New Undergraduate Curriculum Framework (Field et al., 2017), this more recent document is not extensively considered here.

Another approach could have included reviewing documentation that had parallel functions to the GDC ‘Preparing for Practice’ document from other countries. Examples may have included the American Dental Education Association document ‘Competencies for the New General Dentist’ (ADEA, 2013) and the Australian Dental Council’s ‘Professional Competencies of the Newly Qualified Dentist’ (Australian Dental Council, 2016). It is interesting to note the title of the Australian Dental Council’s document was revised when the new edition was published, removing the word ‘attributes’ (Australian Dental Council, 2010). Cultural and social norms, together with international differences will affect aspects of professionalism, so whilst analysis of these documents and the opportunity to compare/contrast be interesting, the approach was not adopted. It would have necessitated reduction in the depth of analysis possible of individual documents and findings may have been taken out of context (the result of a limited awareness of the dental system in other countries). Findings would also not reflect the complex nature of professionalism in terms of the governance from a UK perspective.

5.2 Method

The method adopted was document and thematic analysis (see Methodology chapter for rationale and consideration of rigour), with 'Preparing for Practice' (General Dental Council, 2015a) as the resource. The focus was content and utility implications for education planning and implementation.

5.2.1 Preparing for Practice document description

'Preparing for Practice (revised 2015)' (General Dental Council, 2015a) was available to access without financial charge on the GDC website (www.gdc-uk.org > Education and CPD > Dental Education). In printed form the document was an A4 paper booklet with 104 pages. The document was structured with an introduction, followed by a series of learning outcomes for which Providers must demonstrate attainment. The outcomes were presented by profession 'type' (dentist, dental therapist, dental hygienist, dental nurse, orthodontic therapist, clinical dental technician, dental technician), with the same structure and categories used, but varying number and outcome content between groups.

For each registrant group, outcomes are divided into four common domains; Clinical, Communication, Professionalism, Leadership and Management. Table 5.2 shows the comparison of the number outcomes in each domain in the 'Dentist' category.

Domain	Number of outcomes	Relative outcome distribution by domain
Clinical	96	63%
Communication	13	9%
Professionalism	20	13%
Leadership & Management	23	15%

Table 5.2 Number of learning outcomes in each domain of Preparing for Practice (General Dental Council, 2015a)

Within the 'Aim' section of Preparing for Practice (General Dental Council, 2015a), the skills required in the domain of professionalism were defined as:

> *'…the knowledge, skills and attitudes/behaviours required to practise in an ethical and appropriate way, putting patients' needs first and promoting confidence in the dental team'* (General Dental Council, 2015a p.5)

Further information presented specific to the 'professionalism domain' states '*the professionalism of registrants is a key focus for the GDC'* (General Dental Council, 2015a p.12) and that recognising the importance of professionalism is essential for students from the beginning of their training, as is demonstrating professional attributes and behaviours. There were also clear links to documents applicable to qualified and registered UK dental professionals (Figure 5.2).

Figure 5.2 Documents referred to as further sources of information in Preparing for Practice

Introducing the professionalism domain in Preparing for Practice, the document states: '*This domain draws widely from the GDC Standards for the Dental Team'* (General Dental Council, 2015a p.12). The 2012 iteration of 'Preparing for Practice' referenced an out of date GDC document, the current 'Standards for the Dental Team' (General Dental Council, 2013c) document was updated in 2013. Other documentation referred to was available on the GDC website and included 'Continuing Professional Development for dental professionals' (General Dental Council, 2013a) and 'Scope of Practice' (General Dental Council, 2013b). A further link is made to an NHS resource, 'Learning to Manage Health Information – NHS 2012', unfortunately there is no bibliography section in the document, despite being listed on the contents page, so this document was difficult to fully identify and locate.

Professionalism domain 'outcomes' in the document are further sub-divided and presented in sections under sub-headings, these together with their numerical distribution are shown in Table 5.3.

Domain	Number of learning outcomes
Professionalism	20
Patients and the public	5
Ethical and Legal	5
Teamwork	3
Development of self and others	7

Table 5.3 The distribution of the Professionalism domain learning outcomes by sub-heading

The GDC website underwent significant restructuring in early 2017, until then, search terms 'Preparing for Practice' or 'GDC Preparing for Practice' entered in popular search engines resulted in the highest link to a pdf 2012 version of the document. Following website restructuring, the 2012 version of 'Preparing for Practice' (General Dental Council, 2012) and 'Dentists: The first five years' (General Dental Council, 2008) were not immediately accessible in the education section, but could be found using the site's search facility.

5.2.2 Selection for analysis

The introductory section of 'Preparing for Practice' listed seven 'overarching learning outcomes' which applied across domains, to all registration categories. In this analysis only outcomes listed within domains were considered, the rationale being that overarching outcomes are less detailed conglomerations of domain outcomes. By focusing on outcomes within domains, further detail could be collected and analysed. The focus was the 'dentist' professionalism domain (outcomes specifically associated with 'professionalism' by the GDC) as the aim was consideration of the regulator's perspective of 'professionalism' for those entering the profession as a dentist.

5.2.3 Document analysis

In the scrutiny of whether 'educational' requirements of a 'learning outcome' were fulfilled, and analysis of what was needed to demonstrate attainment, the following were recorded.

- Was the statement a learning outcome? (if not, what type of education goal)
- The 'action verb' in the outcome.
- The Bloom's taxonomy domain (cognitive / affective / psychomotor) and level within the declared Bloom's domain.
- Whether there was a clear means of assessing the outcome: if an established tool existed which is reproducible and assesses what we mean to assess. Possible options included: an

obvious means of assessment; an ability to partially assess the outcome; no reliable way to overtly assess the outcome (Figure 5.3).

- If no clear assessment method, whether absence of an incident or adverse event would imply attainment. In essence, were there 'outcomes' which 'an absence of demonstrable evidence of failure to fulfil an outcome' was more readily identified than attainment of that outcome, and therefore would 'absence of failure' equate to 'successful attainment'?

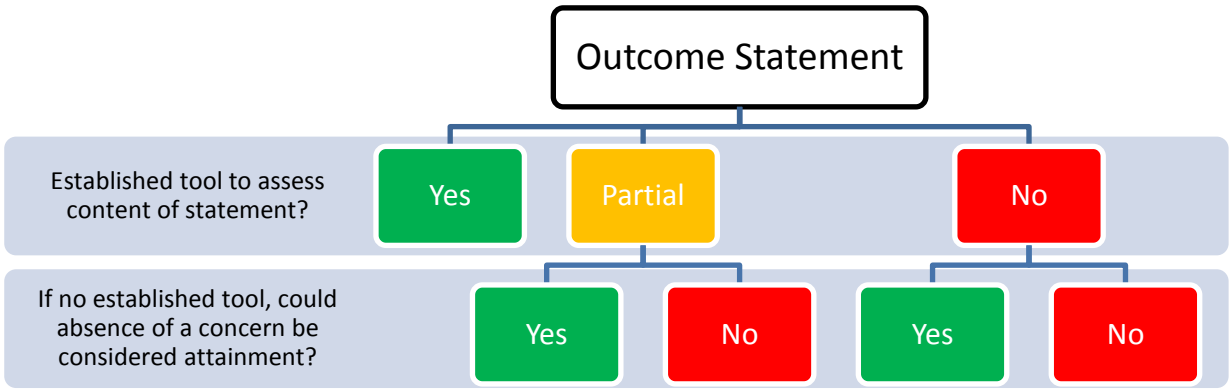

Figure 5.3 Assessment tool considerations for statements within Preparing of Practice

5.2.4 Method critique following initial results

Initially analysis was confined to the 'professionalism' domain, with the rationale of conceptualising how the regulator portrayed the concept of 'professionalism' within the undergraduate document. However, with challenges identified regarding outcome content in the professionalism domain, a further avenue of investigation was whether these challenges were specific to professionalism outcomes, or universal in the document. Therefore, the modified approach included analysis of design and terminology of outcomes in the other domains to permit comparison. The initial approach of limiting analysis to the professionalism domain was appropriate in terms of conceptualising how the regulator presents 'professionalism' in its curricular documents (i.e. the content). However, in terms of application (how 'helpful' and 'attainable' the defined outcomes are in the education arena) extension of the original scope was important/necessary to identify whether it was the concept of 'professionalism' which resulted in outcome challenges, or whether it was the approach taken by the authors of this particular document. Key questions were:

- What 'style' of learning outcomes (or other educational goal) were used in other domains?
- How did this compare to the professionalism domain?
- Did other Preparing for Practice domains focus on specific Bloom's taxonomy domains?

5.3 Findings

5.3.1 Thematic analysis

Sub-themes in 'Preparing for Practice'

11 sub-themes were identified Figure 5.4. Mapping of each statement (outcome) to sub-theme is shown in Table 5.4.

Figure 5.4 Sub-themes identified from 'Preparing for Practice' (General Dental Council, 2015a) following document analysis.

		Communication	Individuality and Values	Confidentiality	Safety	Clinical (case) Management	Record Keeping	Development / Training	Legal & regulatory	Personal actions Health /Integrity	Interplay of roles / collegiality	Management of self
6 Patients and the public	6.1 Put patients' interests first and act to protect them				X					X		
	6.2 Be honest and act with integrity									X		
	6.3 Respect patients' dignity and choices		X									
	6.4 Maintain and protect patients' information			X			X					
	6.5 Recognise and respect the patient's perspective and expectations of dental care and the role of the dental team taking into account current equality and diversity legislation, noting that this may differ in England, Scotland, Wales and Northern Ireland		X						X			
7 Ethical and legal	7.1 Be familiar with and act within the GDC's standards and within other professionally relevant laws, ethical guidance and systems							X	X	X		
	7.2 Recognise and act upon the legal and ethical responsibilities involved in protecting and promoting the health of individual patients								X	X		
	7.3 Act without discrimination and show respect for patients, colleagues and peers and the general public		X							X		
	7.4 Recognise the importance of candour and effective communication with patients when things go wrong, knowing how and where to report any patient safety issues which arise	X			X							
	7.5 Take responsibility for and act to raise concerns about your own or others' health, behaviour or professional performance as described in Standards for the Dental Team, Principle 8 Raise concerns if patients are at risk									X		
8 Teamwork	8.1 Describe and respect the roles of dental and other healthcare professionals in the context of learning and working in a dental and wider healthcare team										X	
	8.2 Ensure that any team you are involved in works together to provide appropriate dental care for patients										X	
	8.3 Explain the contribution that team members and effective team working makes to the delivery of safe and effective high quality care				X						X	

		Communication	Individuality and Values	Confidentiality	Safety	Clinical (case) Management	Record Keeping	Development / Training	Legal & regulatory	Personal actions Health /Integrity	Interplay of roles / collegiality	Management of self
9 Development of self and others	9.1 Recognise and demonstrate own professional responsibility in the development of self and the rest of the team							X				X
	9.2 Utilise the provision and receipt of effective feedback in the professional development of self and others							X				X
	9.3 Explain the range of methods of learning and teaching available and the importance of assessment, feedback, critical reflection, identification of learning needs and appraisal in personal development planning							X				X
	9.4 Develop and maintain professional knowledge and competence and demonstrate commitment to lifelong learning							X				X
	9.5 Recognise and evaluate the impact of new techniques and technologies in clinical practice							X				
	9.6 Accurately assess their own capabilities and limitations in the interest of high quality patient care and seek advice from supervisors or colleagues where appropriate				X	X						X
	9.7 Explain and demonstrate the attributes of professional attitudes and behaviour in all environments and media									X		

Table 5.4 Analysis of Professionalism domain outcomes in Preparing for Practice by sub-themes

The sub-themes identified had significant overlap with those in the GDC 'Standards' document, with the addition of an 'Interplay of roles/collegiality' and 'Management of self' sub-theme. Table 5.5 shows sub-theme frequency and Table 5.6 sub-theme distribution by sub-sections in the 'Preparing for Practice' Professionalism domain.

Sub-theme	No. of LO's
Communication	1
Individuality and Values	3
Confidentiality	1
Safety	4
Clinical (case) management	1
Record Keeping	1
Development / Training	6
Legal and regulatory policies	3
Personal actions / Health / Integrity	5
Interplay of roles / collegiality	3
Management of self	5

Table 5.5 Sub-theme frequency of Preparing for Practice Professionalism domain learning outcomes

Preparing for Practice Professionalism domain sub-heading	Sub-themes identified in thematic analysis
Patients and the public	Individuality and Values Confidentiality Safety Record Keeping Legal and regulatory policies Personal actions / Health / Integrity
Ethical and legal	Communication Individuality and Values Safety Development / Training Legal and regulatory policies Personal actions / Health / Integrity
Teamwork	Safety Interplay of roles / collegiality
Development of self and others	Safety Clinical (case) management Development / Training Personal actions / Health / Integrity

Table 5.6 Sub-theme distribution by sub-sections in 'Preparing for Practice' Professionalism domain

Overarching themes in Preparing for Practice

Each sub-theme had a descriptor developed which reflected content. The next analysis stage was consideration of overarching themes which encompassed sub-themes (Table 5.7).

Sub-theme	Descriptor	Theme
Communication	Importance of candour and effective communication.	Patient Regulatory
Individuality	Recognising and respecting patient's dignity, perspective and choices. Not discriminating, account taken of equality and diversity.	Patient
Confidentiality	Protection of patient information.	Patient Regulatory
Safety	Act to protect patients, report patient safety issues, work as a team to deliver safe patient care, assess own capabilities in interest of safe patient care, seek advice when needed.	Patient
Clinical (case) management	Assess own capabilities in interest of safe patient care, seek advice when needed.	Practitioner
Record Keeping	Maintain and protect patient information.	Regulatory
Development or training	Be familiar with, and take responsibility for development of self and others, utilising the provision and receipt of effective feedback. Find out about, be aware of relevant legislation / laws / regulations. Update and develop knowledge and skills throughout working life. Engage in reflection and personal development planning.	Practitioner Regulatory
Legal and regulatory policies	Familiarity with relevant laws, guidance and systems.	Regulatory
Personal actions / Health / Integrity	Honesty, integrity, putting patient's interests first. Actions must reflect well on you as an individual and the wider profession. Acting within / abiding by laws / regulations. Raising concern where appropriate.	Practitioner Regulatory Patient
Interplay of roles / collegiality	Describe and respect the roles of the dental and wider healthcare team. Work together to deliver safe and effective patient care.	Patient
Management of self	Self-regulation, reflection, self-awareness and development of personal abilities and skills.	Practitioner

Table 5.7 Overarching theme findings for Preparing for Practice

The overarching themes identified (the patient, regulatory, practitioner) had overlapping contributory elements. A descriptor of each overarching theme was developed by considering the component parts (Table 5.8).

Overarching theme	Descriptor
The patient as the focus	Direct relevance to the patient; how they will be kept safe, be respected, be appropriately informed about their care and experience a high standard of care provision.
Regulatory considerations and obligations	Focus on the expectations, legal requirements, standards or guidance which exists from a variety of sources (regulator, public expectation and national regulation) with which compliance is required for individuals acting in the 'professional' role.
The practitioner as the focus	Focus on the practitioner as an individual; their continuing ability to perform their role effectively and safely. Their taking responsibility for their on-going fitness to practise.

Table 5.8 Overarching theme descriptors for Preparing for Practice Professionalism domain

5.3.2 Initial outcome analysis challenges

Challenges arose in both how learning outcome 'status' was assigned, and in the application of Bloom's taxonomy. For many Preparing for Practice outcomes, it was challenging to determine if the statement was actually an outcome. This was in part due to my preconception and experience of working with learning outcomes, where a defining feature is having a tangible 'outcome' or measureable method of assessment. In terms of functionality, considering how the document could assist education providers in demonstrating attainment of the stated requirements in the 'professionalism' domain was necessary. This translated to a practical and pragmatic application from the perspective for those working in educational establishments. Examples of challenges:

- Challenges in applying a taxonomy to outcomes;
- Interpretation of what is required and how 'attainment' could be satisfied;
- Consideration when multiple component elements exist within outcomes.

Taxonomy application

Two challenges arose applying Bloom's taxonomy to Professionalism domain outcomes:

- Assignment of a learning domain;
- Consideration of which level within the learning domain was appropriate.

When it came to determining which learning domain the statements were associated with, it was the outcome they were describing which led to classifying them as either cognitive, affective or psychomotor. In some instances, determination of learning domain proved challenging when specific actions were not apparent – for example GDC 8.2:

> *8.2 Ensure that any team you are involved in works together to provide appropriate dental care for patients (General Dental Council, 2015a)*

There may be affective components of 'team working', cognitive elements of knowing how and why teams work more effectively, or potentially a practical task application. A further example where domain determination was not apparent, potentially cognitive or attitudinal, was GDC 9.2:

> *9.2 Utilise the provision and receipt of effective feedback in the professional development of self and others (General Dental Council, 2015a)*

This outcome does not require actual feedback delivery (this is in the communication domain), therefore is a level of cognitive awareness of feedback and its use required in this instance, or is it an inner value within the affective domain (the value belief in the value of feedback)? As a clinical supervisor, I may attach a greater significance to the connection with the affective domain, making an assumption that if one values something there is a presumption that there is underlying knowledge as to its purpose. However, whether this is this necessary to fulfil the requirement is unclear.

In terms of practical application and assigning a 'level' on the hierarchy, challenges arose when the verb within the statement was not specifically listed in the taxonomy, for example '*maintain'* or '*protect'*, or when an element of interpretation was required as to what was needed or meant by a statement. This necessitated application of a personal interpretation of what was considered necessary, and then trying to transpose that to a pre-defined set of descriptive acts. There were also instances where the same verb appeared in different levels when looking at different versions of the taxonomy. An example of this in the affective domain, 'Act', sometimes appears at the 'Value' level, sometimes at the higher 'internalize value system' level. Determining how to apply levels could be difficult in these cases, and a judgement was made considering the context of the outcome. This judgement was based on my experience as a clinician and clinical educator of what I believed the outcome asked for, and what I deemed the necessary skills to achieve it.

Interpretation of requirements and satisfactory attainment

In some instances outcomes provided guidance on how the elements could, at least in part, be tangibly assessed or considered 'attained'. Examples where a quantifiable approach to demonstrating a skill, knowledge or behaviour was incorporated are:

> *8.3 'Explain the contribution that team members and effective team working makes to the delivery of safe and effective high quality care' (General Dental Council, 2015a)*

> *9.3 'Explain the range of methods of learning and teaching available and the importance of assessment, feedback, critical reflection, identification of learning needs and appraisal in personal development planning' (General Dental Council, 2015a)*

In these examples, the cognitive domain verb 'explain' requirement would lead to an obvious assessment opportunity which would enable demonstration of 'attainment'.

However, it also became clear when analysing the document that there was for some outcomes, a degree of interpretation in what the learning outcomes required to satisfy attainment, therefore different training providers may consider 'attainment' differently. For example GDC 6.5:

> *6.5 Recognise and respect the patient's perspective and expectations of dental care and the role of the dental team taking into account current equality and diversity legislation, noting that this may differ in England, Scotland, Wales and Northern Ireland (General Dental Council, 2015a)*

There are elements of both the cognitive domain, possibly at the 'remembering' level if 'recognise' is taken as the action verb, but also an affective component in terms of 'respect' which may indicate a 'value' level within the learning domain. How an education provider assesses the 'respect' for a patient's expectations a student has may be challenging. It may be that 'listen to and take account of these expectations when delivering patient care' is what was intended, but if that was the case, why not state this explicitly, the potential for variable interpretation between education providers is therefore high.

In many cases statements were 'outcomes' but without currently valid / reliable methods of assessment. An example of this is GDC 7.3:

> *7.3 Act without discrimination and show respect for patients, colleagues and peers and the general public (General Dental Council, 2015a)*

Multiple component elements within outcomes

Document analysis highlighted that many statements comprised of multiple component elements, which could be considered as separate, possibly independent attainments. It was also sometimes possible to demonstrate some elements within a statement, but not others. Examples highlighting these application problems include:

> *6.5 'Recognise and respect the patient's perspective and expectations of dental care and the role of the dental team taking into account current equality and diversity legislation, noting that this may differ in England, Scotland, Wales and Northern Ireland' (General Dental Council, 2015a)*

7.1 'Be familiar with and act within the GDC's standards and within other professionally relevant laws, ethical guidance and systems' (General Dental Council, 2015a)

8.1 'Describe and respect the roles of dental and other healthcare professionals in the context of learning and working in a dental and wider healthcare team' (General Dental Council, 2015a)

In the first example (6.5) there could be an inference that there is a need to know the equality and diversity legislation in order to 'respect' it, therefore a cognitive element which could be assessed in terms of the 'recognise' part of the outcome. The remaining requirement to 'respect' could potentially be interpreted as absence of a concern being raised that a student has not respected a patient's perspective and expectations. The second example (7.1) includes terminology which would normally be avoided when writing learning outcomes in 'be familiar with', but accepting that, the phrase 'to be familiar with' may have a connotation that one must know 'x', therefore again, this cognitive part of the outcome is assessable. The 'act' part of the outcome is more difficult to tangibly assess, but again this could be considered as an absence of concerns raised. In the final example (8.1), 'describe' is assessable and could be demonstrated in a variety of ways, but the '*respect'* is difficult to measure and this outcome therefore relies on an ability to assess attitudes. There is no currently accepted robust tool to consider assessment of attitudes and reliance on observable behaviours also has weaknesses (Rees and Knight, 2007, van Mook et al., 2009, Ginsburg et al., 2004). So, from a practical application perspective, attainment demonstration of this outcome presents challenges Potentially the 'respect' part of outcome 8.1 could be interpreted as 'adhere to', which if considered as a behaviour, could potentially be assessed in the absence of a concern raised.

When multiple component parts exist in outcomes, it is questionable whether providers will mark 'attainment' if only partially attained. This raises questions over consistency in approach across providers when mapping curricula. Different interpretations of 'attainment' could potentially undermine the 'purpose' of having a universal document from the regulator.

5.3.3 Additional considerations following initial analysis

Another issue when considering the practicalities of demonstrating attainment of the statements in Preparing for Practice was how they could be applied in the context of a learner in a supervised environment (i.e. does a learner working under supervision in a learning environment have an opportunity to demonstrate the traits contained in the 'outcome'). The reality of a programme of study as an undergraduate dental student is that they are not

operating as independent practitioners, which raises questions to whether some of the statements should be considered aspirational. An example of this is below (Table 5.9):

GDC Preparing for Practice 'outcome'	Comments
8.2 Ensure that any team you are involved in works together to provide appropriate dental care for patients	Not sure how this could be assessed and is it within the control of a student in the context / constraints that they operate?

Table 5.9 Example of challenges of the supervised environment

When considering student assessment at the highest taxonomy levels (for example Internalise or Characterize Values), how to give students the opportunity to display 'act', 'influence' or 'practice', and reliably assess these certainly poses challenges within an assessment framework. Equality of opportunity, with the ability to enable students to have comparability of experience and occasions for assessment, would be a significant consideration when designing assessments.

When working with the Preparing for Practice document, I also observed apparent elements of commonality with the wording and phrases in the 'Standards for the Dental Team' document previously analysed. This warranted further investigation.

5.4 Revised Method

There were three strands within the revised method:

- Revised approach to consideration of statements as 'outcomes';
- Consideration of the supervised environment;
- Comparison with the language used in 'Standards for the dental team'.

As outlined above, practical application and what would constitute satisfactory 'attainment', was ambiguous for a number of the outcome statements, despite their initially being considered an 'outcome'. 'Outcome' status was therefore revisited, my designation of the potential options in terms of educational goal are shown in Table 5.10.

Principle	An approach that should be applied to activities undertaken as a professional.
Standard	An approach that should be applied to all activities undertaken as a professional. Provides an indication of the appropriate level which is expected to demonstrate achievement.
Objective	An expression of the intended educational purpose from the perspective of the educator. The delivery and direction has been outlined.
Outcome with feasibility challenges	Where the statement contains the characteristics of a learning outcome, but in terms of practical application, challenges arise: Technically defines an endpoint and has an action verb to describe the level of this expectation, but with current available assessment tools not possible to assess attainment of this outcome.
Functional Outcome	Endpoint defined and a tangible means of assessment is available to determine attainment.

Table 5.10 Descriptors developed for educational goals in this study

To demonstrate the complexity of assigning a 'status' to each statement, an example of how components of a statement may be classified differently is displayed below using GDC 8.1 (Table 5.11):

8.1 Describe and respect the roles of dental and other healthcare professionals in the context of learning and working in a dental and wider healthcare team	
Describe ~~and respect~~ the roles of dental and other healthcare professionals in the context of learning and working in a dental and wider healthcare team	Functional outcome: '*Describe'* element of the outcome can be explicitly assessed
~~Describe and~~ respect the roles of dental and other healthcare professionals in the context of learning and working in a dental and wider healthcare team	Outcome with feasibility challenges: *'respect'* although technically an outcome in Bloom's affective domain is difficult to actively assess. The 'assessment' of absence may be more obvious (i.e. demonstrable lack of respect).

Table 5.11 Example of classification of GDC statements using educational goal descriptors

Statements were also annotated with observations, based on my clinical educator experience, of the practicalities in demonstrating attainment in the supervised environment context (i.e. whether a learner has opportunity to demonstrate the 'outcome' traits).

In terms of identifying the commonality of wording with 'Standards for the Dental Team', key words / phrases from Preparing for Practice were entered into a simple document search of the 'Standards' document to investigate wording and phrase commonality.

5.5 Further Findings

Revised 'outcome' status and supervised environment findings were tabulated in an excel spreadsheet (Table 5.12). Comparison with language and wording used in 'Standards for the Dental Team' is shown in Table 5.13.

Upon registration the GDC registrant will be able to:-	Elements of presentation style	Narrative of the quality as an 'outcome', elements of educational style and impact of the supervised learning environment
6.1 Put patients' interests first and act to protect them	Standard / Outcome with feasibility challenges	The first part 'Put patients' interests first' is a standard. The second part is an outcome with the action verb being 'Act', but how is this assessed? Within a supervised environment, the supervising clinician is ultimately responsible for the patient and planning decisions, not the student. The learner does not have the independence but can contribute to the process.
6.2 Be honest and act with integrity	Standard / Outcome with feasibility challenges	'Be honest' is a standard, 'act with integrity' is an outcome. No tangible outcome to assess. Honesty and integrity would ideally be longitudinal qualities? Generally the concept is ok for the learning environment.
6.3 Respect patients' dignity and choices	Outcome with feasibility challenges	'Respect' is technically an Outcome as it is in Bloom's taxonomy affective domain, but can you assess an individual's value of something? Or really is it listen to and take account of? Difficult to 'standardise' an assessment which will allow this to be demonstrated across a cohort. Likely to demonstrate an occurrence, not longitudinal and multiple applications.
6.4 Maintain and protect patients' information	Functional Outcome	Inference of Information Governance compliance? A tangible outcome which can be assessed by current means. Can be delivered by a learner in a supervised environment
6.5 Recognise and respect the patient's perspective and expectations of dental care and the role of the dental team taking into account current equality and diversity legislation, noting that this may differ in England, Scotland, Wales and Northern Ireland	Outcome with feasibility challenges	'Recognise' is not a good verb (although in Bloom's cognitive domain), how do you assess someone's recognition? 'Respect' is an outcome, but how is this assessed? Not clear as to the tangible outcome to be assessed. Many different elements included, it is however possible to consider these elements in a learning / supervised environment.
7.1 Be familiar with and act within the GDC's standards and within other professionally relevant laws, ethical guidance and systems	Objective / Outcome with feasibility challenges	'Be familiar with' is not an 'outcome', how do you measure 'familiarity'? Difficult to quantify as encompasses a range of non-specified elements. Familiarity can be considered at a point in time, but 'act within' implies a more longitudinal activity. Within a learning environment, challenges can arise with the student's ability to display the full scope of activities indicated.
7.2 Recognise and act upon the legal and ethical responsibilities involved in protecting and promoting the health of individual patients	Objective / Outcome with feasibility challenges	Very broad. Not obviously assessable as no specific tangible elements identified. Challenging to consider in terms of equal opportunities to demonstrate for all students, within an environment of supervision, a limited opportunities.
7.3 Act without discrimination and show respect for patients, colleagues and peers and the general public	Outcome with feasibility challenges	Difficult to quantify/assess. This is a longitudinal view and with disparate groups of people mentioned this will happen at different times. Do ALL students actively have interactions with 'the general public' which is distinct from 'patients' in a way that can be actively measured and assessed? Requires assessment of a behaviour.
7.4 Recognise the importance of candour and effective communication with patients when things go wrong, knowing how and where to report any patient safety issues which arise	Functional Outcome	'Recognise' is not a good verb, how do you assess someone's recognition? Describing the importance of candour etc. and reporting of patient safety issues (i.e. protocols) can be assessed. Clear articulation of a tangible outcome measure. Ok for a learner in a supervised environment.
7.5 Take responsibility for and act to raise concerns about your own or others' health, behaviour or professional performance as described in Standards for the Dental Team, Principle 8 Raise concerns if patients are at risk	Outcome with feasibility challenges	In the context of a student environment / practice, are there recognisable opportunities for demonstrating this available to all students? Knowledge about how, why and when to raise concerns could be assessed, but the actual 'act' does not seem a universal and standardised opportunity.
8.1 Describe and respect the roles of dental and other healthcare professionals in the context of learning and working in a dental and wider healthcare team	Functional Outcome / Outcome with feasibility challenges	The 'describe' element of the outcome can be assessed, but 'respect' although an outcome in Bloom's affective domain is difficult to assess, the 'assessment' of 'failure to respect' is more straightforward. Appropriate for a learner in a supervised environment.

8.2 Ensure that any team you are involved in works together to provide appropriate dental care for patients	Objective	Unsure how this could be assessed and whether it within the control of a student in the context that they operate? Tangible outcome measures?
8.3 Explain the contribution that team members and effective team working makes to the delivery of safe and effective high quality care	Functional Outcome	Explicit statement of what needs to be done to demonstrate attainment. Tangible, can be assessed in a number of ways. Appropriate for a student in a learning environment.
9.1 Recognise and demonstrate own professional responsibility in the development of self and the rest of the team	Outcome with feasibility challenges	How to assess someone's recognition of their own professional responsibility? What is an appropriate 'level'? In the context of a student environment / practice, are there recognisable opportunities for demonstrating development of 'the rest of the team'? Will a standardised opportunity exist for all students?
9.2 Utilise the provision and receipt of effective feedback in the professional development of self and others	Functional Outcome / Outcome with feasibility challenges	Delivery of 'effective feedback' can be assessed. How someone uses feedback in their own professional development is more difficult to tangibly determine/assess. A longitudinal, 'cause and effect' action. Limited opportunity within a supervised learning environment in a finite programme.
9.3 Explain the range of methods of learning and teaching available and the importance of assessment, feedback, critical reflection, identification of learning needs and appraisal in personal development planning	Functional Outcome	A fairly descriptive outcome which indicates what needs to be done to demonstrate attainment. Ok for a learner in a supervised environment.
9.4 Develop and maintain professional knowledge and competence and demonstrate commitment to lifelong learning	Outcome with feasibility challenges	No apparent tangible outcome, not time-bound. Maintaining professional knowledge is interesting as the programme is a finite period. 'Demonstration of commitment to lifelong learning' could be achieved, however for a student in a supervised learning programme, there is limited ownership.
9.5 Recognise and evaluate the impact of new techniques and technologies in clinical practice	Outcome with feasibility challenges / Functional Outcome	Again, 'recognise' is not a good verb - how do you assess recognition? 'Evaluate the impact' is explicit. Appropriate for a student in a supervised environment.
9.6 Accurately assess their own capabilities and limitations in the interest of high quality patient care and seek advice from supervisors or colleagues where appropriate	Outcome with feasibility challenges	How do you assess the accuracy of someone's own assessment of their capabilities and limitations? Difficult to standardise and monitor for each student, other than potentially a lack of concerns raised. Longitudinal demonstration of insight. Appropriate for a learner in a supervised environment.
9.7 Explain and demonstrate the attributes of professional attitudes and behaviour in all environments and media	Functional outcome / Outcome with feasibility challenges	'Explain' can be assessed, however wide scope 'all environments and media'. 'Demonstrate' is challenging as all students do not necessarily interact in all 'media', so challenging in terms of equal opportunities. .Assessing an attitude is challenging, assessing the observable behaviours may be more realistic. A longitudinal and multi-faceted remit, difficult to conclude attainment.

Table 5.12 Revised 'outcome' status and consideration of the impact of the supervised environment

GDC Outcome in Preparing for Practice		Relationship with language used in 'Standards for the dental team'
6 Patients and the public	6.1 Put patients' interests first and act to protect them	'Put patients' interests first' is a direct quote of Principle 1. 'Put patients' interests first and act to protect them' is a direct quote from the Guidance section of Principle 8 - 8.1.1 and 8.2.2
	6.2 Be honest and act with integrity	'Be honest and act with integrity' is a direct quote from Patient Expectations section of Principle 1, is Standard 1.3.
	6.3 Respect patients' dignity and choices	No direct link. 'Dignity' in Standards is mentioned with respect to treating patients with dignity (Standard 1.2) and treating team members, colleagues and the public with dignity (9.1.1)
	6.4 Maintain and protect patients' information	Maintain and protect patients' information' is a direct quote of Principle 4.
	6.5 Recognise and respect the patient's perspective and expectations of dental care and the role of the dental team taking into account current equality and diversity legislation, noting that this may differ in England, Scotland, Wales and Northern Ireland	No direct link. Equality is mentioned in respect of finding out about laws etc. in Standard 1.9.1
7 Ethical and legal	7.1 Be familiar with and act within the GDC's standards and within other professionally relevant laws, ethical guidance and systems	Effectively encompasses all of Standards. No direct link in terms of wording. Standard 1.9 is 'Find out about laws and regulations that affect your work and follow them', Standard 1.5.1 is 'You must find out about the laws and regulations', Standard 1.9 is 'You must find out about laws and regulations that affect your work and follow them', Standard 8.4.1 contains 'being aware of and adhering to current laws'
	7.2 Recognise and act upon the legal and ethical responsibilities involved in protecting and promoting the health of individual patients	No direct link. Reference in Standards to Laws does not directly link to patient health. More reference to employment and record keeping.
	7.3 Act without discrimination and show respect for patients, colleagues and peers and the general public	Standard 1.6 'You must treat patients fairly, as individuals and without discrimination'. Standard 6.1.2 'You must treat colleagues fairly and with respect, in all situations and all forms of interaction and communication. You must not bully, harass, or unfairly discriminate against them.' Standard 6.1.4 'You must value and respect the contribution of all team members.'
	7.4 Recognise the importance of candour and effective communication with patients when things go wrong, knowing how and where to report any patient safety issues which arise	'Candour' not specifically mentioned in Standards as introduced after Standards published.
	7.5 Take responsibility for and act to raise concerns about your own or others' health, behaviour or professional performance as described in Standards for the Dental Team, Principle 8 Raise concerns if patients are at risk	Principle 8 is 'Raise Concerns if patients are at risk'. These however focus on the culture and ethos of an environment or raising concerns about others. Own health and professional performance mentioned in: Standard 9.2. ' You must protect patients and colleagues from risks posed by your health, conduct or performance', 9.2.1 'If you know, or suspect, that patients may be at risk because of your health, behaviour or professional performance, you must consult a suitably qualified colleague immediately and follow advice on how to put the interests of patients first.'
8 Teamwork	8.1 Describe and respect the roles of dental and other healthcare professionals in the context of learning and working in a dental and wider healthcare team	This could be interpreted as appropriate team working and referral and therefore, Standard 6.3 'Delegate and refer appropriately and effectively', and Standard 6.4 'Only accept a referral or delegation if you are trained and competent to carry out the treatment and you believe that what you are being asked to do is appropriate for the patient.'
	8.2 Ensure that any team you are involved in works together to provide appropriate dental care for patients	Direct quote from Guidance 6.1.1: 'You should ensure that any team you are involved in works together to provide appropriate dental care for your patients.' Also, Principle 6 in Standards is 'Work with colleagues in a way that is in patients' best interests'.
	8.3 Explain the contribution that team members and effective team working makes to the delivery of safe and effective high quality care	No direct link. However, Principle 6 in Standards is 'Work with colleagues in a way that is in patients' best interests'.

GDC Outcome in Preparing for Practice		Relationship with language used in 'Standards for the dental team'
9 Development of self and others	9.1 Recognise and demonstrate own professional responsibility in the development of self and the rest of the team	No direct link. Guidance 6.6.5 states: 'You must encourage, support and facilitate the continuing professional development (CPD) of your dental team.' Personal development is also stated in 7.3.1 'You must make sure that you know how much continuing professional development (CPD) activity is required for you to maintain your registration and that you carry it out within the required time.' and 7.3.2 'You should take part in activities that maintain update or develop your knowledge and skills. Your continuing professional development (CPD) activity should improve your practice. For more information, see the GDC's advice on CPD.'
	9.2 Utilise the provision and receipt of effective feedback in the professional development of self and others	No direct link.
	9.3 Explain the range of methods of learning and teaching available and the importance of assessment, feedback, critical reflection, identification of learning needs and appraisal in personal development planning	No direct link.
	9.4 Develop and maintain professional knowledge and competence and demonstrate commitment to lifelong learning	'Lifelong learning' not directly mentioned in Standards, or indeed anywhere else in GDC documentation, but specifically mentioned with different terminology. The terminology used tends to be Continuing Professional Development. In Standards, Principle 7 is 'Maintain, develop and work within your professional knowledge and skills'. Standard 7.3 is 'Update and develop your professional knowledge and skills throughout your working life.' Guidance 7.3.2 'You should take part in activities that maintain update or develop your knowledge and skills. Your continuing professional development (CPD) activity should improve your practice. For more information, see the GDC's advice on CPD.
	9.5 Recognise and evaluate the impact of new techniques and technologies in clinical practice	No direct link.
	9.6 Accurately assess their own capabilities and limitations in the interest of high quality patient care and seek advice from supervisors or colleagues where appropriate	Standard 7.2 'You must work within your knowledge, skills, professional competence and abilities'.
	9.7 Explain and demonstrate the attributes of professional attitudes and behaviour in all environments and media	Behaviour with social media is mentioned in 4.2.3, public media is mentioned in 9.1.3 'You should not publish anything that could affect patients' and the public's confidence in you, or the dental profession, in any public media, unless this is done as part of raising a concern. Public media includes social networking sites, blogs and other social media. In particular, you must not make personal, inaccurate or derogatory comments about patients or colleagues. See our guidance on social networking for more information.

Table 5.13 Comparison with language and wording used in 'Standards for the Dental Team'

5.6 Discussion

5.6.1 Consideration of 'Professionalism' from the findings

Analysis identified what was documented about professionalism in the UK regulator's curricular advisory document. Points of note were the relatively few outcomes/statements (20) and the wide range of sub-themes. Eleven sub-themes were identified, some arising from only one outcome. The document may therefore appear to have little depth or direction in terms of guidance of what represents professionalism, or how to demonstrate attainment. The limited number of statements signify a lack of detail and specificity, also making emphasis or relative assumptions of significance difficult to discern. However, the above points may actually be a reflection of the challenges widely acknowledged in the literature in regard to encapsulating and describing what professionalism 'is' (O'Sullivan et al., 2012a, Goldie, 2013, Hodges et al., 2011).

Analysis identified the nature of professionalism, as defined by the GDC document, was reliant on multiple, diverse components. The indication was of multiple sub-themes that characterised important, but distinctive parts of a larger concept. This had resonance with the perception of the phenomenon in the literature where multiple components associated with professionalism are described (Zijlstra-Shaw et al., 2013, van Mook et al., 2009, Burford et al., 2014).

There were more than one sub-theme associated with many outcomes, for example, GDC outcome 9.6 contained elements of clinical management and safety:

Sub-themes identified	Outcome *(General Dental Council, 2015a)*
Clinical Management Safety	*9.6 Accurately assess their own capabilities and limitations in the interest of high quality patient care and seek advice from supervisors or colleagues where appropriate*

A sub-theme overlap was expected, both from practical clinical experience and observations in the literature, where the assessment of professionalism has been considered in terms of a meta-skill, or second order competence; integrally linking with other activities (Zijlstra-Shaw et al., 2012, O'Sullivan et al., 2012a). There was also resonance of the interplay between facets defining competence of a dental practitioner: the interplay of knowledge, skills and behaviours, the ability to adapt to the clinical environment, together with the ability to apply these within a wider social and economic and regulatory framework (ten Cate et al., 2010, Martimianakis et al., 2009).

Some connections that were expected, based on personal experience as a clinician and clinical educator and the literature, were absent. These referred to situation-based challenges facing clinicians (Hodges et al., 2011, Burford et al., 2014), for example an apparent link absence between Interplay of roles/collegiality and Communication:

Sub-themes identified	Outcome *(General Dental Council, 2015a)*
Interplay of roles/collegiality	*8.1 Describe and respect the roles of dental and other healthcare professionals in the context of learning and working in a dental and wider healthcare team*
Interplay of roles/collegiality	*8.2 Ensure that any team you are involved in works together to provide appropriate dental care for patients*
Interplay of roles/collegiality Safety	*8.3 Explain the contribution that team members and effective team working makes to the delivery of safe and effective high quality care*

Considering why there was an apparent absence of overlap between 'Communication' and 'Interplay of roles/collegiality', the written style of the outcomes was the emergent cause. By describing an 'endpoint' rather than including the contributory factors that promote and facilitate achievement, there was an apparent compartmentalisation of skills and their application. This could be considered a 'downfall' of an outcome based approach for a clinical professional. In Preparing for Practice, this finding did not mean essential elements of communication were not referenced, there was a separate 'Communication' domain, but it raised questions of managing integration of skills, knowledge and behaviours.

The complex integrated nature of how clinicians function, continued when recognising that sub-themes identified as contributing to the professionalism phenomena overlapped in other domains of the document, i.e. 'Record Keeping' featured in the professionalism domain, but also in the Clinical and Communication domains. Aspects of 'Development / Training' arose in Communication and Management and Leadership domains:

'Record keeping' examples in other Preparing for Practice domains (General Dental Council, 2015a)	
Clinical domain	*'1.2.1 Obtain, record, and interpret a comprehensive and contemporaneous history'*
Communication domain	*'5.3 Explain the importance of and maintain contemporaneous, complete and accurate patient records in accordance with legal requirements and best practice'*

'Development / Training' examples in other Preparing for Practice domains	
Communication domain	*'4.2 Explain the role of appraisal, training and review of colleagues, giving and receiving effective feedback'*
Management and Leadership domain	*'10.8 Demonstrate appropriate continuous improvement activities'*

Diagrammatic attempts to represent the professionalism phenomenon and sub-theme inter-relationships were limited as detail could not be depicted accurately in terms of which sub-themes overlapped and to what extent.

Further interpretation of Professionalism domain findings was that sub-themes identified were not wholly, or solely, related to the concept of 'professionalism', i.e. the sub-theme was not reliant on, or determined by, also being 'professional'. An example was the sub-theme 'communication'; you can be a good communicator without necessarily being 'professional'. Poor communication is a key contributor in many complaints in the NHS (Pincock, 2004, O'Dowd, 2015) and also within the dental school environment (Sachdeo et al., 2012). However, there is also an argument that some people operating in the profession who could be considered unprofessional, have furthered their own interests by being good communicators. For example, the charming practitioner who may be both unskilled bordering on unsafe, and/or unprincipled, acting contrary to the standards of the profession (e.g. operating for financial gain, not putting the interests of the patient first).

The overlap and inter-relationships between the three overarching themes identified (the patient, regulatory, practitioner) was unsurprising considering the nature of Professionalism as a phenomenon. There is an element of balancing priorities between these three foci, which may create additional considerations/challenges. For example, there is a desire, expectation and obligation/necessity to deliver optimal care to all patients at all times. Whilst this is not contested, in continually striving to deliver, the well-being of individual practitioners may also be impacted in delivering this alongside their other requirements and expectations (for example regulatory compliance). Being a clinician is a privileged, rewarding and skilled role, but there is (wider) acknowledgement that not inconsiderable challenges and stresses exist.

Practitioners need to develop self-management skills, and organisations need to look at systems and process to manage the stresses associated with roles and the obligations to patients and regulatory requirements. Whether there has been a greater emphasis on certain foci over time, different influences will have had variable impact. This may include elements of changing societal expectations, high profile medical negligence cases or increasing awareness of complaints and litigation factors. Quality assurance and risk assessment process have introduced additional regulatory requirements and compliances which introduce additional time requirements. These add an additional burden to an individual practitioner's workload.

5.6.2 Style of outcome preparation

Very few professionalism domain 'outcomes', when taken in their entirety, were written as outcomes from an education environment perspective. In terms of assessment, some did not identify an obvious quantifiable opportunity:

> *6.2 'Be honest and act with integrity' (General Dental Council, 2015a);*
>
> *8.2 'Ensure that any team you are involved in works together to provide appropriate dental care for patients' (General Dental Council, 2015a);*
>
> *9.4 'Develop and maintain professional knowledge and competence and demonstrate commitment to lifelong learning' (General Dental Council, 2015a).*

GDC 6.2 did not provide guidance on how to assess the outcome, but recognising attribute absence may be possible. From that viewpoint, the 'outcome' would actually conform more to a 'standard' rather than an outcome (Bateman et al., 2017a, Bateman et al., 2019c). Similarly, 8.2 could be approached by identifying those not attaining the 'outcome' rather than confirming positive attainment. From a regulatory compliance perspective, a key consequence of absence of obvious assessment would be how training providers can demonstrate successful attainment, and whether differing interpretations would permit the regulator to have confidence in consistently attained.

In the literature, one approach promoted to manage the recognised challenges of both integrating professionalism into a curriculum and assessing it, is acknowledging that some form of definition is required. Whilst this would not be a 'universal' definition, it represents an agreed and shared understanding within an institution (Cruess, 2006, O'Sullivan et al., 2012a, O'Sullivan et al., 2012b). To extrapolate this to the interpretation, application and demonstration of attainment of the outcomes within the regulatory document, this could mean

individual dental schools would determine their own 'standard' and method of attainment demonstration of each outcome. From the perspective of institutional norms and values and local 'cultural' expectations this would help contextualise the application of the outcomes (Rees and Knight, 2007). Whether this was intended by the regulator, and fulfils their expectation of a 'common' set of requirements for all UK dental education providers is uncertain and would be conjecture on the part of this researcher.

The remaining example above (9.4) could also be considered in terms of an absence of concerns, but there is also an inference that knowledge of what commitment to lifelong learning consists is required. However, if taken literally, demonstrable commitment to lifelong learning would prove challenging in the confines of a taught programme. Knowledge of the need for commitment would be possible, but actual demonstration suggests an on-going, longitudinal action. Equally, 'maintain professional knowledge' may infer the knowledge was there to begin with, whereas in reality it will be developed during the programme. In terms of UK dental regulation, there are separate requirements for qualified members of the profession in terms of their commitment to continuing professional development, so this could primarily be simply about being aware of the requirements once qualified.

5.6.3 Comparison with challenges presented by other domains

Outcomes in the 'clinical' and 'communication' domains of Preparing for Practice did not appear to present as many challenges in terms of attainment demonstration as the professionalism domain. Their construction included clear articulation of both requirements and how these could be demonstrated. The scope of outcomes was relatively focused, which facilitated attainment consistency both intra- and inter-institution (Bateman et al., 2018d):

> *1.12.4 Identify and explain appropriately to patients the risks, benefits, complications of and contra-indications to surgical interventions (General Dental Council, 2015a);*
>
> *3.4 Obtain valid consent (General Dental Council, 2015a);*
>
> *12.6 Describe the implications of the wider health economy and external influences (General Dental Council, 2015a).*

Some outcomes did however have wide scope, for example 1.14.1. in the Clinical domain and 12.4 in the Management and Leadership domain, which would create interpretation and consistent application challenges. Neither example could be easily evaluated in a single assessment episode to any degree of depth:

1.14.1 Assess and manage caries, occlusion, and tooth wear (General Dental Council, 2015a);

12.4 Describe the legal, financial and ethical issues associated with managing a dental practice (General Dental Council, 2015a).

Whilst the professionalism domain focused on Bloom's affective and cognitive domain, the clinical, communication and management and leadership domains had relatively higher proportions of psychomotor and cognitive outcomes (although a number of affective outcomes existed in leadership and management). The clinical and communication domains were most easily interpreted, with a clear means of assessment to demonstrate attainment. This could be related to their requirement for knowledge and demonstrable clinical skills. Demonstrating attainment of some of management and leadership domain outcomes posed similar challenges to those experienced in the professionalism domain, again number were reliant on an absence of concerns raised.

10.7 Ensure that all aspects of practice comply with legal and regulatory requirements (General Dental Council, 2015a).

11.1 Take a patient-centred approach to working with the dental and wider healthcare team (General Dental Council, 2015a).

5.6.4 Relationship with 'Standards for the Dental Team'

Range of sub-themes and emphasis

There were far fewer learning outcomes in the professionalism domain of 'Preparing for Practice' than statements in 'Standards for the Dental Team', although a similar number of sub-themes were identified. Preparing for Practice tended to demonstrate less specificity in comparison to Standards for the Dental Team. This effect on the level of detail may have been expected, due to the smaller number of outcomes if the regulator intended a similar content coverage in both documents. For instances where the same sub-theme was identified, the descriptors for Preparing for Practice featured less detail and guidance of how to achieve it.

Comparison of the sub-theme content between the two documents identified that some sub-themes in 'Standards for the Dental Team' demonstrated an emphasis shift, for example where 'communication' and 'information exchange' dominated the Standards document, these were virtually absent in the Preparing for Practice professionalism domain. The

professionalism domain had one outcome referring to communication, and this was with patients. Communication with the rest of the dental team was not referred to.

> *7.4 Recognise the importance of candour and effective communication with patients when things go wrong, knowing how and where to report any patient safety issues which arise (General Dental Council, 2015a).*

This patient-focus continued in the 'Individuality and Values' descriptor, with the outcomes being patient-oriented. The virtual absence of 'communication' in the Professionalism domain could be explained by Preparing for Practice having a separate 'Communication' domain, which has thirteen 'outcomes'. Despite acknowledging the contribution of the separate 'Communication' domain, there are still distinct differences in the outcomes featured in that when compared to statements in 'Standards'. Preparing for Practice outcomes had a tendency to focus on the method of communication, rather than the content and actual information exchanged, for example 3.2, 4.4 and 5.1, although there are a small number with elements of 'information exchange'.

Preparing for Practice outcomes in the Communication domain (General Dental Council, 2015a)
3.2 *Recognise the importance of non-verbal communication, including listening skills, and barriers to effective communication*
4.4 *Communicate appropriately and effectively in professional discussions and transactions within the health and other sectors*
5.1 *Communicate effectively and sensitively by spoken, written and electronic methods and maintain and develop these skills*
5.2 *Use appropriate methods to provide accurate, clear and comprehensive information when referring patients to other dental and healthcare professionals*

A number of the 'Standards' statements had elements of both 'communication' (i.e. the method of delivery) and 'information exchange':

> *2.3 Give patients the information they need, in a way they can understand, so that they can make informed decisions (General Dental Council, 2013c);*

> *2.4 Give patients clear information about costs (General Dental Council, 2013c);*

> *3.1.4 You must check and document that patients have understood the information you have given. (General Dental Council, 2013c).*

In the first example (2.3), the information exchanged is that required to allow patients the ability to make an informed decision, but the communication aspect is that information needs to be delivered '*in a way they can understand*'. The '*clear'* requirement of 2.4 and the

'*check'* in 3.1 give an additional quality dimension to the exchange with the patient rather than solely an information exchange consideration.

Returning to the earlier observation of apparent compartmentalisation, resulting in an absence of overlap of roles/collegiality and communication within outcomes, this could be seen as compartmentalisation of skills, knowledge and behaviours, again possibility contributed to by the document being written using a learning outcome format.

Absent sub-themes

Three sub-themes, identified in Standards for the Dental Team, did not feature in the Preparing for Practice professionalism domain.

- Information exchange
- Consent
- Financial

The sub-themes omitted within the professionalism domain do appear, albeit to differing extents, within the wider Preparing for Practice document. As alluded to earlier in this section, 'Information exchange' has little coverage, primarily due to the way in which Preparing for Practice is written; there is a greater focus on identification of elements and articulation of these to a 'supervisor', rather than transferring information directly to patients. The contrast between the documents is that patients are not actively mentioned in the Preparing for Practice document but are in the Standards document. This could potentially lead to educational units removing the patient factor from programmes if less specific emphasis and demonstrable evidence of attainment is not required. A failure to involve live/actual patients in teaching and assessment of communication skills in dental education was highlighted by a review in 2010 (Carey et al., 2010). However, this is unlikely to be a concern as the GDC specifically require, in their 'Standards for Education' (General Dental Council, 2015d) document, patient and public input into programmes in terms of individual feedback to students and input into programme design. As always, the benefits of 'real' patients in assessment (unseen live patient cases and role players) must be balanced with the challenge of consistency and fairness of the examination process to all students in that cohort.

Consent appears in the 'Clinical' and 'Communication' domains of Preparing for Practice (one learning outcome in each domain) and arguably it is impossible to fully separate elements when gaining valid consent as they are integrally linked.

There was minimal mention of the 'Financial' sub-theme in Preparing for Practice, with only one oblique reference in the 'Management and Leadership' domain in outcome 12.4:

> *'Describe the legal, financial and ethical issues associate with managing a dental practice'(General Dental Council, 2015a).*

This is interesting as it was prominent within Standards for the Dental Team and could arguably feature more prominently in Preparing for Practice to 'equip' new graduates, enabling them to comply with the standards expected. Alternative reasons for the lack of prominence could include a lack of 'space' in the curriculum, although if it was a prominent section in the GDC document education providers would be required to actively incorporate it into the delivered and assessed curriculum. Alternatively, it could be a belief that development in this respect is for the Foundation Dental (FD) year to cover. There is a Foundation year curriculum (Committee of Postgraduate Dental Deans and Directors (COPDEND) UK, 2015), this is divided into 'competencies' under the same 4 domain titles as Preparing for Practice and 'costs' are mentioned briefly under the clinical and professionalism domains. However, FD is not a requirement for all graduates unless working within the NHS, so this may not be a reliable way of ensuring financial aspects have a focus. This also invites the question of what an undergraduate programme should prepare a student for in terms of entering working life. This is an interesting and multi-layered question and is outside the scope of the current study, but perhaps demonstrates the continuum of learning that all professionals encounter in a career.

Commonality of wording

A number of phrases appeared verbatim in both Preparing for Practice and Standards for the Dental Team. This was unsurprising and may have been expected, as the message conveyed to a practising dental professional and to a new graduate entering that same profession would be expected to have similar level, content and be consistent. What was challenging, was Standards for the Dental Team presented 'standards' and achievement guidance. Preparing for Practice purports to present 'learning outcomes' which have subtle, but important differentiating features to 'standards' (Bateman et al., 2017a).

The key difference, and a relevant one when considering the challenges identified in attempting to use a learning outcome format to conceptualise complex phenomena, is that standards are fundamentally different expressions of learning goals to learning outcomes. Standards outline an approach that should be applied to all activities undertaken as a professional. They provides an indication of the appropriate level expected to demonstrate

achievement. Beyond that, intricacies of planning, delivering and demonstration are not specified. The nuances of individual context and complexities of multi-faceted considerations can be managed as the ultimate goal is delivery of a standard, however simple or complex the surrounding context. This could be seen as a more appropriate approach to a clinical environment where the specifics of circumstances will change, management of change and ambiguity are key and dealing with uncertainty is a daily occurrence. It could be argued that managing this, whilst maintaining core standards is the fundamental principle behind behaviour as a professional and learning to behave as a professional. The format of 'standards' therefore appear to be more appropriate and it is utilised by the GDC for its registrants (General Dental Council, 2013c). That raises the question of why those training to join the profession and registrants are managed 'differently' by the regulator. Could there be a feeling there needs to be a more 'prescriptive' curriculum for education providers, either in an attempt to address aspects of consistency or potentially quality assurance between/across providers?

5.6.5 Implications from the findings

The 'professionalism' domain of Preparing for Practice presented the nature of professionalism as multifaceted (many contributing sub-themes) with interlinking and overlapping component parts. There were three elements of focus; the individual practitioner, the patient, and consideration of regulatory aspects. Looking at the literature this would appear to be a consistent outcome and the sub-themes identified as being involved in 'professionalism' have resonance with those identified by others. What has been published also highlights the challenges in defining professionalism which have resulted in lengthy statements, incorporating multifaceted theoretical ideals which gives rise to challenges in terms of assessing professionalism (Swick, 2000, van Mook et al., 2009, Ginsburg et al., 2004). There is a consensus that assessment of professionalism requires aspects of longitudinal consideration and triangulation of different sources (Goldie, 2013, Hodges et al., 2011, van der Vleuten and Schuwirth, 2005, Zijlstra-Shaw et al., 2012, O'Sullivan et al., 2012b).

Does the regulatory document support/address the challenges of assessing (or demonstrating attainment of) professionalism? One way of approaching this question may be to consider why the regulator produces this document in the first place. The reasons include; protection of, and service to the public, and as a means of standardising the quality of new registrants. By producing a set of outcomes required of education providers, the regulator may have confidence on receipt of confirmation of 'attainment', that a programme is fulfilling its

obligations associated with developing new graduates at the level of a 'safe beginner'. Taking this approach, it could therefore be considered that the GDC strapline 'Protecting patients, regulating the profession' has been addressed. The interesting thing is that educational units are making the day-to-day decisions on this, with the regulator sampling via visitations to see if the claims of attainment appear legitimate. There is an argument that this is a weakness and could be manipulated by providers of education, but this researcher would consider that unlikely, given the values of the education institutions and those developing and delivering the undergraduate programme in the UK (the majority of whom will be registrants of the GDC). There are also rigorous monitoring processes requiring supporting evidence, which must be supplied by education providers to the GDC. However, does the format presented by the regulator (the outcomes) have the intended effect? An 'outcome' format would not immediately seem compatible with a longitudinal approach and demonstrable ability over a sustained period of time. In terms of application, would an outcome be deemed 'attained' following a single episode of successful assessment? In all likelihood 'yes', due to the way mapping of curricula is managed within institutions. In some institutions there has been a conscious choice to 'triangulate' attainment of the outcomes, by working towards ensuring that each is covered on at least three occasions, but this is not universal and each institution will develop their own 'criteria' for how they feel the content of the GDC document should be managed.

With the regulator writing learning outcomes and education providers using these as the focus of both the curriculum, teaching and assessment, there could be a risk that, by necessity, each are being forced down an avenue to what can actually be 'defined'. Is there a risk of giving a 'false' interpretation of 'professionalism' by limiting it to what can actually be tangibly defined as an outcome? Is there potential for 'stifling' and constraining students and preventing the deeper, more complex, levels of understanding? This depth of understanding may be what permits scope for the context-dependent elements which have such prominence in any determination of professionalism. Perhaps this risk may be the case with a section of our learners who are strategic in their learning, planning this based on assessment drivers alone, however the majority do very well in their own professional development and associated behaviours and attitudes without this driver.

The small number of outcomes from the regulator, together with their lack of specificity has been noted, and it may be questioned why the list of attainment is not more extensive or precise. It may be that the regulator wants to permit education providers scope to interpret the requirements and permit them the freedom to design opportunities to demonstrate attainment

in the way they feel most appropriate without the 'prescription' from the regulator. Alternatively, it may be that it is difficult, if not impossible to be this precise with the concept of 'professionalism'. Although both these reasons may be pertinent, in terms of principle causality, this researcher is inclined to believe it is the latter. However, by presenting the desires of the regulator as 'outcomes' for professionalism, which themselves do not conform to an established educational format, there is a risk of compounding the challenges education providers have in demonstrating attainment of 'professionalism'. There is also the potential to undermine the educational role and benefit of true, well-designed learning outcomes.

For these reasons, defining attributes of professionalism in terms of learning outcomes does not appear to be the most appropriate or effective way for a regulator to present expectations.

5.7 Critique of methodology applied

Limitations of this phase of the study include how institutions (dental education providers) interpret the application and demonstration of attainment of the Professionalism domain outcomes of Preparing for Practice. Assumptions have been made as to the challenges faced by providers. These assumptions have been made using a considered approach of the educational basis of the construction and application of learning outcomes, and the personal experience of the researcher as a clinical educator with a substantive role in BDS curriculum and assessment mapping to the GDC Preparing for Practice document. The research has not included how a specific outcome has been interpreted or it's attainment recorded by a variety of different providers, which would potentially be a further line of enquiry.

The literature has variation over specific details of the methods for document and thematic analysis. For example, the stages of conducting thematic analysis and the terminology employed. However, a pragmatic approach was used in terms of what 'works' with the type of data in this research, and what would be useful to know from the data in terms of planning future developments. After considering aspects to ensure rigour in the study, whilst this research reaches a personal conclusion on a personal journey, it has been underpinned by careful, considered and balanced academic practices.

5.8 Summary

In the UK, 'Preparing for Practice' is the primary focus for training programme requirements of professionalism. The document list requirements, described as learning outcomes, for which training programmes must demonstrate attainment. Failure to demonstrate attainment

could lead to education providers being deemed ‘insufficient’, posing a risk in ability to deliver academic qualifications permitting GDC registration. In education terms, learning outcomes should guide an institution’s programme delivery and assessment design. This then poses the question ‘can properly developed learning outcomes exist for a complex phenomenon such as Professionalism?’

The presented published outcomes demonstrated the nature of professionalism, as presented by the regulator, was multi-faceted with interlinking and overlapping component parts. Overarching themes focused on the individual practitioner, the patient, and regulatory elements.

In terms of application of presented learning outcomes, challenges arose due to ‘outcome’ preparation style (too broad, content unclear, no obvious assessment), and when demonstration of attainment was unclear. This reflects professionalism curriculum management challenges reported in the literature, and the experienced reality of clinical educators. The ‘outcome’ style may risk differing interpretations of attainment by education providers, which potentially defeats the purpose of having a common outcome document for all.

There were links and shared elements with other regulator-produced documentation. This was logical, but also introduced an interesting dimension in that the different documents, prepared for different target groups, have adopted contrasting presentation formats.

The findings from this research indicate the ‘learning outcome’ format is not the most appropriate to present regulator requirements of professionalism in the new graduate. In order to deliberate alternate formats, and whether these present a more favourable or practicable approach for the end-user, consideration was taken of professions outside of dentistry. Analysis of the approach adopted by other professions formed the focus for the next chapter in this thesis.

Chapter 6. Understanding professionalism through the Regulatory documents of other UK professions

The findings in the previous chapter identified that when analysing documentation produced by the UK dental regulator, professionalism had numerous sub-themes and 3 over-arching themes. However, also apparent were challenges for education providers in demonstrating attainment, due to using a 'learning outcome' format where it was often difficult to determine 'attainment'. This suggested the 'learning outcome' format may not be the most appropriate for regulator professionalism requirements for the new graduate. One way of considering alternate formats was to review how other regulators have approached the challenge of ensuring professionalism is embedded within learning programmes. In this chapter, the documentation of a diverse group of regulators is considered to identify levels of commonality in their approach to delivery of education around professionalism. The objectives of the chapter are:

- To identify professions other than dentistry which have a UK regulator.
- For these, to identify which regulators have documents that contribute to the curricula requirements for training in this profession.
- To undertake analysis of the content of the relevant sections of the document(s) influencing professionalism curricula and determine key themes, with a view to identifying the depiction of professionalism.
- To compare and contrast the nature of professionalism depicted by the regulators to the findings for UK dentistry.
- To compare and contrast the way in which the regulator has determined to display its requirements for professionalism in the curricula to the findings for UK dentistry.

6.1 Selection of professions

6.1.1 Possible professions

Clinical and non-clinical professions with significant interaction with the public were listed by the primary researcher (HB), then added to following suggestions from a range of colleagues within the University and Hospital setting. Additional professions were added after examination of some regulatory body websites (where they included more than one profession). Professions initially considered are shown in Table 6.1:

Clinical		
Acupuncturist	Hypnotherapists	Pharmacists
Arts Therapist	Medical Doctor	Physiotherapist
Audiologist	Midwife	Practitioner Psychologists
Biomedical Scientist	Nurse	Prosthetists / orthotists
Chiropodists / Podiatrists	Occupational Therapists	Radiographers
Chiropractors	Operating Department Practitioners	Sonographer
Clinical Scientist	Optometrist	Speech & Language Therapists
Dietician	Orthoptists	Vet
Dispensing Optician	Osteopaths	
Hearing Aid Dispensers	Paramedics	
Non-Clinical		
Clergy	Local government officers	Social workers in England**
Lawyers*	Police	Teachers in England**

*Excluded at this stage as further study and qualification required following initial undergraduate qualification prior to registration

** These groups of professionals have been restricted due to different regulation in the different countries within the UK

Table 6.1 Professions considered to investigate further in terms of regulatory requirements

6.1.2 Inclusion criteria

To enable comparable review and opportunity to compare/contrast features, inclusion criteria were applied to the identified professions:

- Profession had a national regulatory body;
- Current registration with national regulatory body mandatory to practise in the UK;
- Sufficient information available on regulatory body website to make judgement of above.

The search strategy to gain the information included a web search with the search terms:

(profession) UK Registration

Findings were tabulated in a simple Excel table.

Findings of initial profession regulation search

The results of applying the above inclusion criteria are presented in Table 6.2.

Profession	Regulatory Body			Comments
	Yes / No	Name of Body	Registration Mandatory?	
Clinical				
Acupuncturist	Yes	British Acupuncture Council	No	Self-regulatory body
Arts Therapist	Yes	Health and Care Professions Council	Yes	Protected title
Audiologist	Yes	Registration Council for Clinical Physiologists	No	Voluntary register
Biomedical Scientist	Yes	Health and Care Professions Council	Yes	Protected title
Chiropodists / Podiatrists	Yes	Health and Care Professions Council	Yes	Protected title
Chiropractors	Yes	General Chiropractic Council	Yes	Protected title
Clinical Scientist	Yes	Health and Care Professions Council	Yes	Protected title
Dietician	Yes	Health and Care Professions Council	Yes	Protected title
Dispensing Optician	Yes	General Optical Council (GOC)	Yes	Protected title. Requires all students to be registered
Hearing Aid Dispensers	Yes	Health and Care Professions Council	Yes	Protected title
Hypnotherapists	No	The Complementary and Natural Healthcare Council General Hypnotherapy Standards Council (GHSC) National Council for Hypnotherapy (NCH)	No	Voluntary registers
Medical Doctor	Yes	General Medical Council (GMC)	Yes	
Midwife	Yes	Nursing and Midwifery Council (NMC)	Yes	
Nurse	Yes	Nursing and Midwifery Council (NMC)	Yes	Use of specific titles
Occupational Therapists	Yes	Health and Care Professions Council	Yes	Protected title
Operating Department Practitioners	Yes	Health and Care Professions Council	Yes	Protected title
Optometrist	Yes	General Optical Council (GOC)	Yes	Protected title. Requires all students to be registered
Orthoptists	Yes	Health and Care Professions Council	Yes	Protected title
Osteopaths	Yes	General Osteopathic Council (GOsC)	Yes	
Paramedics	Yes	Health and Care Professions Council	Yes	Protected title
Pharmacists	Yes	General Pharmaceutical Council (GPhC)	Yes	
Physiotherapist	Yes	Health and Care Professions Council	Yes	Protected title
Practitioner Psychologists	Yes	Health and Care Professions Council	Yes	

Continued overleaf

Profession	Regulatory Body			Comments
	Yes / No	Name of Body	Registration Mandatory?	
Clinical				
Prosthetists / orthotists	Yes	Health and Care Professions Council	Yes	
Radiographers	Yes	Health and Care Professions Council	Yes	Sometimes it will be necessary to check under clinical scientist rather than radiographer
Sonographer	No		No	Not a recognised profession by HCPC. Voluntary register by College of Radiographers, but registration highly recommended either with HCPC, GMC or NMC dependent on training background
Speech and Language Therapists	Yes	Health and Care Professions Council	Yes	
Vet	Yes	Royal College of Veterinary Surgeons (RCVS)	Yes	
Non-clinical				
Clergy		??		
Local Government officers	No?			
Police				All Police officers employed by one of the police forces in the UK. As employees there a number of requirements and Federations. Actions covered by the Statutory Instrument for police in England and Wales - The Police Regulations 2003
Social workers in England	Yes	Health and Care Professions Council	Yes	Protected title since 2005. Register opened in 2012
Teachers in England	Yes	National College for Teaching and Leadership (NCTL)	Yes (in majority of instances)	General Teaching Council in England abolished. Must have Qualified Teacher Status (QTS) to take up a teaching post in England in a range of designated school types. National College for Teaching and Leadership (NCTL) is the competent authority in England for the teaching profession

Table 6.2 Results of applying inclusion criteria

Professions to investigate further

Applying the initial inclusion criteria, the number of professions with mandatory registration with a national regulator was 26, with 7 professions being excluded. Excluded professions were: Acupuncturist, Audiologist, Hypnotherapists, Sonographer, Clergy, Local government officers, Police.

Protection of titles

During my search I encountered the term 'protected titles', which limits use of a specific title to individuals registered with the appropriate regulatory body. 'Doctor' is not a protected title, neither is 'Nurse', but the more specific 'Medical doctor' and 'Registered Nurse' are examples of variations which do have protected status.

In the UK, the 1984 Dentists Act Part IV designates '*Restrictions on Practice of Dentistry and on Carrying on Business of Dentistry*' (1984). The '*Practice of dentistry*' was defined in section 37(1) and '*prohibition on practice of dentistry by layman*' at section 38(1). Contravention of the Act can result in conviction. Use of various protected dental titles ('dentist', 'dental nurse', 'dental hygienist' 'dental technician') or to imply being a registered dental professional is a criminal offence under Section 39 of the Act. Unlawfully carrying on the business of dentistry, defined in section 40 of the Act, is contrary to Section 41 (for individuals) and 42 (for bodies corporate). In the UK, the GDC as the regulatory body, pursues 'illegal practice prosecutions', many of which result in a fine if found guilty of illegally practicing dentistry. The GDC website issues press releases on its 'illegal practice prosecutions' and as of February 2017, the majority of those for the previous year were related to tooth whitening. This trend appears to have continued through 2018/9.

6.1.3 Rationale for profession selection

To the list of professions with a national regulatory body and mandatory registration requirement in order to work in that role in the UK, further inclusion criteria were applied:

- Regulators with documents in the public domain (online access);
- Regulators with curriculum guidance for those training to join the profession;
- Regulator-produced documents had comparable function to the GDC's Preparing for Practice (i.e. regulation of undergraduate study), therefore permitting comparison.

Further information was recorded about each of the professions identified, with details of the guidance documents produced by their regulator. These included:

- Whether guidance documents were produced by the regulator;
- The name of the document(s);
- A description of the application / scope of the document;
- The format they were presented in (i.e. style of information presented, outcomes etc.);
- Comments with initial impressions of document comparison with GDC documents Standards for the Dental Team (Standards) and Preparing for Practice (PfP);
- Web link to the appropriate guidance document, if available.

Findings of further search for regulatory documents

The findings of applying the above are presented in Table 6.3.

Profession	Guidance Documents					
	Yes / No	Name	Description	Format	Comments wrt dentistry	Link
Arts Therapist	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.HCPC-uk.org/assets/documents/10004FBStandards_of_Proficiency_Arts_Therapists.pdf
Biomedical Scientist	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10004FDStandards_of_Proficiency_Biomedical_Scientists.pdf
Chiropodists / Podiatrists	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000DBBStandards_of_Proficiency_Chiropodists.pdf
Chiropractors	Yes	Degree recognition criteria The Code: Standards of conduct, performance and ethics for chiropractors	Section in Degree recognition criteria entitled 'Programme outcomes'. The Code has a series of Standards	In Degree recognition criteria section described as 'learning outcomes'	Degree Recognition Criteria has a section akin to PfP. 'The Code' appears to be an equivalent to 'Standards'.	https://www.gcc-uk.org/education/ http://www.gcc-uk.org/UserFiles/Docs/DegreeRecCriteriaUPDATED2012.pdf
Clinical Scientist	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000050AStandards_of_Proficiency_Clinical_Scientists.pdf
Dietician	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives.	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000050CStandards_of_Proficiency_Dietitians.pdf
Dispensing Optician	Yes	Core competencies	Requirements to receive a GOC approved award	Described as 'Competencies' - 'the ability to'	Appears to be equivalent to PfP	https://www.optical.org/download.cfm?docid=F7FFC49D-C731-49C5-8ECDBA9C5732C6FE
Hearing Aid Dispensers	Yes	Standards of proficiency	Academic and professional (competency and patient experience) requirements.	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/Assets/documents/10002CBCStandardsofProficiency-Hearingaiddispensers.pdf
Medical Doctor	Yes	Outcomes for graduates	Knowledge, Skills and Behaviours required of new UK medical graduates	Outcome document, 3 domains	Appears to be equivalent to PfP	http://www.gmc-uk.org/education/undergraduate/undergrad_outcomes.asp

Profession	Guidance Documents					
	Yes / No	Name	Description	Format	Comments wrt dentistry	Link
Midwife	Yes	Standards for pre-registration midwifery education	Includes the following sections: 'Competencies required to achieve the NMC standards' and 'Essential Skills clusters'	Described as 'Competencies'	Appears to be equivalent to PfP	https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-preregistration-midwifery-education.pdf
Nurse	Yes	Standards for pre-registration nursing education Standards for competence for registered nurses	For pre-reg, Section 2 has standards for competence required for NMC reg. Also requirements listed to achieve 2 progression points. 'Essential Skills clusters'	Described as 'Competencies'. Separate sets of requirements for each of the 4 fields of nursing. Each has 4 domains. One is professional values	….. for registered nurses' appears equivalent to 'Standards', but more detailed	https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf
Occupational Therapists	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000512Standards_of_Proficiency_Occupational_Therapists.pdf
Operating Department Practitioners	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000514Standards_of_Proficiency_ODP.pdf
Optometrist	Yes	Core Competencies	Requirements to receive a GOC approved award	Described as 'Competencies' - 'the ability to'	Appears to be equivalent to PfP	https://www.optical.org/download.cfm?docid=585C9509-2C54-4AAF-B282C47C3868453D
Orthoptists	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000516Standards_of_Proficiency_Orthoptists.pdf
Osteopaths	Yes	Osteopathic practice standards Guidance for Osteopathic Pre-registration Education	To gain a recognised qualification all graduates have to demonstrate compliance with the 'Standards' document. Guidance document provides additional outcomes	Written as outcomes. One section is 'professionalism'	Appears to be equivalent to PfP	http://www.osteopathy.org.uk/standards/standards-of-education-and-training/
Paramedics	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000051CStandards_of_Proficiency_Paramedics.pdf
Pharmacists	Yes	Future pharmacists: Standards for the initial education and training of pharmacists	A series of outcomes	Described as outcomes	Appears to incorporate a section equivalent to PfP	https://www.pharmacyregulation.org/sites/default/files/GPhC_Future_Pharmacists.pdf
Physiotherapist	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	

Profession	Guidance Documents					
	Yes / No	Name	Description	Format	Comments wrt dentistry	Link
Practitioner Psychologists	Yes	Standards of proficiency (Clinical, Counselling, Educational, Forensic, Health, Occupational, Sport & Exercise)	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	Multiple documents
Prosthetists / orthotists	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000522Standards_of_Proficiency_Prosthetists_and_Orthotists.pdf
Radiographers	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000DBDStandards_of_Proficiency_Radiographers.pdf
Speech and Language Therapists	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.hpc-uk.org/assets/documents/10000529Standards_of_Proficiency_SLTs.pdf
Vet	Yes	Day One Competences	Integration of knowledge, skills and attitudes as 'competences' which are a minimal requirement for all graduates	37 Competence statements	Appears to be equivalent to PfP	http://www.rcvs.org.uk/document-library/day-one-competences/
Social workers in England	Yes	Standards of proficiency	Standards for the profession and also 'threshold standards' designating what a student must know, understand and be able to do at the end of training to register	Written in a combination of outcomes and objectives. Some elements only applicable to certain sub-groups	Appears to be a combination of the Dental 'Standards' and 'PfP'.	http://www.HCPC-uk.org/assets/documents/10003B08Standardsofproficiency-SocialworkersinEngland.pdf
Teachers in England		(need to complete this section)				

Table 6.3 Results of search for guidance documents produced by regulatory bodies

General comments / observations

Of the professions identified, a number were regulated by the Health and Care Professions Council (HCPC). Each of these professions had a tailored 'Standards of proficiency' document which appeared to have a dual function for those training to join the profession and for those already in the profession to maintain registration. It would therefore be equivalent to a combination of 'Standards for the Dental Team' and 'Preparing for Practice' in UK dentistry.

6.1.4 Professions selected

From the professions identified, further analysis and selection was made by applying the following criteria:

- No more than one profession per regulatory body (so data could be compared across different regulatory bodies);
- Documents available with a purpose and format permitting comparison to UK dentistry's GDC 'Preparing for Practice' document;
- (Ideally) Documents which actively identify sections within their document as 'professionalism' or similar explicit references to professional actions or values.

Table 6.4 shows the professions selected, the specific regulatory document and sections of that document (if applicable).

Profession	Document	Section
Medical Doctor	Outcomes for graduates	Outcomes 3 – the doctor as a professional
Nurse	Standards for pre-registration nursing education	Competencies for entry to the register: Adult nursing. Domain 1: Professional values
Osteopath	Guidance for Osteopathic Pre-registration Education	Outcomes for graduates: Professionalism section
Social workers in England	Standards of proficiency	Whole document

Table 6.4 Professions selected for further analysis of their regulator documentation following application of all inclusion and exclusion criteria.

6.2 Methodology

6.2.1 Document and Thematic analysis

See Methodology chapter for document analysis rationale and consideration of rigour.

6.2.2 Approach taken in this study

For each profession selected, the following were considered:

- Background: The 'profession' and its regulation in comparison with dentistry. Regulatory body overview and document range/style produced for registrants;
- Document context (when produced, to whom applicable, relation to graduation / registration);
- Comparison of document to those in dentistry (primarily 'Preparing for Practice', but others if applicable i.e. 'Standards for the Dental Team' or 'Standards for Education');
- Document structure, rationale for the selection of the section to be analysed;
- Analysis;
- Sub-themes and overarching themes identified (conceptualising professionalism);
- Style of writing regulator expectations;
- Comparison of the above with dentistry and specifically 'Preparing for Practice'.

6.3 Medical Doctor

6.3.1 Background

Medical doctors in the UK are regulated by the General Medical Council (GMC). Legislatively, the 1983 Medical Act (1983) governs the role of the GMC (their statutory purpose), governance of the GMC, and responsibilities in terms of medical education, registration and revalidation. A number of Statutory Instruments have amended the Act since 1983, one of these, which is key to understanding the central tenet of the GMC reform, The Medical Act 1983 (Amendment) Order 2002, amends section 1A to:

> *(1A) The overarching objective of the General Council in exercising their functions is the protection of the public.*

Medical doctors in the UK require both Registration with the GMC and a Licence to Practise. The GMC introduced licensing in November 2009 and revalidation in December 2012. In order to meet their responsibilities with respect to education, the GMC produce documents applicable to undergraduate, postgraduate (provisionally registered doctors and specialty trainees) and continuing professional development. In addition, a standards document applies to all stages of education and training (Table 6.5).

	Applicable to	Reference
Promoting excellence: standards for medical education and training	All stages of education and training	(General Medical Council, 2016c)
Excellence by design: standards for postgraduate curricula	Postgraduate education	(General Medical Council, 2017)
Outcomes for graduates	Undergraduate education	(General Medical Council, 2015b)
Medical students: professionalism and fitness to practise Achieving good medical practice: guidance for medical students Professional behaviour and fitness to practise: guidance for medical schools and their students	Undergraduate education	(General Medical Council, 2016a) (General Medical Council, 2016b)
Gateways guidance Advising medical schools: encouraging disabled students	Undergraduate education	(General Medical Council, 2015a)
Outcomes for provisionally registered doctors	Provisionally registered doctors	(General Medical Council, 2015c)

Table 6.5 Documents produced by the GMC in respect of their role in education and training

6.3.2 Outcomes for graduates

'Outcomes for graduates' (General Medical Council, 2015b), was implemented in July 2015 and replaced 'Tomorrow's Doctors', which had been in effect since 2009. 'Outcomes for graduates' had supplementary guidance documents, intended to provide advice for medical schools on how to practically apply the requirements of 'Promoting excellence' (General Medical Council, 2016c) and 'Outcomes for graduates' (General Medical Council, 2015b). Figure 6.1 depicts a timeline of GMC documents produced outlining standards requirements, and associated supplemental guidance documents.

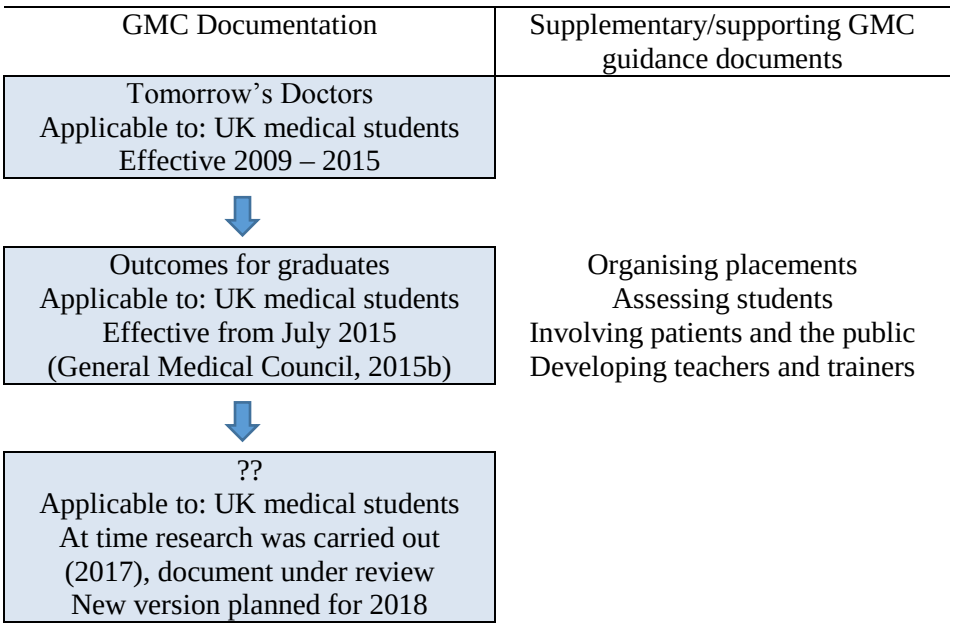

Figure 6.1 Development of Outcomes for graduates document produced by GMC

Outcomes for graduates document description

The 'Outcomes for graduates' document was available to access without financial charge on the GMC website http://www.gmc-uk.org/education/undergraduate/undergrad_outcomes.asp in an online format, or downloadable in a pdf format. The document is still available on the GMC website, but the 2018 updated version now has prominence (released after this research phase was completed). In printed form the 'Outcomes for graduates' document was an A4 paper booklet with 18 pages. It was applicable to UK medical students. The document was structured with a main 'Outcomes for graduates' section, followed by two appendices (Figure 6.2). The 'Outcomes for graduates' section contained an overarching outcome for graduates, and three 'themes' of outcomes. Each 'theme' had what I termed *component outcomes*, which each had sub-outcomes. The number of outcomes in each theme are shown in Figure 6.2.

Outcomes for graduates
Overarching outcome for graduates
Outcomes 1 – The doctor as a scholar and a scientist (5 component outcomes)
Outcomes 2 – The doctor as a practitioner (7 component outcomes)
Outcomes 3 – The doctor as a professional (4 component outcomes)
Appendix 1 – Practical procedures for graduates
Diagnostic procedures
15 listed procedures
Therapeutic procedures
12 listed procedures
General aspects of practical procedures
5 listed aspects
Appendix 2 – Related documents
GMC guidance
8 listed resources
Other documents
26 listed resources

Figure 6.2 Structure of 'Outcomes for graduates' and numerical distribution of outcomes

The section analysed in this research was 'Outcomes 3 – The doctor as a professional' as this represents how the GMC convey student professionalism requirements.

6.3.3 Thematic Analysis

Sub-themes in 'Outcomes for graduates' Outcomes 3: The doctor as a professional

Following analysis, ten sub-themes were identified in the section of the document 'Outcomes 3: The doctor as a professional' (Figure 6.3).

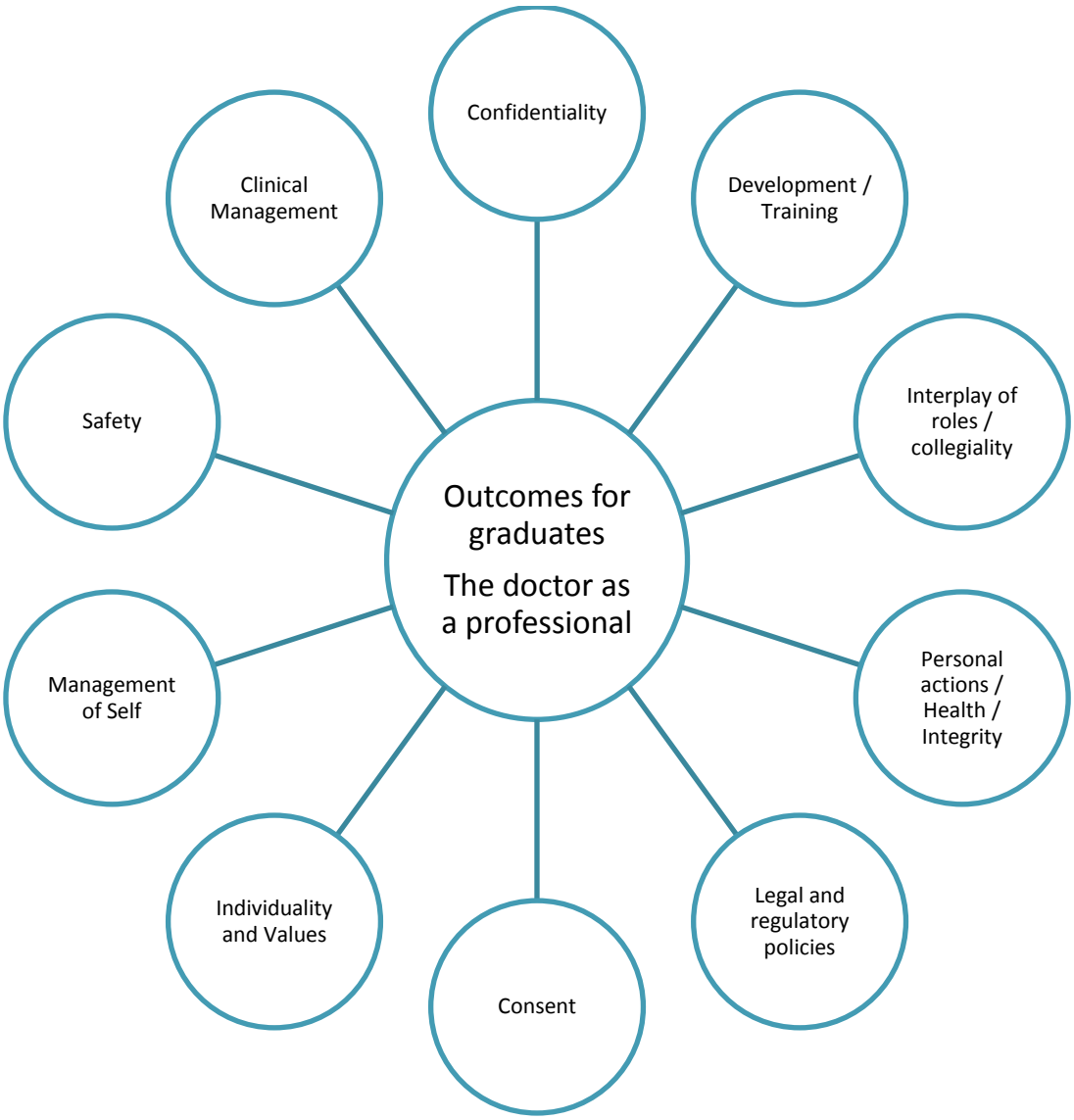

Figure 6.3 Sub-themes identified in Outcomes 3: The doctor as a professional (General Medical Council, 2015b)

Mapping of each statement (outcome) to one or multiple sub-themes is shown in Table 6.6.

	Management of self	Individuality and Values	Consent	Confidentiality	Safety	Clinical Management	Legal and regulatory policies	Development / Training	Personal actions / Health / Integrity	Interplay of roles / collegiality
20. The graduate will be able to behave according to ethical and legal principles. The graduate will be able to:										
a. Know about and keep to the GMC's ethical guidance and standards including Good medical practice, the 'Duties of a doctor registered with the GMC' and supplementary ethical guidance which describe what is expected of all doctors registered with the GMC.							X		X	
b. Demonstrate awareness of the clinical responsibilities and role of the doctor, making the care of the patient the first concern. Recognise the principles of patient-centred care, including self-care, and deal with patients' healthcare needs in consultation with them and, where appropriate, their relatives or carers.		X				X				
c. Be polite, considerate, trustworthy and honest, act with integrity, maintain confidentiality, respect patients' dignity and privacy, and understand the importance of appropriate consent.		X	X	X					X	
e. Recognise the rights and the equal value of all people and how opportunities for some people may be restricted by others' perceptions.		X								
f. Understand and accept the legal, moral and ethical responsibilities involved in protecting and promoting the health of individual patients, their dependants and the public including vulnerable groups such as children, older people, people with learning disabilities and people with mental illnesses.							X			
g. Demonstrate knowledge of laws, and systems of professional regulation through the GMC and others, relevant to medical practice, including the ability to complete relevant certificates and legal documents and liaise with the coroner or procurator fiscal where appropriate.							X			X
21. Reflect, learn and teach others.										
a. Acquire, assess, apply and integrate new knowledge, learn to adapt to changing circumstances and ensure that patients receive the highest level of professional care.								X		
b. Establish the foundations for lifelong learning and continuing professional development, including a professional development portfolio containing reflections, achievements and learning needs.	X							X		
c. Continually and systematically reflect on practice and, whenever necessary, translate that reflection into action, using improvement techniques and audit appropriately for example, by critically appraising the prescribing of others.	X									
d. Manage time and prioritise tasks, and work autonomously when necessary and appropriate.	X									
e. Recognise own personal and professional limits and seek help from colleagues and supervisors when necessary.	X									X
f. Function effectively as a mentor and teacher including contributing to the appraisal, assessment and review of colleagues, giving effective feedback, and taking advantage of opportunities to develop these skills.	X									X
22. Learn and work effectively within a multi-professional team.										

	Management of self	Individuality and Values	Consent	Confidentiality	Safety	Clinical Management	Legal and regulatory policies	Development / Training	Personal actions / Health / Integrity	Interplay of roles / collegiality
a. Understand and respect the roles and expertise of health and social care professionals in the context of working and learning as a multi-professional team.										X
b. Understand the contribution that effective interdisciplinary teamwork makes to the delivery of safe and high quality care.										X
c. Work with colleagues in ways that best serve the interests of patients, passing on information and handing over care, demonstrating flexibility, adaptability and a problem-solving approach.										X
d. Demonstrate ability to build team capacity and positive working relationships and undertake various team roles including leadership and the ability to accept leadership by others.										X
23. Protect patients and improve care.										
a. Place patients' needs and safety at the centre of the care process.					X	X				
b. Deal effectively with uncertainty and change.	X									
c. Understand the framework in which medicine is practised in the UK, including: the organisation, management and regulation of healthcare provision; the structures, functions and priorities of the NHS; and the roles of, and relationships between, the agencies and services involved in protecting and promoting individual and population health.							X			
d. Promote, monitor and maintain health and safety in the clinical setting, understanding how errors can happen in practice, applying the principles of quality assurance, clinical governance and risk management to medical practice, and understanding responsibilities within the current systems for raising concerns about safety and quality.					X					
e. Understand and have experience of the principles and methods of improvement, including audit, adverse incident reporting and quality improvement, and how to use the results of audit to improve practice.								X		
f. Respond constructively to the outcomes of appraisals, performance reviews and assessments.	X									
g. Demonstrate awareness of the role of doctors as managers, including seeking ways to continually improve the use and prioritisation of resources.										X
h. Understand the importance of, and the need to keep to, measures to prevent the spread of infection, and apply the principles of infection prevention and control.					X					
i. Recognise own personal health needs, consult and follow the advice of a suitably qualified professional, and protect patients from any risk posed by own health.					X				X	
j. Recognise the duty to take action if a colleague's health, performance or conduct is putting patients at risk.					X				X	X

Table 6.6 Analysis of outcomes within Outcomes 3: The doctor as a professional section of Outcomes for graduates by sub-theme

Table 6.7 shows sub-theme distribution and frequency for learning outcomes in the 'The doctor as a professional'. Sub-theme distribution according to regulator-defined subsections is shown in Table 6.8.

Sub-theme	No. of statements
Management of Self	7
Individuality and Values	3
Confidentiality	1
Consent	1
Safety	5
Clinical Management	2
Legal and regulatory policies	4
Development / Training	3
Personal actions / Health / Integrity	4
Interplay of roles / collegiality	9

Table 6.7 Sub-theme distribution and frequency for learning outcomes in 'The doctor as a professional'

Professionalism sub-sections as listed in the GMC document	Sub-theme
The graduate will be able to behave according to ethical and legal principles	Individuality and values Consent Confidentiality Clinical Management Legal and regulatory policies Personal actions / Health / Integrity
Reflect, learn and teach others	Management of self Development / Training Interplay of roles / collegiality
Learn and work effectively within a multi-professional team	Interplay of roles / collegiality
Protect patients and improve care.	Management of self Safety Clinical Management Legal and regulatory policies Development / Training Personal actions / Health / Integrity Interplay of roles / collegiality

Table 6.8 Sub-theme distribution by regulator determined sub-sections of the 'The doctor as a professional'

Overarching themes featuring in Outcomes for graduates

Each sub-theme had descriptors developed which reflected content. The next analysis stage was consideration of overarching themes which encompassed sub-themes (Table 6.9).

Sub-theme	Descriptor	Overarching Theme
Management of self	Self-regulation, reflection, self-awareness and development of personal abilities and skills.	Practitioner
Individuality and values	Respecting patient's dignity and rights. Account taken of equality and patient-centred approach to care.	Patient Regulatory
Consent	Awareness of importance of appropriate consent.	Patient
Confidentiality	Maintain confidentiality.	Patient
Safety	Patient safety, including infection prevention, has a central role in care process. Apply quality assurance, clinical governance and risk management principles, raise concerns were necessary. Assess own and colleagues capabilities in interest of safe patient care, seek advice when needed.	Patient
Clinical management	Central place of patients' needs in the care process.	Patient
Development or training	Knowledge and skills development and experience of improvement activities to improve patient delivered care.	Practitioner (Patient)
Legal and regulatory policies	Awareness of and compliance with regulator developed and national legal policies, guidance, and standards of responsibilities and ethics. Understanding of the framework in which medicine in practised in the UK.	Practitioner Regulatory
Personal actions / Health / Integrity	Honesty, integrity and ethical performance. Abiding by laws / regulations. Raising concern where appropriate.	Practitioner Regulatory
Interplay of roles / collegiality	Work within and develop a team. Work with those in own field and applied professionals. Raising concern where appropriate.	Practitioner Patient

Table 6.9 Overarching theme findings in Outcomes for graduates

Descriptor development for each overarching theme was considered, those previously developed for 'Preparing for Practice' were reviewed (they had the same headings, and it was determined those descriptors were appropriate, with only minimal modification (Table 6.10).

One modification was the removal of reference to public expectation from the Regulatory descriptor.

Overarching theme	Descriptor
The patient as the focus	Direct relevance to the patient; how they will be kept safe, be respected, be appropriately informed about their care and experience a high standard of care provision.
Regulatory considerations and obligations	Focus on the expectations, legal requirements, standards or guidance which exists from a variety of sources (regulator, and national regulation) with which compliance is required for individuals acting in the 'professional' role.
The practitioner as the focus	Focus on the practitioner as an individual; their continuing ability to perform their role effectively and safely. Their taking responsibility for their going fitness to practise.

Table 6.10 Overarching theme descriptors for Outcomes for graduates

The overarching themes identified were not discrete, but had overlapping contributory elements. The 'patient as the focus' had the greatest number of contributing sub-themes which perhaps reflects the focus of the document as 'patient centric', reflecting the GMC's central tenet of '*protecting the public*'.

6.3.4 Outcome Analysis

Findings

The findings of the outcome analysis are shown in Table 6.11.

	Style classification	Comments on the 'outcome'	Elements included	Focus
20. The graduate will be able to behave according to ethical and legal principles. The graduate will be able to:				
a. Know about and keep to the GMC's ethical guidance and standards including Good medical practice, the 'Duties of a doctor registered with the GMC' and supplementary ethical guidance which describe what is expected of all doctors registered with the GMC.	Objective / Standard / Functional Outcome	'Know about' is poor language for an outcome - what is the level? It is probably 'remembering' as it is a verb sometimes included in this level, but in terms of assessment - no explicit action verb to describe level of expectation. 'keep to' appears to be a Standard which has been applied to the GMC's stated documents. 'Describe' is an explicit outcome. Combination of requirements here, and the scope is broad and not time-bound.	Multiple	Regulatory
b. Demonstrate awareness of the clinical responsibilities and role of the doctor, making the care of the patient the first concern. Recognise the principles of patient-centred care, including self-care, and deal with patients' healthcare needs in consultation with them and, where appropriate, their relatives or carers.	Outcome with feasibility challenges??	'Demonstrate awareness' - not the best language of an outcome as the assessment still needs to determine how 'awareness' is assessed - what level is required? 'Awareness' could be achieved at a very low level. Could this be replaced with 'describe the clinical …..'. 'Recognise the principles….' is poor language for a learning outcome, but is an attempt, however in terms of the level of attainment required by 'recognise' - again this is a low level, does this seem sufficient for a new registrant?? This section could be more concisely described to become a more appropriately worded outcome. 'deal with' is an interesting use of language for management of healthcare needs, but again suggests an application of knowledge and skills, so has characteristics of an outcome.	Multiple	Patient
c. Be polite, considerate, trustworthy and honest, act with integrity, maintain confidentiality, respect patients' dignity and privacy, and understand the importance of appropriate consent.	Standard / Objective	The first section of this is written as a Standard - 'Be polite, considerate, trustworthy and honest, act with integrity, maintain confidentiality, respect patients' dignity and privacy', however the last part of ' understand the importance of appropriate consent' is not written as an outcome as there is no tangible endpoint or way of assessing, it is more an objective (general objective).	Multiple	Patient
e. Recognise the rights and the equal value of all people and how opportunities for some people may be restricted by others' perceptions.	Objective?	'Recognise' is not a good verb (although in Bloom's cognitive domain) as how do you assess someone's recognition? Lower level of cognitive domain - 'Remembering' and recall of information given. Is recognition without action 'enough'?	Dual	Patient
f. Understand and accept the legal, moral and ethical responsibilities involved in protecting and promoting the health of individual patients, their dependants and the public including vulnerable groups such as children, older people, people with learning disabilities and people with mental illnesses.	Outcome with feasibility challenges?	Technically 'understand' could be considered as included in the understanding / comprehension level of Bloom's cognitive domain, but it does not explicitly state how this comprehension could be assessed. 'Accept' is interesting - is this part of an affective domain? Probably it would be considered here, possibly at the lower levels of the domain as there doesn't appear to be a 'value' component to this statement.	Multiple	Regulatory /Patients
g. Demonstrate knowledge of laws, and systems of professional regulation through the GMC and others, relevant to medical practice, including the ability to complete relevant certificates and legal documents and liaise with the coroner or procurator fiscal where appropriate.	Outcome with feasibility challenges	Tangible actions described, however it is very broad with a global view, to the point that the scope within this is immense. The outcome could cover any law / system so how can it be consistently applied / interpreted by education providers.	Multiple	Regulatory
21. Reflect, learn and teach others.				

	Style classification	Comments on the 'outcome'	Elements included	Focus
a. Acquire, assess, apply and integrate new knowledge, learn to adapt to changing circumstances and ensure that patients receive the highest level of professional care.	Objective / Functional outcome	'Acquire' is a process objective, whereas 'assess, apply and integrate' can be considered as a component of a learning outcome. 'learn to adapt to' is in the style of an objective. 'Ensure that' forms part of an outcome. There is an element of both direction for learning and endpoint in this statement.	Multiple	Practitioner / Patient
b. Establish the foundations for lifelong learning and continuing professional development, including a professional development portfolio containing reflections, achievements and learning needs.	Objective	No clear measurable component here, but does outline the direction of travel and goal, with detail of how these may be addressed - an objective without a tangible endpoint.	Single	Practitioner
c. Continually and systematically reflect on practice and, whenever necessary, translate that reflection into action, using improvement techniques and audit appropriately for example, by critically appraising the prescribing of others.	Outcome	How to review and assess someone's reflection? Suggests an inner value of reflection (affective domain). There is a suggestion of ongoing activity, but some elements could be clearly 'assessed', i.e. critical appraisal of others.	Multiple	Practitioner
d. Manage time and prioritise tasks, and work autonomously when necessary and appropriate.	Objective?	A way of approaching and managing self, endpoint could be considered in terms of prioritisation.	Multiple	Practitioner
e. Recognise own personal and professional limits and seek help from colleagues and supervisors when necessary.	Outcome with feasibility challenges	'Recognise' is not a good verb (although in Bloom's cognitive domain) as how do you assess someone's recognition? Is this something all students will have opportunity for within the confines of working within an undergraduate programme. How would it be consistently applied to students in terms of attainment? More likely to be visible as 'failure' to attain through concerns raised.	Dual	Practitioner
f. Function effectively as a mentor and teacher including contributing to the appraisal, assessment and review of colleagues, giving effective feedback, and taking advantage of opportunities to develop these skills.	Outcome with feasibility challenges	A number of tangible endpoints listed, but discrete aspects covered within the statement (giving feedback and developing skills in giving feedback).	Multiple	Practitioner
22. Learn and work effectively within a multi-professional team.				
a. Understand and respect the roles and expertise of health and social care professionals in the context of working and learning as a multi-professional team.	Objective	No tangible endpoint and way of qualifying/quantifying statement attainment. How do you assess someone's 'respect'? Again, this may be considered in the absence of a concern being raised.	Dual	Practitioner
b. Understand the contribution that effective interdisciplinary teamwork makes to the delivery of safe and high quality care.	Objective	No clear measurable component here.	Single	Patient
c. Work with colleagues in ways that best serve the interests of patients, passing on information and handing over care, demonstrating flexibility, adaptability and a problem-solving approach.	Standard /??	Unusual combination and amalgamation of language and grammar. Not sure how this can be demonstrated within the constraints that an undergraduate student works in. Multi-faceted aspects here - the collegial working, passing over information and handover of care. In addition, there is reference to the attributes of flexibility, adaptability and the type of approach to be taken.	Multiple	Patient

	Style classification	Comments on the 'outcome'	Elements included	Focus
d. Demonstrate ability to build team capacity and positive working relationships and undertake various team roles including leadership and the ability to accept leadership by others.	Outcome with feasibility challenges	Equal opportunities for all undergraduate students to demonstrate this - comparable opportunities? Challenging for an education provider to 'assess', although may be possible to identify 'failure' to attain, if issues have been identified / raised.	Multiple	Practitioner
23. Protect patients and improve care.				
a. Place patients' needs and safety at the centre of the care process.	Standard		Dual	Patient
b. Deal effectively with uncertainty and change.	Objective	Again, the use of the word 'deal' is interesting - would 'manage' have been more appropriate? How would attainment be considered here? There is a suggestion of an action here, so starting to move toward an outcome, but no tangible endpoint or outline of the scope of the content. Interpretation required on behalf of the education provider as to how attainment would be considered.	Dual	Practitioner
c. Understand the framework in which medicine is practised in the UK, including: the organisation, management and regulation of healthcare provision; the structures, functions and priorities of the NHS; and the roles of, and relationships between, the agencies and services involved in protecting and promoting individual and population health.	Objective	A rather broad outline here of constituent parts. Certainly not something that could be assessed in one episode. Not explicit about content in that different providers will necessarily interpret content and how to map to their programme with inevitable inconsistency due to vast coverage in this 'outcome'.	Multiple	Regulatory
d. Promote, monitor and maintain health and safety in the clinical setting, understanding how errors can happen in practice, applying the principles of quality assurance, clinical governance and risk management to medical practice, and understanding responsibilities within the current systems for raising concerns about safety and quality.	Outcome with feasibility challenges	Very broad coverage of a number of large topics here. 'Promote', 'monitor', 'maintain' necessitate 3 different points along a continuum. A longitudinal approach? This may be desired and pragmatic, but in terms of demonstration by a learning provider - this could not be 'assessed' in one episode, but multiple points required. 'Understanding responsibilities' - what level is required here? outline? Describe? Explain?	Multiple	Patient
e. Understand and have experience of the principles and methods of improvement, including audit, adverse incident reporting and quality improvement, and how to use the results of audit to improve practice.	Objective	2 different actions here - 1) 'understanding' - what constitutes this and what level is required? And 2) 'have experience of' - does this mean by participation or by observation of others? Listening to a presentation may address these, but doesn't mean a student is able to undertake or actively participate.	Multiple	Practitioner
f. Respond constructively to the outcomes of appraisals, performance reviews and assessments.	Outcome with feasibility challenges	Multi-faceted outcome, so would necessitate multiple instances of assessment to fully demonstrate attainment. Challenging for a provider to 'map' to in one assessment. Interpretation of 'constructive response'.	Multiple	Practitioner

	Style classification	Comments on the 'outcome'	Elements included	Focus
g. Demonstrate awareness of the role of doctors as managers, including seeking ways to continually improve the use and prioritisation of resources.	Outcome with feasibility challenges	‘Demonstrate awareness' - not the best language of an outcome as the assessment still needs to determine how 'awareness' is assessed - what level is required? 'Awareness' could be achieved at a very low level. So is it just awareness that doctors need to seek ways to continually improve use and prioritisation of resources, or actually 'doing' this? Within the undergraduate programme, do all students have an opportunity to do this?	Dual	Practitioner
h. Understand the importance of, and the need to keep to, measures to prevent the spread of infection, and apply the principles of infection prevention and control.	Objective / Functional outcome	‘Understand' does not give an indication of how knowledge would be assessed, therefore this is not presented with tangible endpoint. 'Apply' is in the format of an outcome, however it is a rather broad statement, is it time bound or situation specific?	Dual	Patient
i. Recognise own personal health needs, consult and follow the advice of a suitably qualified professional, and protect patients from any risk posed by own health.	Outcome with feasibility challenges	‘Recognise' is not a good verb (although in Bloom's cognitive domain) as how do you assess someone's recognition? 'Consult and follow the advice of a suitably qualified professional' - will all students have an opportunity to do this? What if a student does not have a health issue during the course, therefore doesn't need to consult / follow advice. In terms of provider mapping, likely that absence of failure to do this if needed would necessarily constitute attainment.	Multiple	Practitioner / Patient
j. Recognise the duty to take action if a colleague’s health, performance or conduct is putting patients at risk.	Outcome with feasibility challenges	‘Recognise' is not a good verb (although in Bloom's cognitive domain) as how do you assess someone's recognition? Again as with many of these, is recognition sufficient - would the ability to outline the reasons and mechanism of implementing this be more appropriate?	Single	Patient

Table 6.11 Analysis findings of presentation style in Outcomes for Graduates, Outcomes 3 - the doctor as a professional

6.3.5 Discussion

In terms of who or what was the 'focus' of each statement, when considered by overarching theme, there was a predominance of patient and practitioner focus. The number of statements related directly to the practitioner was interesting to note, memoing noted that the researcher (HB) made a subjective observation of a different 'feeling' when reading this document, compared to 'Preparing for Practice', with a more personal approach to the practitioner focus. There were also a large proportion of statements which had multiple elements (Table 6.12):

Overarching theme	No. of statements with this focus		Elements included	No. of statements
Regulatory	3		Single	3
Patient	11		Dual	7
Practitioner	13		Multiple	16

Table 6.12 Summary of Outcomes for Graduates, Outcomes 3 - the doctor as a professional analysis

Allocation of a 'style' was challenging, partly as each statement had multiple elements, which were often discrete and disparate entities which had been combined into one statement. The combination of 'styles' included objective, outcome and standard, sometimes with combinations found within a single statement, for example:

> *GMC 20a. 'Know about and keep to the GMC's ethical guidance and standards including Good medical practice, the 'Duties of a doctor registered with the GMC' and supplementary ethical guidance which describe what is expected of all doctors registered with the GMC.' (General Medical Council, 2015b)*

In the example above, 'Know about' is inadequate for an outcome, as it is challenging to know what level of knowledge would be expected. It arguably fits within the domain of 'remembering' as it is a verb sometimes included in this level, but in terms of assessment, no explicit action verb describes the level of expectation. 'Keep to' better reflects a Standard which has been applied to the GMC's stated documents. 'Describe' is a functional outcome. In summary, a combination of requirements, with a broad scope, which are not time-bound.

> *GMC 21a. 'Acquire, assess, apply and integrate new knowledge, learn to adapt to changing circumstances and ensure that patients receive the highest level of professional care.' (General Medical Council, 2015b)*

In the example above, 'Acquire' is a process objective, whereas 'assess, apply and integrate' can be considered as a component of a learning outcome. 'Learn to adapt to' is in the style of an objective, and 'Ensure that' forms part of an outcome as there are elements of both direction for learning and endpoint in the statement.

Other observations were that some of the use of language and the construction of the statements appeared 'unusual', for example '*deal with'* occurs in GMC 20b and 23b, which may not be the way an action's description was expected. The use of 'manage' may have been an alternative, however another perspective of '*deal with*' is suggestive of taking less detailed handling of a situation, possibly where the extent required was only to 'superficially' pass on the responsibility to someone else who would then 'manage' the situation. The differing interpretations however are another example of ambiguities and how variation in interpretation could occur. The interpretation of the use of language here is interesting and further analysis would be outside the scope of the current work, but would be a potential area for future research.

The inclusion of very specific elements within statement (20g) seemed to HB slightly incongruous when considering the broad and non-specific nature of the other statements:

> *GMC 20g. 'Demonstrate knowledge of laws, and systems of professional regulation through the GMC and others, relevant to medical practice, including the ability to complete relevant certificates and legal documents and liaise with the coroner or procurator fiscal where appropriate.' (General Medical Council, 2015b)*

This could be due to the influence of the Harold Shipman inquiry (Smith, 2002-2005) and highlights the regulatory procedures surrounding the certification of death and subsequent arrangements. These are bounded by a legal framework associated with a death which determines the profession / GMC response, rather than an element of self-regulation / determination.

In consideration of the comparison with dentistry documentation, an assumption was made prior to analysis of the GMC document that the overall content and coverage of themes would be similar to those identified in Preparing for Practice. This stemmed from a belief that, from initial outward appearance, the document held similarities in purpose and structure for medical undergraduates as 'Preparing for Practice' had for dental undergraduates. This extrapolated to an assumption that the way professionalism of undergraduate students was represented would be similar from the two regulators.

Two approaches for analysis were considered:

1. Read document and identify sub-themes 'from scratch' that are appropriate, with no intentional relation to those identified in 'Preparing for Practice' or 'Standards for the Dental Team' analyses.

The benefit of this approach would be identification of a true reflection of that document content, although there was acknowledgement that the researcher's (HB) knowledge of the previous sub-themes that had been identified may influence in future sub-theme identification.

The disadvantage of this approach may have been that direct comparability with other documents (i.e. the distribution of sub-themes identified) would have been compromised if sub-themes were not the same.

2. Use sub-themes identified in previous analysis of 'Standards for the Dental Team' and 'Preparing for Practice' as a starting point and see how an initial mapping would transfer to these sub-themes.

   An advantage of that approach may have been to provide a starting point and provide an indication of the similarities (or differences) in the document.

The second approach was adopted, working initially from sub-themes identified in 'Preparing for Practice'. However, there was rapid realisation that the GMC style was different to GDC documents, with respect both to how 'outcomes' were prepared (their construction) and sub-themes covered. Therefore the sub-theme identification 'from scratch' approach was subsequently adopted, whilst acknowledging likely overlap of sub-themes with those identified from previous documents.

There appeared to be greater emphasis in the GMC document on the 'Management of self', including greater reference to reflection and progression of personal development attributes. The apparent difference in emphasis may be solely that sub-themes identified are present in different sections of 'Preparing for Practice' (other than 'Professionalism'), but HB noted a different 'feeling' of emphasis when reading the GMC document compared to the GDC document. The style in which the statements were written may also have contributed to the difference in 'feel' when reading the document, which appeared to be more 'personal' and individual-centred than that in 'Preparing for Practice', which had greater emphasis on the individual as a professional.

The same three overarching themes were identified in the document as had been identified in Preparing for Practice: the Practitioner as the focus; the Patient as the focus; Regulatory issues. Their constituent sub-themes did however vary slightly from those in Preparing for Practice, i.e. in the 'Regulatory' category there was no reference to public expectation being an area of guidance.

6.4 General Adult Nurses

6.4.1 Background

Nursing in the UK is regulated by the Nursing and Midwifery Council (NMC). Legislatively, the Nursing and Midwifery Order 2001, which came into effect on 1st April 2002, established the role of the NMC. Nurses must be registered with the NMC in order to practise in the UK and use of the 'registered general nurse' title is protected. The NMC sets standards for education, training and conduct for the profession. The NMC 'role' stated on the 'Our Role: What we do' section of the NMC website was '*We exist to protect the public*' (Nursing and Midwifery Council, 2017).

The NMC website (21/09/17) stated there were 79 approved education institutions and approximately 1000 accredited education programmes. Therefore guidance and standards produced were applied by a large number of different organisations (more so than in dentistry). Table 6.13 displays documents for education providers produced by the NMC. The key undergraduate document was 'Standards for pre-registration nursing education' (Nursing and Midwifery Council, 2010).

	Applicable to	Reference
Standards for pre-registration nursing education	Undergraduate education	(Nursing and Midwifery Council, 2010)
Standards for competence	Registered nurses	(Nursing and Midwifery Council, 2004a)
Standards for specialist education and practice	For specialist education and practice	(Nursing and Midwifery Council, 2001)
The Code: Professional standards of practice and behaviour for nurses and midwives	All registered and student nurses	(Nursing and Midwifery Council, 2015)

Table 6.13 Documents produced by the NMC in respect of their role in education and training

6.4.2 Standards for pre-registration nursing education

Standards for pre-registration nursing education (Nursing and Midwifery Council, 2010) were published in 2010. A timeline depicting document development is shown in Figure 6.4.

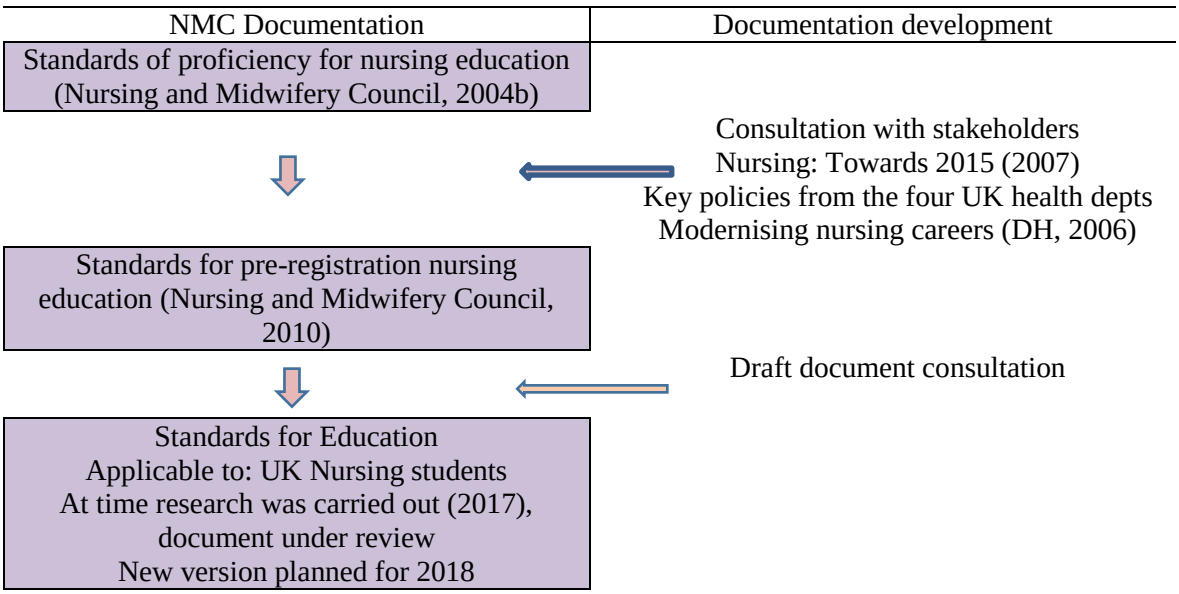

Figure 6.4 Development of Pre-registration standards document produced by NMC

Document description

The 'Standards for pre-registration nursing education' document was available to access without financial charge on the NMC website https://www.nmc.org.uk/standards/additional-standards/standards-for-pre-registration-nursing-education/ and was accessible in a downloadable pdf format. In printed form the document was an A4 paper booklet with 152 pages. It was applicable to UK nursing students. Figure 6.5 shows the document structure. The section selected for analysis of the conceptual portrayal of professionalism by the regulator was 'Competencies for entry to the register, Domain 1: Professional values'. The section had a generic standard of competence statement, followed by a list of nine Competencies.

Introduction
Standards for competence
Context
The competency framework
Competencies for entry to the register: Adult nursing
Domain 1: Professional values
Domain 2: Communication and interpersonal skills
Domain 3: Nursing practice and decision making
Domain 4: Leadership, management and team working
Competencies for entry to the register: Mental health nursing
Competencies for entry to the register: Learning disabilities nursing
Competencies for entry to the register: Children's nursing
Standards for education
Annexe 1: Extract from Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications
Annexe 2: Progression criteria
Annexe 3: Essential skills clusters (2010) and guidance for their use

Figure 6.5 Structure of 'Standards for pre-registration nursing education'

6.4.3 Thematic Analysis

Sub-themes in Adult nursing, Domain 1: Professional values

Following analysis, eight sub-themes were identified (Figure 6.6). Subsequent mapping of each statement (outcome) to sub-themes is shown in Table 6.14.

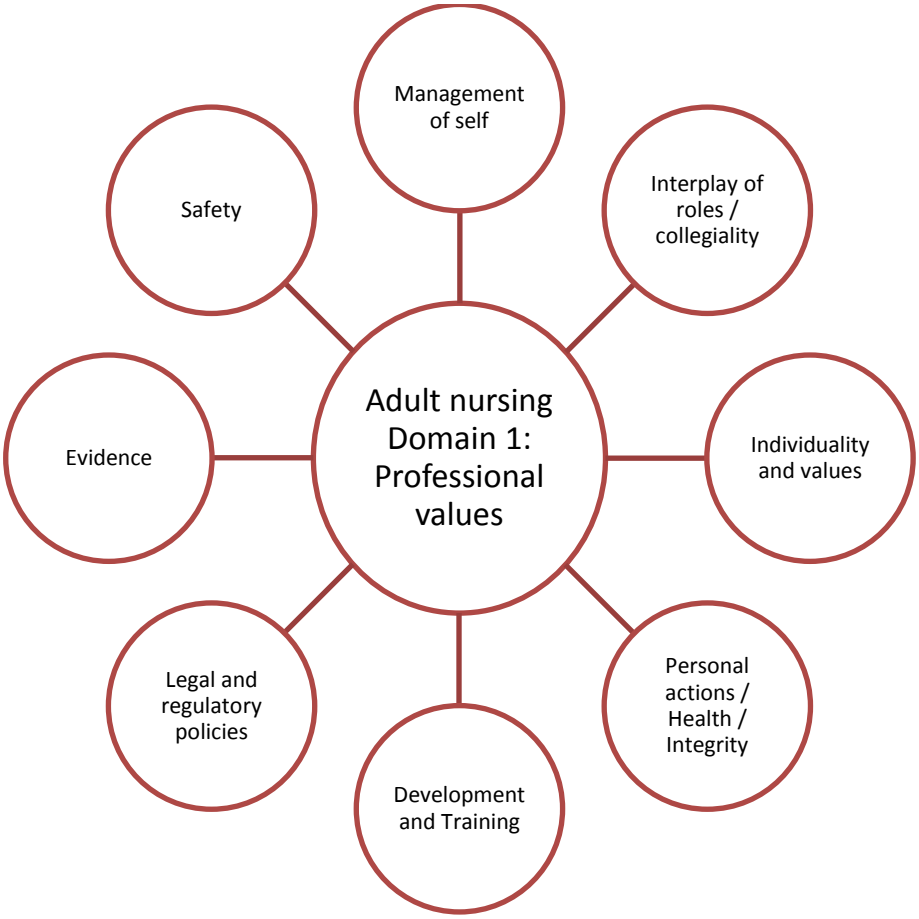

Figure 6.6 Sub-themes identified in Adult nursing, Domain 1: Professional values (Nursing and Midwifery Council, 2010)

	Management of self	Individuality and Values	Safety	Legal and regulatory policies	Development / Training	Personal actions / Health / Integrity	Interplay of roles / collegiality	Evidence
Generic standard for competence								
All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks. They must work in partnership with other health and social care professionals and agencies, service users, their carers and families in all settings, including the community, ensuring that decisions about care are shared.	**X**	**X**	**X**	**X**		**X**	**X**	**X**
Field standard for competence								
Adult nurses must also be able at all times to promote the rights, choices and wishes of all adults and, where appropriate, children and young people, paying particular attention to equality, diversity and the needs of an ageing population. They must be able to work in partnership to address people's needs in all healthcare settings.		**X**					**X**	
Competencies								
1. All nurses must practise with confidence according to *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC 2015), and within other recognised ethical and legal frameworks. They must be able to recognise and address ethical challenges relating to people's choices and decision-making about their care, and act within the law to help them and their families and carers find acceptable solutions.		**X**		**X**		**X**		
1.1 Adult nurses must understand and apply current legislation to all service users, paying special attention to the protection of vulnerable people, including those with complex needs arising from ageing, cognitive impairment, long-term conditions and those approaching the end of life.				**X**				
2 All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care.		**X**				**X**		
3 All nurses must support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations. These include people whose lives are affected by ill health, disability, ageing, death and dying. Nurses must understand how these activities influence public health.		**X**						
4 All nurses must work in partnership with service users, carers, families, groups, communities and organisations. They must manage risk, and promote health and wellbeing while aiming to empower choices that promote self-care and safety.			**X**				**X**	
5 All nurses must fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations.							**X**	
6 All nurses must understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.							**X**	

	Management of self	Individuality and Values	Safety	Legal and regulatory policies	Development / Training	Personal actions / Health / Integrity	Interplay of roles / collegiality	Evidence
7 All nurses must be responsible and accountable for keeping their knowledge and skills up to date through continuing professional development. They must aim to improve their performance and enhance the safety and quality of care through evaluation, supervision and appraisal.	**X**		**X**		**X**			
8 All nurses must practise independently, recognising the limits of their competence and knowledge. They must reflect on these limits and seek advice from, or refer to, other professionals where necessary.	**X**						**X**	
9 All nurses must appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.								**X**

Table 6.14 Analysis of outcomes within Adult Nursing Domain 1: Professional values section of 'Standards for pre-registration nursing education' by sub-theme

Sub-theme distribution and frequency is shown in Table 6.15.

Sub-theme	No. of statements
Management of Self	3
Individuality and Values	5
Safety	3
Legal and regulatory policies	3
Development / Training	1
Personal actions / Health / Integrity	3
Interplay of roles / collegiality	6
Evidence	2

Table 6.15 Sub-theme distribution and frequency in 'Adult Nursing Domain 1: Professional values'

Overarching themes featuring in Standards for pre-registration nursing education

Sub-theme descriptors were developed to reflect content (Table 6.16). The next analysis stage was consideration of overarching themes.

Sub-theme	Descriptor	Overarching theme
Management of self	Autonomous Practise. Reflection and recognition of personal limits and development of personal skills.	Practitioner
Individuality and values	Respecting patient's dignity and rights. Account taken of equality and patient-centred approach to care. Emphasis on variety of situations which must be respected.	Patient Regulatory
Safety	Patient safety. Apply processes to improve personal skills which will enhance safety.	Patient
Development or training	Engage in continuing personal development.	Practitioner
Legal and regulatory policies	Awareness of and compliance with regulator developed and national ethical and legal frameworks, guidance, and standards of responsibilities.	Regulatory
Personal actions / Health / Integrity	Care for and safeguard the public. Ethical performance. Abiding by laws / regulations.	Regulatory Patient
Interplay of roles / collegiality	Collaborative working for patient benefit with those in own field and applied professionals.	Patient
Evidence	Application of evidence based practice, appraisal and integration of research evidence.	Practitioner

Table 6.16 Overarching theme findings for Standards for pre-registration nursing education

Overarching theme descriptors were considered and modified as appropriate (Table 6.17). One notable modification was removal of fitness to practise from the Practitioner category –

there was no mention of raising concern in this section of the document. The themes identified were not discrete, but had overlapping contributory elements.

Overarching theme	Descriptor
The patient as the focus	Direct relevance to the patient; how they will be kept safe, respected, appropriately informed about their care and experience a high standard of care provision.
Regulatory considerations and obligations	Focus on the expectations, legal requirements, standards or guidance which exists from a variety of sources (regulator, and national regulation) with which compliance is required for individuals acting in the 'professional' role.
The practitioner as the focus	Focus on the practitioner as an individual; their continuing ability to perform their role effectively and safely.

Table 6.17 Overarching theme descriptors for Standards for pre-registration nursing education

6.4.4 Outcome Analysis

Findings

The findings of the outcome analysis are shown in Table 6.18

	Style classification	Comments on the 'outcome'	Elements included	Focus
Generic standard for competence				
All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks. They must work in partnership with other health and social care professionals and agencies, service users, their carers and families in all settings, including the community, ensuring that decisions about care are shared.	Standard / Outcome with feasibility challenges	The initial part of this is written as a standard outlining the expectations required and the level expected. 'They must show professionalism' - is technically an outcome, but with the current assessment tools we have, how is this to be assessed? The last part of the statement is again a standard, outlining the expected level. Taken in its entirety this is a very broad statement which is multi-faceted and would prove challenging for an education provider to confirm attainment of without consideration of the elements within the statement.	Multiple	Patient Regulatory
Field standard for competence				
Adult nurses must also be able at all times to promote the rights, choices and wishes of all adults and, where appropriate, children and young people, paying particular attention to equality, diversity and the needs of an ageing population. They must be able to work in partnership to address people's needs in all healthcare settings.	Objective	Whilst 'Promote' could be an action verb, the statement is looking at the future and in writing it as a direction of travel. In the context of this statement 'work in partnership' is an objective, again, and direction to apply when approaching situations.	Multiple	Patient
Competencies				
1. All nurses must practise with confidence according to *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC 2015), and within other recognised ethical and legal frameworks. They must be able to recognise and address ethical challenges relating to people's choices and decision-making about their care, and act within the law to help them and their families and carers find acceptable solutions.	Standard / Functional outcome	A very broad scope of coverage here - actually includes adherence to another NMC document which is 20 pages, which has a sub-title of 'Professional standards of practice and behaviour for nurses and midwives' - this document itself has lists of 25 Standards for the Profession, either of which has sub-sections. 'They must be able to 'recognise and address' is an outcome, but again, the scope of coverage of this outcome is very broad which would make consistent application by education providers challenging.	Multiple	Regulatory
1.1 Adult nurses must understand and apply current legislation to all service users, paying special attention to the protection of vulnerable people, including those with complex needs arising from ageing, cognitive impairment, long-term conditions and those approaching the end of life.	Objective / Functional outcome	'Understand' is not an outcome, but an objective. Apply is an outcome, but the broad scope of 'current legislation' which is also non-specific would make this difficult to consistently apply and demonstrate attainment of between students and between education providers.	Multiple	Regulatory Patient
2 All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care.	Standard / Functional outcome	The first part is a standard. Using 'challenge' as the action verb, the last sentence is an outcome. But to be able to get this in terms of assessment, a simulated situation would be needed to permit a standardised approach and therefore allow all students to have a suitable and comparable opportunity to demonstrate.	Multiple	Patient

	Style classification	Comments on the 'outcome'	Elements included	Focus
3 All nurses must support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations. These include people whose lives are affected by ill health, disability, ageing, death and dying. Nurses must understand how these activities influence public health.	Standard / Objective	'Support' is a standard of approach and 'promote the health' again seems to be written as a standard, rather than an outcome to achieve. It also has a broad scope of coverage which makes consistent application of this challenging. 'Nurses must understand...' is an objective.	Multiple	Patient
4 All nurses must work in partnership with service users, carers, families, groups, communities and organisations. They must manage risk, and promote health and wellbeing while aiming to empower choices that promote self-care and safety.	Standard / Objective	'Work in partnership' is the standard to be achieved, managing risk and promote health are objectives of how the student should act, rather than stating they will achieve….'while aiming to empower' is an objective to how the students will carry out an outcome. If changed to 'will take action to empower' this would start to become more outcome focussed.	Multiple	Patient
5 All nurses must fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations.	Objective	No tangible endpoint, this appears to be a method of approach to manage situations. It is also too broad to be able to consistently apply / assess	Multiple	Patient
6 All nurses must understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.	Objective	'Understand' is not a good action verb - how do you assess if they 'understand'? 'seek to work' is an objective.	Dual	Patient
7 All nurses must be responsible and accountable for keeping their knowledge and skills up to date through continuing professional development. They must aim to improve their performance and enhance the safety and quality of care through evaluation, supervision and appraisal.	Standard / Objective	This is written as a standard initially, followed by an objective of how to proceed and how they could achieve an aim with some process directive.	Multiple	Practitioner
8 All nurses must practise independently, recognising the limits of their competence and knowledge. They must reflect on these limits and seek advice from, or refer to, other professionals where necessary.	Standard / Objective	The first sentence is written as a standard. 'Reflect' and 'seek advice' is an objective. Is there an opportunity for all students within the learning environment to be able to experience and demonstrate attainment of all of this?	Multiple	Practitioner
9 All nurses must appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.	Objective / Functional outcome	'Appreciate the value' is not tangible, but moving toward an affective domain state. Be able to understand is an objective, while 'appraise' and 'apply' are outcomes, as is 'identify'.	Multiple	Practitioner

Table 6.18 Analysis findings of presentation style in Standards for pre-registration nursing education, Domain 1 - Professional values

6.4.5 Discussion

There was a predominant patient focus to the document (Table 6.19):

Overarching theme	No. of statements with this focus		Elements included	No. of statements
Regulatory	3		Single	0
Patient	8		Dual	1
Practitioner	3		Multiple	11

Table 6.19 Summary of Standards for pre-registration nursing education, Domain 1 - Professional values analysis

The statements in the NMC document were very broad, non-specific and multifaceted. Some of the multi-faceted elements were homogeneous, but not consistently so, although when they were not homogeneous, the elements were not as disparate as some of those seen in the GMC document. The majority of statements had multiple elements, making the ability to determine and deliver assessable requirements challenging without fragmenting the statements, which then causes challenges in consistency of approach of how this is achieved within the assessment of a student.

An observation was made that <u>all</u> statements were prefaced by the words '*All nurses must…*', which suggests the statement is more akin to a standard rather than an outcome. This has parallel with the GDC 'Standards for the Dental Team' document, which uses '*should'* and '*must'* before statements. It was difficult to determine where on a continuum, a 'standard' became an 'objective'. Some statements were clearly one or the other, but some had the distinction blurred, particularly when prefaced by '*all nurses must*'. An example would be:

> *NMC 5. 'All nurses must fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations' (Nursing and Midwifery Council, 2010)*

In analysis, this was assigned the status 'objective'. It has no tangible endpoint, so is not an outcome. It is a way of approaching and managing situations, however, there is no 'level' outlined to be a 'benchmark', and therefore was not a standard. Following this application of assignment, the example below was determined to be a 'standard'. It is written in such a way that it could be the benchmark to make a judgement concerning an individual nurse's delivery of care:

> *NMC 2. 'All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions…..' (Nursing and Midwifery Council, 2010)*

In terms of possible contributory influences on the NMC document, the Beverly Allitt case in 1991 (report published by the High Court 1994) had a similarly detrimental effect on the reputation of nurses to that experienced by Shipman for doctors. The influence of such cases on the 'tone' and focus of regulatory documents must be considered (although further analysis is outside the scope of this thesis). The appointment of the NMC as a regulatory body is more recent than that of the GDC in dentistry. It was formed from the Order of 2001. The document in this analysis however predates the comparable 'Preparing for Practice' document. There was no mention of raising concern in the NMC document, this could possibly be due to when it was produced (2010), i.e. prior to the publication of the Francis report (Francis, 2013), following which the 'raising concern' wording became widespread. However, despite this timing which would mean that explicit use of the 'raising concern' terminology would not be expected, the section does not appear to contain content which would have a similar intent. There was also no mention of 'team' in the document. For some professions there may be a different way of working in comparison to dentists and doctors (more independent and without an integral small team structure), but if that argument was considered, it would be conceivable that nurses would align more closely to the working pattern of dentists and doctors. There was mention of collaborative working, whether this is similar in meaning is a point of debate, again the shift in terminology which has happened in the last decade may be responsible. It could be that the term 'team' is used more readily within dentistry because it tends to be a fixed team with the same key members, whereas nurses work in a variety of contexts.

6.5 Osteopaths

6.5.1 Background

UK Osteopathy is regulated by the General Osteopathic Council (GOsC). The Osteopaths Act 1993 was the primary legislation and established the role of the GOsC. Osteopaths must be registered with the GOsC to practise in the UK, use of the title 'osteopath' is protected. It was one of only two complementary and alternative medicines (CAMs) regulated by UK law (NHS Choices, 2017). The GOsC produce documents for education providers including key undergraduate ones are shown in Table 6.20.

	Applicable to	Reference
Osteopathic Practice Standards	Qualified osteopaths Must be met by new graduates	(General Osteopathic Council, 2012)
The Guidance for Osteopathic Pre-registration education	Undergraduate education	(General Osteopathic Council, 2015)
Guidance about student fitness to practise fitness to practise	Undergraduate education	
Guidance about the management of health and disability	Undergraduate education	
Guidance about tutor and student boundaries	Undergraduate education	

Table 6.20 Documents produced by the GOsC in respect of their role in education and training including key undergraduate education documents

6.5.2 Guidance for Osteopathic Pre-registration Education

Document description

The 'Guidance for Osteopathic Pre-registration Education' document, implemented in 2015, was available to access without financial charge on the GOsC website http://www.osteopathy.org.uk/news-and-resources/document-library/training/guidance-for-osteopathic-pre-registration-education/ and was accessible in a downloadable pdf format. In printed form the document was an A4 paper booklet with 19 pages and was applicable to UK osteopathy students. Figure 6.7 shows the document structure. The Outcomes for graduates: Professionalism section was selected for analysis, it contained three outcomes, the last of which had twelve sub-sections.

About this guidance
Introduction
Outcomes for graduates Communication and patient partnership Knowledge, skills and performance Safety and quality in practice Professionalism
Common presentations all osteopaths should be familiar with at graduation
The transition into practice
Standards for osteopathic education and training

Figure 6.7 Structure of 'Guidance for Osteopathic Pre-registration Education

6.5.3 Thematic Analysis

Sub-themes in Guidance for Osteopathic Pre-registration Education: Professionalism

Following analysis, 7 sub-themes were identified (Figure 6.8). Sub-theme mapping of each statement (outcome) is shown in Table 6.21

Figure 6.8 Sub-themes identified in Outcomes for graduates: Professionalism (General Osteopathic Council, 2015)

	Management of self	Safety	Clinical Management	Legal & regulatory policies	Development / Training	Personal actions / Health / Integrity	Interplay of roles / collegiality
23. Osteopaths must behave in a professional manner appropriate to the situation, context and time, taking into account the views of the patient, society, the osteopathic profession, healthcare professionals and the regulator. This should take account of the obligation to maintain public confidence in the profession.				X		X	
24. Osteopaths must deliver safe, effective and ethical healthcare by interacting with professional colleagues and patients in a respectful and timely manner.		X	X				X
25. The graduate will be able to do the following:							
a. Practise in accordance with the principles and standards set out in the Osteopathic Practice Standards and associated guidance published from time to time.				X			
b. Take personal responsibility for, and be able to justify, decisions and actions.	X					X	
c. Demonstrate professional integrity, including awareness of and ability to take action to meet their responsibilities related to the duty of candour and whistleblowing.				X		X	
d. Demonstrate an understanding of the role of organisations and bodies involved in osteopathic education and regulation and the wider healthcare environment.				X			
e. Demonstrate an understanding of their duty as a healthcare professional to take appropriate action to ensure patient safety (including if they have concerns about a colleague). This may include seeking advice, dealing with the matter directly or reporting concerns to an appropriate authority.		X				X	
f. Reflect on feedback from patients, colleagues and others to improve skills.	X						
g. Participate in peer learning and support activities, and provide feedback to others.					X		X
h. Act with professionalism in the workplace, when using other communication media (including online), and in interactions with patients and colleagues.						X	X
i. Recognise personal learning needs and address these.	X						
j. Maintain a professional development portfolio to document reflection; this should also include career development and planning.	X				X		
k. Act as a role model and (where appropriate) as a leader, and assist and educate others where appropriate.	X						X
l. Ensure punctuality and organisation in their practice.						X	

Table 6.21 Analysis of Osteopathic pre-registration education outcomes for graduates Professionalism section by sub-theme

Sub-theme distribution and frequency for learning outcomes is shown in Table 6.22.

Sub-theme	No. of statements
Management of Self	5
Safety	2
Clinical Management	1
Legal and regulatory policies	3
Development / Training	2
Personal actions / Health / Integrity	6
Interplay of roles / collegiality	4

Table 6.22 Sub-theme distribution and frequency for learning outcomes in 'Professionalism' section of Outcomes for graduates

Overarching themes featuring in Guidance for Osteopathic Pre-registration Education

Following sub-theme identification, the next stage of analysis was consideration of the overarching themes (Table 6.23).

Sub-theme	Descriptor	Overarching theme
Management of self	Personal accountability, reflection and development of personal abilities and role model for others.	Practitioner
Safety	Patient safety. Raise concerns were necessary.	Patient
Clinical management	Delivery of safe, effective care.	Patient
Development or training	Engagement with personal professional development, including engagement with peers.	Practitioner
Legal and regulatory policies	Awareness of and compliance with regulator developed standards and guidance. Understanding of the regulation of the profession and wider healthcare environment.	Regulatory
Personal actions / Health / Integrity	Integrity and ethical performance. Organisation and 'professional' interactions. Abiding by regulations. Raising concern where appropriate.	Practitioner Regulatory
Interplay of roles / collegiality	Work with colleagues to deliver safe and effective patient care.	Practitioner Patient

Table 6.23 Overarching theme findings for Guidance for Osteopathic Pre-registration Education

Overarching theme descriptors were considered, and modified as appropriate (Table 6.24). Themes were not discrete, but had overlapping contributory elements.

Overarching theme	Descriptor
The patient as the focus	Direct relevance to the patient; how they will be kept safe and have effective care delivery.
Regulatory consideration and requirements	Focus on the standards and guidance from the regulator with which compliance is required for individuals acting in the 'professional' role.
The practitioner as the focus	Focus on the practitioner as an individual; their continuing ability to perform their role effectively and safely and work within and develop collaborative working.

Table 6.24 Overarching theme descriptors for Guidance for Osteopathic Pre-registration Education

6.5.4 Outcome Analysis

Findings

The findings of the outcome analysis are shown in Table 6.25

	Style classification	Comments on the 'outcome'	Elements included	Focus
23. Osteopaths must behave in a professional manner appropriate to the situation, context and time, taking into account the views of the patient, society, the osteopathic profession, healthcare professionals and the regulator. This should take account of the obligation to maintain public confidence in the profession.	Standard	An overarching approach to actions, all seems clear and sensible, however if an education provider needed to confirm 'attainment' this would likely be following a number of 'sub' confirmations of elements.	Multiple	Patient / Regulatory
24. Osteopaths must deliver safe, effective and ethical healthcare by interacting with professional colleagues and patients in a respectful and timely manner.	Standard	A standard itemising elements that must be addressed and the level expected. Difficult for an education provider to easily say is 'attained' without breaking this down into elements and including a number of different assessment tools for the various elements.	Multiple	Patient
25. The graduate will be able to do the following:				
a. Practise in accordance with the principles and standards set out in the Osteopathic Practice Standards and associated guidance published from time to time.	Standard	Reference to another GOsC document, which means there is a broad scope of coverage of elements in this statement. Interesting use of language 'published from time to time' - rather informal?	Multiple	Regulatory
b. Take personal responsibility for, and be able to justify, decisions and actions.	Standard / Functional outcome	Take personal responsibility for is the expected standard of behaviour, 'Justify', when in the context of decision making and taking action is an explicit outcome.	Single	Practitioner
c. Demonstrate professional integrity, including awareness of and ability to take action to meet their responsibilities related to the duty of candour and whistleblowing.	Outcome with feasibility challenges / Functional Outcome	Demonstrating integrity may be seen as something that is easier to make an assumption has happened, unless there is evidence to the contrary in terms of a concern raised, however the next part of the statement goes on to outlines the content and what may be included in an assessment to demonstrate attainment. In terms of duty of candour and whistleblowing, this is likely to either a theoretical demonstration of knowledge and/or a simulated environment as unlikely for students in a supervised environment to all get comparable opportunity to do this. Multiple but homogenous across a theme/continuum.	Multiple	Practitioner
d. Demonstrate an understanding of the role of organisations and bodies involved in osteopathic education and regulation and the wider healthcare environment.	Functional outcome	With the use of language 'demonstrate an understanding' there is not a specific 'level' defined - what is 'understanding' but this would be interpreted by education providers and attained (albeit perhaps differently between providers).	Dual	Regulatory
e. Demonstrate an understanding of their duty as a healthcare professional to take appropriate action to ensure patient safety (including if they have concerns about a colleague). This may include seeking advice, dealing with the matter directly or reporting concerns to an appropriate authority.	Functional outcome	Taking action / raising a concern is the activity to be undertaken (therefore single element), in doing this there may be various components, but they are all for the same action.	Single	Patient
f. Reflect on feedback from patients, colleagues and others to improve skills.	Functional outcome	Clear direction on how this would be demonstrated.	Single	Practitioner

	Style classification	Comments on the 'outcome'	Elements included	Focus
g. Participate in peer learning and support activities, and provide feedback to others.	Functional outcome	Again, clear indication of how educations providers could address and demonstrate attainment of this statement. 'Participate' does not indicate a high level of attainment is required, but the action itself is easily demonstrable.	Dual	Practitioner
h. Act with professionalism in the workplace, when using other communication media (including online), and in interactions with patients and colleagues.	Outcome with feasibility challenges	Act with professionalism in the workplace' is not straightforward to assess consistently with the current tools available. The scope of the statement is however clearly defined and indication of component contributory parts described.	Multiple	Practitioner
i. Recognise personal learning needs and address these.	Functional outcome	'Recognise' is not a good verb, but the scope and how to demonstrate in terms of 'address' is clear and tangible for an education provider to assess attainment.	Dual	Practitioner
j. Maintain a professional development portfolio to document reflection; this should also include career development and planning.	Functional outcome	The keeping of a PDP is workable and engagement with it would be straightforward for an education provider to 'assess'. Career development and planning may have to be interpreted slightly more - as this is within the confines of an undergraduate student programme in a supervised environment.	Single	Practitioner
k. Act as a role model and (where appropriate) as a leader, and assist and educate others where appropriate.	Functional outcome	Clearly defined outcomes and gives the education provider a clear endpoint for demonstration of attainment.	Multiple	Practitioner
l. Ensure punctuality and organisation in their practice.	Standard	A way of performing tasks/roles, with an indicated level of expectation.	Dual	Practitioner

Table 6.25 Finding of analysis of style of presentation of Guidance for Osteopathic Pre-registration Education, Outcomes for Graduates - Professionalism

6.5.5 Discussion

There was a predominant practitioner focus to the document, which was a different emphasis from the other documents analysed (Table 6.26). There were also a smaller proportion of multi-faceted outcomes, suggesting they were straightforward to implement.

Overarching theme	No. of statements with this focus		Elements included	No. of statements
Regulatory	3		Single	4
Patient	3		Dual	4
Practitioner	9		Multiple	6

Table 6.26 Summary of Guidance for Osteopathic Pre-registration Education, Outcomes for Graduates - Professionalism analysis

A general impression when reading the statements was that they were 'user friendly' for the education provider, more so than those in other documents. Fewer statements were 'conglomerations' of elements and scope appeared more confined/described. In terms of how statements were 'styled', a greater proportion met the requirements of an 'outcome' than were found in comparable documents for other professions. Even outcomes where there was a question of how an education provider would use the currently available tools to demonstrate attainment (for example 25c and 25h), further detail is provided which could be seen as helpful in supporting education providers to determine how they will deem attainment:

> *GOsC 25c. 'Demonstrate professional integrity, including awareness of and ability to take action to meet their responsibilities related to the duty of candour and whistleblowing.' (General Osteopathic Council, 2015)*

> *GOsC 25h. 'Act with professionalism in the workplace, when using other communication media (including online), and in interactions with patients and colleagues.' (General Osteopathic Council, 2015)*

In 25c, demonstrating integrity may be seen as something for which an assumption that it has happened is made, unless there is evidence to the contrary (a concern raised), however the statement outlines content that may form a demonstrable assessment. In 25h, '*Act with professionalism in the workplace*' is challenging to assess consistently with current tools, however scope is clearly defined and indication of component contributory parts described.

6.6 Social Workers in England

6.6.1 Background

Social work in England was regulated by the Health and Care Professions Council (HCPC). The primary legislation, the Health and Social Work Professions Order 2001, established the role of the HCPC. It was made under section 60 of the Health Act 1999 and came into effect 12 February 2002. Social workers in England must be registered with the HCPC in order to practise in the UK and use of the title 'social worker' is protected. It is a criminal offence to deceive (intentional or by implication) with respect to entry on the HCPC register or use a protected title under Article 39(1). The Children and Social Work Act 2017 was granted royal assent on 27 April 2017 (Health and Care Professions Council, 2017a) and will establish a new regulator, at the time of writing (October 2017) no timeline was in place for this. In an update (November 2019), Social Work England becomes the new regulator for social workers from Monday 2 December.

The HCPC produced documents for education providers are shown in Table 6.27. The key undergraduate document is Standards of Proficiency – Social workers in England (Health and Care Professions Council, 2017c).

	Applicable to	Reference
Standards of Proficiency – Social workers in England	Prospective registrants, Registrants	(Health and Care Professions Council, 2017c)
Standards of education and training	Education and training programme providers	(Health and Care Professions Council, 2017b)

Table 6.27 Documents produced by the HCPC in respect of their role in education and training

6.6.2 Standards of Proficiency – Social workers in England

'Standards of Proficiency – Social workers in England' (Health and Care Professions Council, 2017c) has been effective since 9 January 2017. Standards were first published in August 2012 and were subsequently revised.

Document description

The 'Standards of Proficiency – Social workers in England' document was available to access without financial charge on the HCPC website https://www.HCPC-uk.org/resources/standards/standards-of-proficiency-social-workers-in-england/ and was accessible in a downloadable pdf format. In printed form the document was an A4 paper booklet with 16 pages. It was applicable to registrant social worker in England and students.

The document was structured with a foreword and introduction followed by fifteen standards of proficiency, each of which had multiple sub-sections (Figure 6.9). There was no specific 'professionalism' section, so the full document was analysed.

Foreword
Introduction
Standards of proficiency 1. be able to practise safely and effectively within their scope of practice 2. be able to practise within the legal and ethical boundaries of their profession 3. be able to maintain fitness to practise 4. be able to practise as an autonomous professional, exercising their own professional judgement 5. be aware of the impact of culture, equality and diversity on practice 6. be able to practise in a non-discriminatory manner 7. understand the importance of and be able to maintain confidentiality 8. be able to communicate effectively 9. be able to work appropriately with others 10. be able to maintain records appropriately 11. be able to reflect on and review practice 12. be able to assure the quality of their practice 13. understand the key concepts of the knowledge base relevant to their profession 14. be able to draw on appropriate knowledge and skills to inform practice understand the need to establish and maintain a safe practice environment

Figure 6.9 Structure of Standards of Proficiency – Social workers in England

6.6.3 Thematic Analysis

Standards of Proficiency – Social workers in England

Following analysis, thirteen sub-themes were identified from the 'Standards of Proficiency' document (Figure 6.10). Sub-theme mapping is shown in Table 6.28.

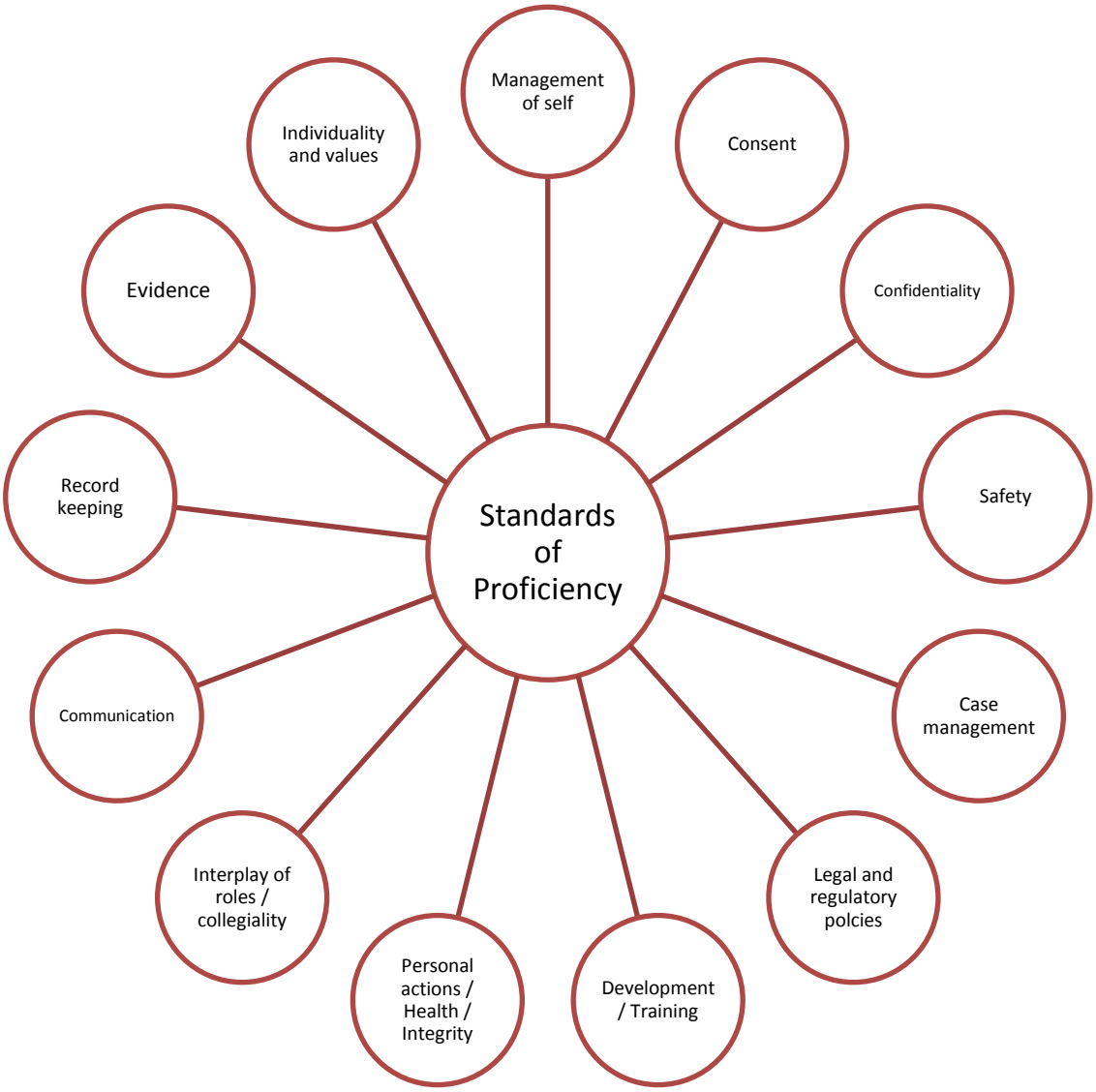

Figure 6.10 Sub-themes identified in Standards of Proficiency – Social workers in England (Health and Care Professions Council, 2017c)

	Mx of self	Individuality and Values	Consent	Confidentiality	Safety	Case Mx	Legal / regulatory policies	Development / Training	Personal actions/ Health / Integrity	Interplay of roles /collegiality	Communication	Record Keeping	Evidence
1 be able to practise safely and effectively within their scope of practice													
1.1 know the limits of their practice and when to seek advice or refer to another professional	**X**									**X**			
1.2 recognise the need to manage their own workload and resources effectively and be able to practise accordingly	**X**												
1.3 be able to undertake assessments of risk, need and capacity and respond appropriately						**X**							
1.4 be able to recognise and respond appropriately to unexpected situations and manage uncertainty	**X**												
1.5 be able to recognise signs of harm, abuse and neglect and know how to respond appropriately, including recognising situations which require immediate action						**X**							
2 be able to practise within the legal and ethical boundaries of their profession													
2.1 understand current legislation applicable to social work with adults, children, young people and families							**X**						
2.2 understand the need to promote the best interests of service users and carers at all times									**X**				
2.3 understand the need to protect, safeguard, promote and prioritise the wellbeing of children, young people and vulnerable adults					**X**								
2.4 understand, and be able to address, practices which present a risk to or from service users and carers, or others					**X**	**X**							
2.5 be able to manage and weigh up competing or conflicting values or interests to make reasoned professional judgements	**X**					**X**							
2.6 be able to exercise authority as a social worker within the appropriate legal and ethical frameworks and boundaries							**X**		**X**				
2.7 understand the need to respect and so far as possible uphold, the rights, dignity, values and autonomy of every service user and carer		**X**											
2.8 recognise that relationships with service users and carers should be based on respect and honesty									**X**				
2.9 recognise the power dynamics in relationships with service users and carers, and be able to manage those dynamics appropriately									**X**				
2.10 understand what is required of them by the Health and Care Professions Council							**X**						
3 be able to maintain fitness to practise													
3.1 understand the need to maintain high standards of personal and professional conduct									**X**				
3.2 understand the importance of maintaining their own health and wellbeing	**X**								**X**				
3.3 understand both the need to keep skills and knowledge up to date and the importance of career-long learning								**X**					
3.4 be able to establish and maintain personal and professional boundaries	**X**								**X**				
3.5 be able to manage the physical and emotional impact of their practice	**X**												

	Mx of self	Individuality and Values	Consent	Confidentiality	Safety	Case Mx	Legal / regulatory policies	Development / Training	Personal actions/ Health / Integrity	Interplay of roles /collegiality	Communication	Record Keeping	Evidence
3.6 be able to identify and apply strategies to build professional resilience	X												
4 be able to practise as an autonomous professional, exercising their own professional judgement													
4.1 be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with it	X												
4.2 be able to initiate resolution of issues and be able to exercise personal initiative									X				
4.3 recognise that they are personally responsible for, and must be able to justify, their decisions and recommendations	X								X				
4.4 be able to make informed judgements on complex issues using the information available	X												
4.5 be able to work effectively whilst holding alternative competing explanations in mind	X												
4.6 be able to make and receive referrals appropriately										X			
4.7 understand the importance of participation in training and mentoring								X					
5 be aware of the impact of culture, equality and diversity on practice													
5.1 be able to reflect on and take account of the impact of inequality, disadvantage and discrimination on those who use social work services and their communities		X											
5.2 understand the need to adapt practice to respond appropriately to different groups and individuals		X											
5.3 be aware of the impact of their own values on practice with different groups of service users and carers		X											
5.4 understand the impact of different cultures and communities and how this affects the role of the social worker in supporting service users and carers		X											
6 be able to practise in a non-discriminatory manner													
6.1 be able to work with others to promote social justice, equality and inclusion		X								X			
6.2 be able to use practice to challenge and address the impact of discrimination, disadvantage and oppression						X							
7 understand the importance of and be able to maintain confidentiality													
7.1 be able to understand and explain the limits of confidentiality				X									
7.2 be able to recognise and respond appropriately to situations where it is necessary to share information to safeguard service users and carers or others				X									
7.3 understand the principles of information governance and be aware of the safe and effective use of health and social care information							X						
8 be able to communicate effectively													
8.1 be able to use interpersonal skills and appropriate forms of verbal and non-verbal communication with service users, carers and others											X		

	Mx of self	Individuality and Values	Consent	Confidentiality	Safety	Case Mx	Legal / regulatory policies	Development / Training	Personal actions/ Health / Integrity	Interplay of roles /collegiality	Communication	Record Keeping	Evidence
8.2 be able to demonstrate effective and appropriate skills in communicating advice, instruction, information and professional opinion to colleagues, service users and carers											**X**		
8.3 understand the need to provide service users and carers with the information necessary to enable them to make informed decisions or to understand the decisions made			**X**										
8.4 understand how communication skills affect the assessment of and engagement with service users and carers											**X**		
8.5 understand how the means of communication should be modified to address and take account of a range of factors including age, capacity, learning ability and physical ability											**X**		
8.6 be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by a range of factors including age, culture, disability, ethnicity, gender, religious beliefs and socio-economic status		**X**									**X**		
8.7 understand the need to draw upon available resources and services to support service users' and carers' communication wherever possible										**X**	**X**		
8.8 be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5							**X**						
8.9 be able to engage in inter-professional and inter-agency communication										**X**			
8.10 be able to listen actively to service users and carers and others											**X**		
8.11 be able to prepare formal reports in line with applicable protocols and guidelines											**X**		
8.12 be able to present reports in formal settings											**X**		
9 be able to work appropriately with others													
9.1 understand the need to build and sustain professional relationships with service users, carers and colleagues as both an autonomous practitioner and collaboratively with others										**X**			
9.2 be able to work with service users and carers to enable them to assess and make informed decisions about their needs, circumstances, risks, preferred options and resources			**X**			**X**							
9.3 be able to work with service users to promote individual growth, development and independence and to assist them to understand and exercise their rights						**X**							
9.4 be able to support service users' and carers' rights to control their lives and make informed choices about the services they receive						**X**							
9.5 be able to support the development of networks, groups and communities to meet needs and outcomes										**X**			
9.6 be able to work in partnership with others, including service users and carers, and those working in other agencies and roles										**X**			
9.7 be able to contribute effectively to work undertaken as part of a multi-disciplinary team										**X**			

	Mx of self	Individuality and Values	Consent	Confidentiality	Safety	Case Mx	Legal / regulatory policies	Development / Training	Personal actions/ Health / Integrity	Interplay of roles /collegiality	Communication	Record Keeping	Evidence
9.8 recognise the contribution that service users' and carers' own resources and strengths can bring to social work										**X**			
9.9 be able to identify and work with resistance to change and conflict	**X**												
9.10 be able to understand the emotional dynamics of interactions with service users and carers						**X**							
10 be able to maintain records appropriately													
10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines												**X**	
10.2 recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines							**X**					**X**	
11 be able to reflect on and review practice													
11.1 understand the value of critical reflection on practice and the need to record the outcome of such reflection appropriately	**X**												
11.2 recognise the value of supervision, case reviews and other methods of reflection and review	**X**												
12 be able to assure the quality of their practice													
12.1 be able to use supervision to support and enhance the quality of their social work practice	**X**									**X**			
12.2 be able to contribute to processes designed to evaluate service and individual outcomes													**X**
12.3 be able to engage in evidence-informed practice, evaluate practice systematically and participate in audit procedures													**X**
13 understand the key concepts of the knowledge base relevant to their profession													
13.1 understand the roles of other professions, practitioners and organisations in health, social care, justice and in other settings where social work is practised										**X**			
13.2 be aware of the different social and organisational contexts and settings within which social work operates							**X**						
13.3 be aware of changes in demography and culture and their impact on social work													**X**

	Mx of self	Individuality and Values	Consent	Confidentiality	Safety	Case Mx	Legal / regulatory policies	Development / Training	Personal actions/ Health / Integrity	Interplay of roles /collegiality	Communication	Record Keeping	Evidence
13.4 understand in relation to social work practice: – social work theory; – social work models and interventions; – the development and application of relevant law and social policy; – the development of and application of social work and social work values; – human growth and development across the lifespan and the impact of key developmental stages and transitions; – the impact of injustice, social inequalities, policies and other issues which affect the demand for social work services; – the relevance of psychological, environmental, sociological and physiological perspectives to understanding personal and social development and functioning; – concepts of participation, advocacy, co-production, involvement and empowerment; and – the relevance of sociological perspectives to understanding societal and structural influences on human behaviour							**X**						**X**
13.5 understand the concept of leadership and its application to practice	**X**									**X**			
14 be able to draw on appropriate knowledge and skills to inform practice													
14.1 be able to gather, analyse, critically evaluate and use information and knowledge to make recommendations or modify their practice						**X**							
14.2 be able to select and use appropriate assessment tools						**X**							
14.3 be able to prepare, implement, review, evaluate, revise and conclude plans to meet needs and circumstances in conjunction with service users and carers						**X**							
14.4 be able to use social work methods, theories and models to identify actions to achieve change and development and improve life opportunities						**X**							
14.5 be aware of a range of research methodologies													**X**
14.6 recognise the value of research and analysis and be able to evaluate such evidence to inform their own practice													**X**
14.7 be able to use research, reasoning and problem solving skills to determine appropriate actions													**X**
14.8 be able to demonstrate a level of skill in the use of information technology appropriate to their practice													
14.9 be able to change their practice as needed to take account of new developments or changing contexts	**X**							**X**					
15 understand the need to establish and maintain a safe practice environment													
15.1 understand the need to maintain the safety of service users, carers and colleagues					**X**								

	Mx of self	Individuality and Values	Consent	Confidentiality	Safety	Case Mx	Legal / regulatory policies	Development / Training	Personal actions/ Health / Integrity	Interplay of roles /collegiality	Communication	Record Keeping	Evidence
15.2 be aware of applicable health and safety legislation and any relevant safety policies and procedures in force at the workplace, such as incident reporting, and be able to act in accordance with these					**X**		**X**						
15.3 be able to work safely in challenging environments, including being able to take appropriate actions to manage environmental risk					**X**								

Table 6.28 Analysis of Standards of Proficiency – Social workers in England by sub-theme

Overarching themes featuring in Standards of Proficiency – Social workers in England

Following sub-theme identification, the next stage of analysis was consideration of overarching themes (Table 6.29).

Sub-theme	Descriptor	Overarching theme
Management of self	Self-regulation, reflection, self-awareness and resultant responsiveness. Ability to develop and maintain personal and professional boundaries. Critical thinking and ability to adapt.	Practitioner
Individuality and values	Respecting service user's dignity, autonomy and rights. Account taken of equality, values, discrimination, inclusion and culture.	Service user
Consent	Sufficient information provision to permit informed decisions and to support decision making.	Service user
Confidentiality	Appropriate use of confidentiality to include necessity of information sharing.	Service user
Safety	Assess, manage and maintain own, colleagues, service users and carers safety with account of appropriate legislation.	Service user Regulatory Practitioner
Case Management	Recognise, plan and implement necessary actions using judgement based decisions. Utilise frameworks in place to develop service users.	Service user Practitioner
Legal / regulatory policies	Awareness of and compliance with legislation and HCPC expectations. Level of communication skills outlined.	Regulatory Practitioner
Development / Training	Career-long knowledge and skills maintenance, engagement with training and mentoring	Practitioner
Personal actions / Health / Integrity	Honesty, integrity and ethical performance. Abiding by laws / regulations and boundaries. Respect for the power dynamics that exist, ownership of personal responsibility for decisions.	Service user Practitioner Regulatory
Interplay of roles / collegiality	Work with those in own field and allied professionals. Give and receive collegial support. Develop networks to support needs and outcomes. Work within a multi-disciplinary team. Recognise role and skills of service users and carers.	Service user Practitioner
Communication	Effective communication to all roles in a variety of formats, recognising importance of this in engagement. Development of communication skills of others (inc. service users).	Service user Practitioner
Record Keeping	Keeping of appropriate records, which conform to legislative requirements, policies, protocols and recommendations.	Regulatory
Evidence	Engage in evidence informed practice and evaluate outcomes.	Practitioner

Table 6.29 Overarching theme findings for Standards of Proficiency – Social workers in England

Overarching theme descriptors were considered and modified as necessary (Table 6.30).

Themes were not discrete, but had overlapping contributory elements.

Overarching theme	Descriptor
The service user as the focus	Direct relevance to the service user; how they will be kept safe, be respected, be appropriately informed and involved in decisions about their care.
Regulatory consideration and requirements	Focus on the expectations and requirements which exists from a variety of sources (regulator, and national regulation) with which compliance is required.
The practitioner as the focus	Focus on the practitioner as an individual; their continuing ability to perform their role effectively and safely. Taking responsibility for decisions.

Table 6.30 Overarching theme descriptors for Standards of Proficiency – Social workers in England

6.6.4 Outcome Analysis

Findings

The findings of the outcome analysis are shown in Table 6.31.

	Style	Comments on the 'outcome'	Elements	Focus
1 be able to practise safely and effectively within their scope of practice				
1.1 know the limits of their practice and when to seek advice or refer to another professional			Dual	Practitioner
1.2 recognise the need to manage their own workload and resources effectively and be able to practise accordingly	Objective/ functional outcome	The first part is about saying what they need to know, the second about doing it. The second element has an endpoint, could possibly be some to consider attained in the absence of a concern raised?	Dual	Practitioner
1.3 be able to undertake assessments of risk, need and capacity and respond appropriately	Functional outcome	Dual elements, but these are linked and could be assessed separately or together	Dual	Patient
1.4 be able to recognise and respond appropriately to unexpected situations and manage uncertainty	Functional outcome	'Recognise' is not a good verb to use, but respond is a clear outcome. However, the content is broad and there is a non-specific scope.	Dual	Practitioner
1.5 be able to recognise signs of harm, abuse and neglect and know how to respond appropriately, including recognising situations which require immediate action	Functional outcome	Clear, explicit actions and endpoint.	Dual	Patient
2 be able to practise within the legal and ethical boundaries of their profession				
2.1 understand current legislation applicable to social work with adults, children, young people and families	Objective	Broad scope and 'understand' has no demonstrable / tangible endpoint expressed (as would a verb like 'apply').	Single	Regulatory
2.2 understand the need to promote the best interests of service users and carers at all times	Objective	'Understand' is not a demonstrable outcome - how will the understanding be demonstrated? It is also a very generic statement.	Single	Patient
2.3 understand the need to protect, safeguard, promote and prioritise the wellbeing of children, young people and vulnerable adults	Objective	Do they really only need to 'understand the need to' - don't they actually need to 'do' it?	Multiple	Patient
2.4 understand, and be able to address, practices which present a risk to or from service users and carers, or others	Objective/ Functional outcome	Understanding is an objective, whereas 'address' will be the outcome implemented.	Dual	Patient
2.5 be able to manage and weigh up competing or conflicting values or interests to make reasoned professional judgements	Functional outcome	Integrating information to make a judgement - I can see opportunities of how to assess this.	Single	Practitioner
2.6 be able to exercise authority as a social worker within the appropriate legal and ethical frameworks and boundaries	Objective	Broad scope - how would an education provider satisfy this consistently? Behaviour - how would you measure this?	Single	Regulatory
2.7 understand the need to respect and so far as possible uphold, the rights, dignity, values and autonomy of every service user and carer	Objective	No tangible endpoint, broad scope with multiple elements included - how to assess?	Multiple	Patient
2.8 recognise that relationships with service users and carers should be based on respect and honesty	Objective	General statement of conduct expectation, recognition does not give a tangible endpoint and it is not written as a 'standard'.	Single	Patient
2.9 recognise the power dynamics in relationships with service users and carers, and be able to manage those dynamics appropriately	Objective/ Functional outcome	Assessment of 'recognition'? Not a good verb to use. The second part of 'manage' could be tangibly assessed.	Dual	Patient
2.10 understand what is required of them by the Health and Care Professions Council	Objective	Quite a broad statement. Does this include conduct / Regulator / Management?	Single	Practitioner /Regulatory
3 be able to maintain fitness to practise				

	Style	Comments on the 'outcome'	Elements	Focus
3.1 understand the need to maintain high standards of personal and professional conduct	Objective	If just said 'maintain' this would have become tangible. Currently it suggests there is only a need to 'understand' and not actually do' - is this correct?	Single	Practitioner
3.2 understand the importance of maintaining their own health and wellbeing	Objective	No tangible action described.	Single	Practitioner
3.3 understand both the need to keep skills and knowledge up to date and the importance of career-long learning	Objective	No tangible action described.	Dual	Practitioner
3.4 be able to establish and maintain personal and professional boundaries	Functional outcome	Outline of conduct, likely to be assumed in the absence of a concern raised?	Single	Practitioner
3.5 be able to manage the physical and emotional impact of their practice	Functional outcome	Absence of a concern raised, or knowledge f how this could be done?	Single	Practitioner
3.6 be able to identify and apply strategies to build professional resilience	Functional outcome	Defined endpoint, can see how this would be reviewed.	Dual	Practitioner
4 be able to practise as an autonomous professional, exercising their own professional judgement				
4.1 be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with it	Functional outcome	Multi-faceted, multiple stages outlined in managing a situation.	Multiple	Practitioner
4.2 be able to initiate resolution of issues and be able to exercise personal initiative	Functional outcome	Clear, tangible action	Dual	Practitioner
4.3 recognise that they are personally responsible for, and must be able to justify, their decisions and recommendations	Objective	Are they only recognising they must justify their decisions or actually 'doing' the justification - ambiguous statement.	Dual	Practitioner
4.4 be able to make informed judgements on complex issues using the information available	Functional outcome	Assessable scenarios could be developed which would demonstrate this.	Single	Practitioner
4.5 be able to work effectively whilst holding alternative competing explanations in mind	Objective	A state of working, an approach rather than an endpoint?	Single	Practitioner
4.6 be able to make and receive referrals appropriately	Functional outcome	Clear, unambiguous endpoint.	Single	Practitioner
4.7 understand the importance of participation in training and mentoring	Objective	Understanding but no actual action?	Single	Practitioner
5 be aware of the impact of culture, equality and diversity on practice				
5.1 be able to reflect on and take account of the impact of inequality, disadvantage and discrimination on those who use social work services and their communities	Functional outcome	Assessment of reflection may be challenging, but the follow-up 'take account of' is tangible.	Dual	Patient
5.2 understand the need to adapt practice to respond appropriately to different groups and individuals	Objective	Knowing that need to but not actually doing?	Single	Patient
5.3 be aware of the impact of their own values on practice with different groups of service users and carers	Objective	Awareness of' is not a tangible action.	Single	Patient
5.4 understand the impact of different cultures and communities and how this affects the role of the social worker in supporting service users and carers	Objective	How is the understanding demonstrated? No tangible action.	Dual	Patient
6 be able to practise in a non-discriminatory manner				
6.1 be able to work with others to promote social justice, equality and inclusion	Functional outcome	This would be challenging to consistently apply. Are these things single or multiple elements?	Single	Patient

	Style	Comments on the 'outcome'	Elements	Focus
6.2 be able to use practice to challenge and address the impact of discrimination, disadvantage and oppression	Functional outcome	Challenge for application, also in how this could be applied within the scope of a student/trainee in a learning programme. Again are these single/dual or multiple?	Multiple	Patient
7 understand the importance of and be able to maintain confidentiality				
7.1 be able to understand and explain the limits of confidentiality	Objective/ Functional outcome	Understanding is not tangible, but 'explain' is an outcome.	Single	Patient
7.2 be able to recognise and respond appropriately to situations where it is necessary to share information to safeguard service users and carers or others	Functional outcome	Recognise is on the same continuum as respond appropriate to.	Single	Patient
7.3 understand the principles of information governance and be aware of the safe and effective use of health and social care information	Functional outcome	Understanding and awareness - neither have a tangible endpoint/ action.	Dual	Practitioner
8 be able to communicate effectively				
8.1 be able to use interpersonal skills and appropriate forms of verbal and non-verbal communication with service users, carers and others	Functional outcome	Wide range of coverage, although a homogeneous theme.	Single	Patient
8.2 be able to demonstrate effective and appropriate skills in communicating advice, instruction, information and professional opinion to colleagues, service users and carers	Functional outcome	Could be multiple elements here.	Single	Patient
8.3 understand the need to provide service users and carers with the information necessary to enable them to make informed decisions or to understand the decisions made	Objective	Understanding the need to, but not actually doing?	Single	Patient
8.4 understand how communication skills affect the assessment of and engagement with service users and carers	Objective	How to demonstrate this understanding?	Single	Patient
8.5 understand how the means of communication should be modified to address and take account of a range of factors including age, capacity, learning ability and physical ability	Objective	Again, only understand - not 'do'?	Single	Patient
8.6 be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by a range of factors including age, culture, disability, ethnicity, gender, religious beliefs and socio-economic status	Objective	Aware of? How would this be determined? Is 'awareness' sufficient?	Single	Patient
8.7 understand the need to draw upon available resources and services to support service users' and carers' communication wherever possible	Objective	Understand only - not actually 'do'?	Single	Patient
8.8 be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5	Functional outcome	Interesting interpretation of how to incorporate an entry into the profession criterion. Is it possible that there is no other place that this requirement could be placed to ensure it applies to all?	Single	Practitioner
8.9 be able to engage in inter-professional and inter-agency communication	Functional outcome	Broad, but can be assessed.	Dual	Patient
8.10 be able to listen actively to service users and carers and others	Functional outcome	Can imagine an assessment scenario for this.	Single	Patient
8.11 be able to prepare formal reports in line with applicable protocols and guidelines	Functional outcome	Tangible endpoint described.	Single	Practitioner

	Style	Comments on the 'outcome'	Elements	Focus
8.12 be able to present reports in formal settings	Functional outcome	Tangible endpoint described.	Single	Practitioner
9 be able to work appropriately with others				
9.1 understand the need to build and sustain professional relationships with service users, carers and colleagues as both an autonomous practitioner and collaboratively with others	Objective	Only understand the need to? Not actually 'do'? Multi-faceted.	Multiple	Patient
9.2 be able to work with service users and carers to enable them to assess and make informed decisions about their needs, circumstances, risks, preferred options and resources	Functional outcome	Multi-faceted, but all in the same continuum of action.	Single	Patient
9.3 be able to work with service users to promote individual growth, development and independence and to assist them to understand and exercise their rights	Functional outcome	Clear, tangible outcome / endpoint, although possibly not all demonstrated together.	Dual	Patient
9.4 be able to support service users' and carers' rights to control their lives and make informed choices about the services they receive	Functional outcome	Tangible endpoint.	Single	Patient
9.5 be able to support the development of networks, groups and communities to meet needs and outcomes	Functional outcome	? Achievable in the scope of a trainee / student?	Multiple	Patient
9.6 be able to work in partnership with others, including service users and carers, and those working in other agencies and roles	Functional outcome	Challenging to 'assess' although may be more apparent if 'not' done, i.e. in the absence of a concern raised.	Dual	Patient
9.7 be able to contribute effectively to work undertaken as part of a multi-disciplinary team	Functional outcome	? In the absence of a concern raised or a demonstration of working as a group?	Single	Practitioner
9.8 recognise the contribution that service users' and carers' own resources and strengths can bring to social work	Objective	Only recognise? Do they need to do anything with this recognition?	Single	Patient
9.9 be able to identify and work with resistance to change and conflict	Functional outcome	Endpoint - but comparable opportunities for all?	Dual	Practitioner
9.10 be able to understand the emotional dynamics of interactions with service users and carers	Objective	Again - only need to understand?	Single	Patient
10 be able to maintain records appropriately				
10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines	Functional outcome	Clear endpoint.	Single	Regulatory
10.2 recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines	Objective	Could have been re-worded to become an outcome.	Single	Regulatory
11 be able to reflect on and review practice				
11.1 understand the value of critical reflection on practice and the need to record the outcome of such reflection appropriately	Objective	Self-development, but no tangible endpoint.	Dual	Practitioner
11.2 recognise the value of supervision, case reviews and other methods of reflection and review	Objective	'Recognise' is not a good verb for an outcome.	Multiple	Practitioner
12 be able to assure the quality of their practice				
12.1 be able to use supervision to support and enhance the quality of their social work practice	Functional outcome	A bit challenging to think of how to actually demonstrate.	Single	Practitioner

	Style	Comments on the 'outcome'	Elements	Focus
12.2 be able to contribute to processes designed to evaluate service and individual outcomes	Functional outcome	Opportunities for all to do this within a training programme?	Dual	Practitioner
12.3 be able to engage in evidence-informed practice, evaluate practice systematically and participate in audit procedures	Functional outcome	Each one is an outcome, but the statement in its entirety is multi-faceted.	Multiple	Practitioner
13 understand the key concepts of the knowledge base relevant to their profession				
13.1 understand the roles of other professions, practitioners and organisations in health, social care, justice and in other settings where social work is practised	Objective	Only 'understand' - not a demonstrable endpoint.	Multiple	Practitioner
13.2 be aware of the different social and organisational contexts and settings within which social work operates	Objective	Again - only awareness of?	Single	Practitioner
13.3 be aware of changes in demography and culture and their impact on social work	Objective	Be aware of' is not a demonstrable endpoint.	Dual	Practitioner
13.4 understand in relation to social work practice: – social work theory; – social work models and interventions; – the development and application of relevant law and social policy; – the development of and application of social work and social work values; – human growth and development across the lifespan and the impact of key developmental stages and transitions; – the impact of injustice, social inequalities, policies and other issues which affect the demand for social work services; – the relevance of psychological, environmental, sociological and physiological perspectives to understanding personal and social development and functioning; – concepts of participation, advocacy, co-production, involvement and empowerment; and – the relevance of sociological perspectives to understanding societal and structural influences on human behaviour	Objective	All of these are 'understand', they could easily have been modified to make into tangible outcomes. A significant coverage of items here - why not separate into more manageable 'sections' - difficult currently for education providers to apply.	Multiple	Practitioner
13.5 understand the concept of leadership and its application to practice	Objective	Only 'understanding' needed?	Dual	Practitioner
14 be able to draw on appropriate knowledge and skills to inform practice				
14.1 be able to gather, analyse, critically evaluate and use information and knowledge to make recommendations or modify their practice	Functional outcome	Implementation of knowledge and demonstrable action / endpoint. All on a continuum of action, although may be assessed in smaller chunks.	Multiple	Practitioner
14.2 be able to select and use appropriate assessment tools	Functional outcome	Select is one element, use is another - but clear actions.	Dual	Practitioner
14.3 be able to prepare, implement, review, evaluate, revise and conclude plans to meet needs and circumstances in conjunction with service users and carers	Functional outcome	Multi-faceted - but all along a continuum of demonstrable actions.	Multiple	Patient
14.4 be able to use social work methods, theories and models to identify actions to achieve change and development and improve life opportunities	Functional outcome	Clear, demonstrable endpoint / actions.	Single	Patient
14.5 be aware of a range of research methodologies	Objective	Only 'awareness' of.	Single	Practitioner

	Style	Comments on the 'outcome'	Elements	Focus
14.6 recognise the value of research and analysis and be able to evaluate such evidence to inform their own practice	Objective/ Functional outcome	Recognise is not tangible, but the evaluation element of the statement is.	Dual	Practitioner
14.7 be able to use research, reasoning and problem solving skills to determine appropriate actions	Functional outcome	Application of knowledge	Single	Practitioner
14.8 be able to demonstrate a level of skill in the use of information technology appropriate to their practice	Functional outcome	The level may be interpreted differently - but demonstrable endpoint.	Single	Practitioner
14.9 be able to change their practice as needed to take account of new developments or changing contexts	Functional outcome	May be challenging to give comparable opportunities of all and equitably assess?	Single	Practitioner
15 understand the need to establish and maintain a safe practice environment				
15.1 understand the need to maintain the safety of service users, carers and colleagues	Objective	Only understand?	Single	Patient
15.2 be aware of applicable health and safety legislation and any relevant safety policies and procedures in force at the workplace, such as incident reporting, and be able to act in accordance with these	Objective/ Functional outcome	Being aware of is not demonstrable, but the 'acting' is an outcome. Broad scope here.	Dual	Regulatory
15.3 be able to work safely in challenging environments, including being able to take appropriate actions to manage environmental risk	Functional outcome	Clear, tangible outcome.	Single	Practitioner

Table 6.31 Analysis findings of presentation in Standards of Proficiency – Social workers in England

6.6.5 Discussion

During analysis, it was appropriate to modify terminology, due to the nature of the work of the target group (social workers). 'Clinical management' was changed to 'case management' to reflect the terminology in the document itself, and one of the overarching themes became 'service user' where other documents used 'patient'.

Unlike other documents analysed (those for Doctors, Nurses and Osteopaths), this document is common to both students training to join the profession and qualified registrants. Therefore for the purposes of this research, it was key to consider statements with the lens of an education provider, and with consideration that the education provider needs to demonstrate 'attainment' to the regulator, as opposed to the lens of a registrant.

The predominant focus of the document was towards patients and practitioners, similar to the GMC documentation. There were fewer multi-faceted statements, possibly making demonstration less ambiguous for education providers.

Overarching theme	No. of statements with this focus		Elements included	No. of statements
Regulatory	6		Single	46
Service user	36		Dual	25
Practitioner	41		Multiple	12

Table 6.32 Summary of Standards of Proficiency – Social workers in England analysis

There were a greater number of sub-themes identified than previous documents. However, this could be expected with the wider scope compared to the sectional analysis completed on the other documents. An example is 'communication' which featured in nine statements, compared to only one Preparing for Practice outcome, as in Preparing for Practice there is a separate 'communication' domain. In this respect the Social Workers document should also be considered in relation to the conceptualisation of professionalism in the GDC 'Standards for the Dental Team' document. There were also more statements with a 'case management' focus, again this may be because in other regulatory documentation there are additional sections, for example the clinical domain in Preparing for Practice.

Interestingly, English language requirements were included in the document (HCPC 8.8).

> *HCPC 8.8. 'be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5' (Health and Care Professions Council, 2017c)*

These are not specifically in either the GDC Preparing for Practice or Standards document. In dentistry, if English is not the first language of the potential student or registrant, this will be addressed in the admissions or registration process. For HCPC, inclusion within 'Standards of Proficiency' may be the only (or most effective) place to universally apply this criterion.

Statements were seen to have two approaches: 1) those prefaced with 'to be able to', 2) those that started with words like 'recognise' and 'understand'. Some statements also had two 'phases' to them: 1) knowing about, 2) implementation of that knowledge. Examples of this were:

> *HCPC 1.2 'recognise the need to manage their own workload and resources effectively and be able to practise accordingly' (Health and Care Professions Council, 2017c)*

> *HCPC 2.4 'understand, and be able to address, practices which present a risk to or from service users and carers, or others' (Health and Care Professions Council, 2017c)*

Many statements only required 'understanding', not actual 'doing', which raises questions; what was really intended? Is understanding alone sufficient? Examples include:

> *HCPC 5.2. 'understand the need to adapt practice to respond appropriately to different groups and individuals' (Health and Care Professions Council, 2017c)*

> *HCPC 8.3. 'understand the need to provide service users and carers with the information necessary to enable them to make informed decisions or to understand the decisions made' (Health and Care Professions Council, 2017c)*

The reason may be connected to this document also being applicable to registered social workers, so presented as a standard for practice, however not actually written as a 'standard'.

6.7 Comparison of findings

6.7.1 Thematic content of professionalism

When comparing curriculum documents, parallels were seen in the overarching themes identified related to undergraduate student professionalism attainment. There was also sub-theme commonality, with general content being similar, however slight differences existed in details within the sub-theme descriptors.

Overarching themes were: Patient/service user focus; Regulatory focus and; Practitioner focus, however the emphasis of these differed in each document. Figure 6.11 shows the contribution of each overarching theme by regulator, Figure 6.12 shows sub-themes identified.

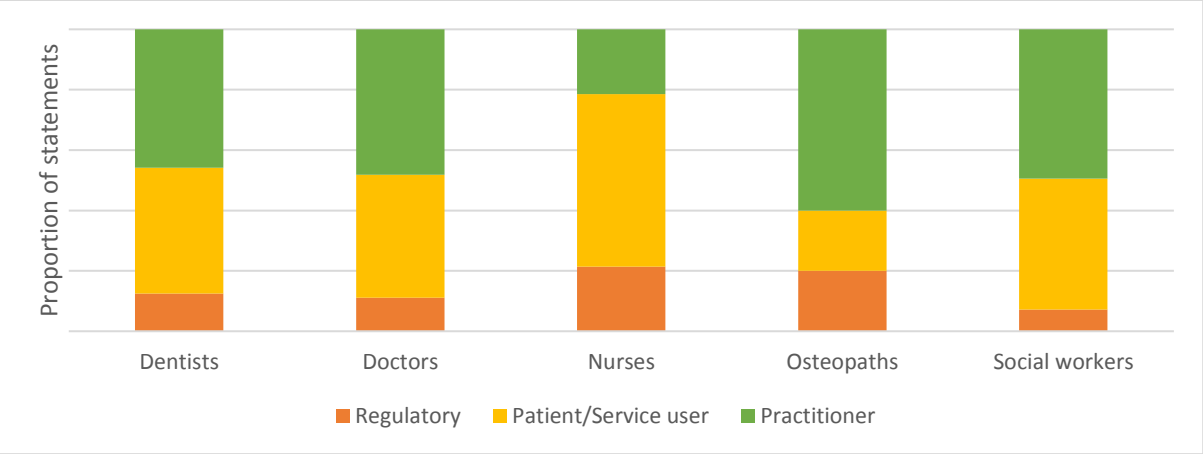

Figure 6.11 Overarching themes identified in regulator-produced curriculum documents

Differences in emphasis of themes between regulators/documents may have been a manifestation of several factors:

- When the document was written: societal changes and expectations at that time; timing related to a specific case or incident that had influence in terms of regulation.
- There may be an element of the autonomy and status of the profession in the document.

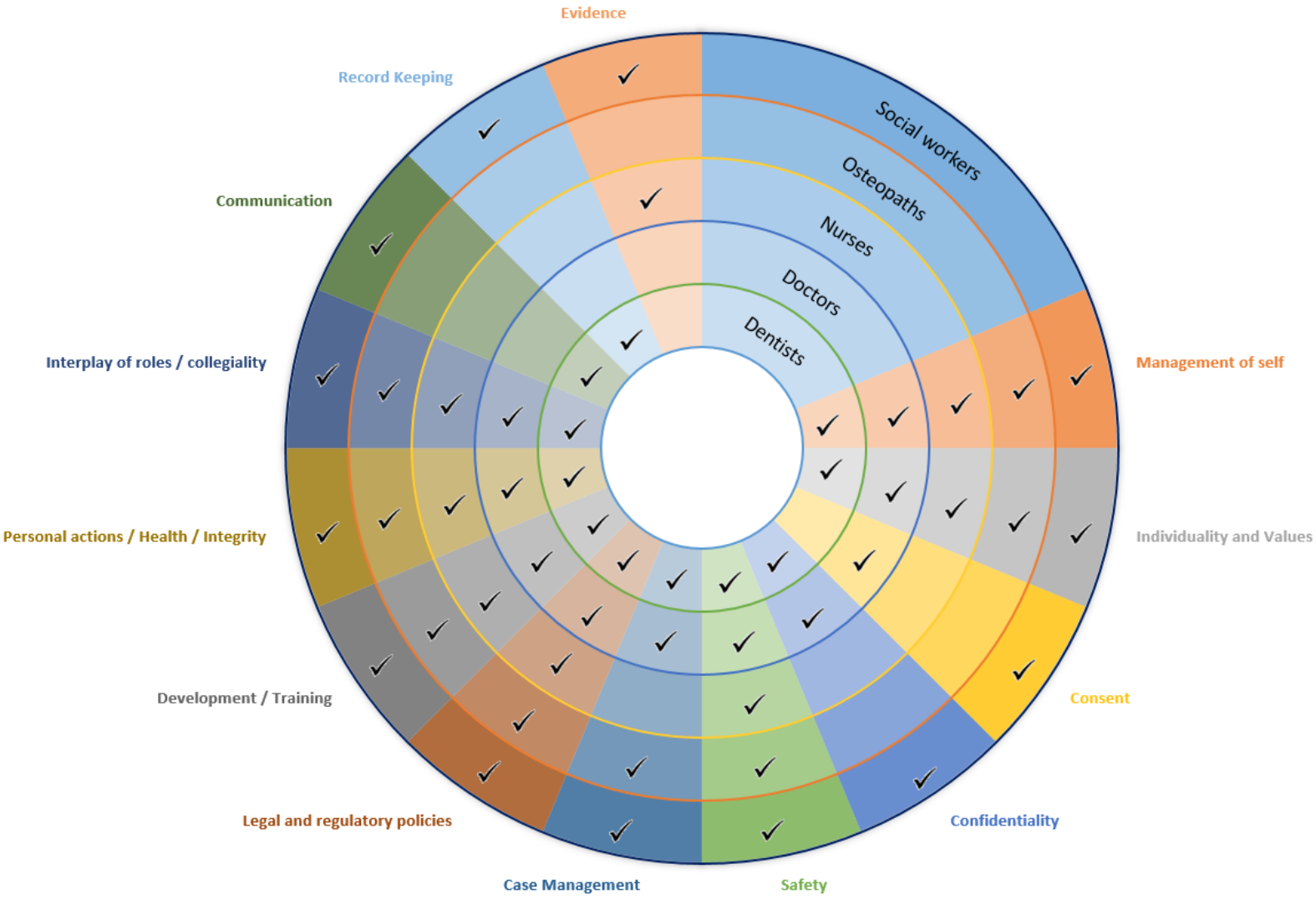

Figure 6.12 Sub-themes identified in the regulator-produced curricular documentation of the 5 professions analysed

The documents analysed ranged from production in 2010 to 2017. Whilst this may be a relatively short time-frame, there have been a number of notable events within this period which may have had varying degrees of influence on regulator-produced documentation as well as shift in public expectations. Examples include the higher profile of patient and public consultation which is now integral to both educational developments by providers, regulatory policy and decision making. The Department of Health document 'Liberating the NHS: No decision about me, without me – Government response to the consultation' (Department of Health, 2012) could have been one such influencing factor. In articulating the need for society as a whole to be instrumental in influencing change, the significance of the role of the 'expert' has been moderated. The profile of representation on regulatory councils and panels has also changed, moving to include 'lay' (or non-registrant) members outside the profession's direct membership. The Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry (Francis, 2013) included a requirement for the General Medical Council to involve lay representation in its inspections of medical education providers. Similarly, the GDC includes lay representatives as members of the Council and on their Panels and on their inspection teams of dental education providers (General Dental Council, 2015c, General Dental Council, 2015b). The Francis Report also highlighted the necessity of 'raising concern', which is now a cornerstone of clinical institutions. Whilst the 2010 NMC document pre-dated the Francis Report, both the 2015 GMC and 2015 GDC documents included the phrase 'raising concern', whilst the 2015 GOsC document included how to manage concerns about colleagues.

Another influential publication was the Care Quality Commission 'Duty of candour' information (Care Quality Commission, 2015), duty of candour was also a recommendation in the Francis Report (Francis, 2013). Duty of candour is explicitly referenced in both the GDC and GOsC documents. Although not in the 2015 GMC document, it is in the 2018 revised GMC version of 'Outcomes for Graduates' (General Medical Council, 2018a).

Looking further back at the general shift in clinical professional behaviour and public expectations, the question of ethics and etiquette was considered by Brazier and Cave (2007). They outlined the shift in current understanding of medical ethics, from the behaviour expected of 'an English gentleman', to providing some concrete advice by regulators, but in essence this conformed to expectations of gentlemanly behaviour and often resulted in the practise of benevolent paternalism. Today, the respect demanded of clinicians for their patients requires that patients are able to make maximally autonomous choices. These are

informed, free decisions by those with the capacity to make that choice (Brazier and Cave, 2007).

Overarching themes

Having a 'patient focus' as one of the overarching themes was expected, as the primary function of regulators is patient protection. For example (Table 6.33):

Regulator	Stated regulator function on website (recorded in late 2017)
GDC 'The role of the GDC – Our purpose' section of website	*'To protect, promote and maintain the health, safety and well-being of the public'* *'To promote and maintain public confidence in the profession'* *'To promote and maintain proper professional standards and conduct for members of those professions'*
GMC 'What we do' section of website	*'We help protect patients and improve UK medical education and practice by supporting students, doctors, educators and healthcare providers.'*
NMC 'About us - Our role' section of website	*'We regulate nurses and midwives in England, Wales, Scotland and Northern Ireland. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.* *We make sure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses and midwives who fall short of our standards. We maintain a register of nurses and midwives allowed to practise in the UK.'*
GosC Main section of website	*'We work with the public and the osteopathic profession to promote patient safety by setting, maintaining and developing standards of osteopathic practice and conduct.'*
HCPC 'About us' section of website	*'We are a regulator, and we were set up to protect the public. To do this, we keep a Register of health and care professionals who meet our standards for their training, professional skills, behaviour and health'*

Table 6.33 The website-published function of each regulator

All of these stated and legislative functions have a significant patient focus, with less on those delivering dental care, other than their regulation. Only the GMC statement begins to allude to the well-being of members of the profession. This element of consideration of the health and well-being of the practitioner could be considered integral to maintaining patient care and public confidence, but arguably (and legislatively) this may not be the role of a regulator.

Sub-themes

Where differences existed in the sub-themes identified in regulator documents, in some cases this was because the sub-theme content did not fall under the 'professionalism' section of the document being reviewed. For example 'consent' was a sub-theme absent from the GDC

'Preparing for Practice' document, but included in the GMC and HCPC documents. Consent *is* included in the 'Preparing for Practice' learning outcome document, it is explicitly listed in both the 'clinical' and 'communication' domain, so in this case is it more how the document has been 'packaged' rather than an omission or noticeable absence. Consent is a prominent element in the GDC's 'Standards for the Dental team' document. This is one of the factors to be aware of when analysing only parts of a document, and there is a risk of losing the overall messages and relevance of the content. To illustrate, the HCPC document was structured as a combined document for students and registrants, so the whole document was analysed. This meant that there was no specific signposting of 'professionalism' and therefore 'consent' cannot be specifically linked to 'professionalism'.

It could be argued that it does not matter that consent doesn't come under professionalism 'outcomes' if it is ultimately included. To consider this issue further, the 'purpose' and relational link with professionalism should be explored:

- Is it the process (mechanics) of gaining 'consent' that is the principal component which informs 'professionalism'?
- Or, is it the practitioner providing their patient with appropriate information for them to make an informed choice, respecting the patient's individuality and values in the process?

The latter approach includes elements of 'communication' and 'individuality and values', so could translate to the underpinning 'professional' elements associated with 'consent' without having to explicitly have 'consent' as an element within 'professionalism'.

What differs in this current work is that many previous studies have identified personal qualities associated with professionalism, rather than 'responsibilities' (Kearney, 2005). This study differs from that position in that more tangible requirements of professionals have been identified. This may be due to the nature of the data source; analysis of regulator documentation. Work identifying 'qualities' have arisen from employing interviews and Delphi methods, considering personal views and opinions of 'professionalism'. Whilst the sub-themes identified are different in their naming and specific content, there were recognisable similarities to other work involving thematic approaches to exploring professionalism. Zijlstra-Shaw et al. (2013) in their qualitative study which employed semi-structured interviews to consider perceptions of professionalism in dentistry, described a framework incorporating tacit and overt aspects of professionalism. Tacit aspects of professionalism that were included in the model included 'self-awareness' and 'awareness of others' (Zijlstra-Shaw et al., 2013) which could be tangentially correlated to aspects of

'management of self' identified in this study. Kearney (2005) identified qualities for professionalism in anaesthesiology using the Delphi technique with Canadian anaesthesiology educators. She identified a number of Humanistic, personal development and meta-competence qualities that resonated with those in this study. These included: integrity; maintenance of confidentiality; adherence to ethical and legal codes; respect for colleagues and co-workers, commitment to lifelong learning and communicativeness (Kearney, 2005).

6.7.2 Style of portraying undergraduate professionalism attributes

There was no consistency of approach, in terms of the style of statements, used to portray the concept of professionalism (either intra- or inter-document). It was also often difficult to determine which 'educational status' to apply to a statement, highlighting challenges from an education provider perspective. Figure 6.13 also demonstrates that all regulators, to differing degrees, have included statements which have multiple component elements. As discussed in the 'Preparing for Practice' chapter, inclusion of 'broad' outcomes makes consistent determination of attainment challenging.

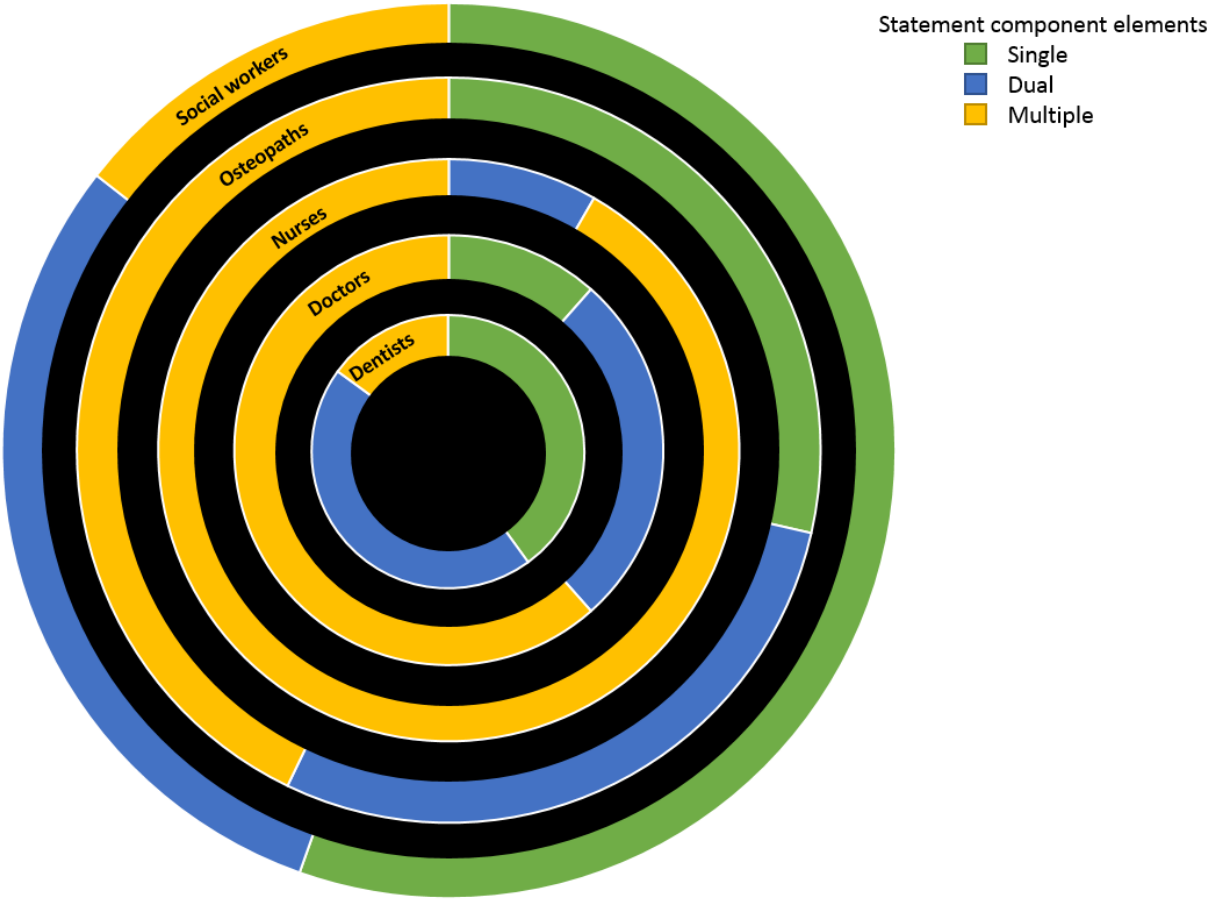

Figure 6.13 Statement component element proportions in regulator curriculum documentation

The potential effect of such utility challenges requires consideration of document purpose, i.e. why regulators produce this type of documentation. This will be explored further in the following chapter.

6.8 Summary

The documents analysed in this chapter had several similarities in terms of purpose:

- Description of professionalism requirements (professional attributes)
- Produced for similar user groups (undergraduate education providers), and
- Produced by professional regulatory bodies.

The way in which professionalism has been conceptualised by each regulator further supports the position in the literature of a complex phenomenon which is multi-faceted with overlapping and interlinking component parts. There were elements of commonality in thematic content and therefore the way different regulators have conceptualised professional attributes. There was consistency in the overarching themes identified related to professionalism attainment in the undergraduate student: Patient/service user focus; Regulatory focus; Practitioner focus. However, the emphasis differed in each document.

In terms of format, the documents lacked a consistent approach in terms of style of portraying the concept of professionalism. From analysing the different approaches in style of presentation of requirements, we can identify the aspects that make some of the educational goals written for professionalism challenging for education providers to work with.

The final chapter will draw together findings and use these to inform recommendations for future articulation of curriculum requirements of professionalism by regulators.

Chapter 7. Implications and discussion of findings

The earlier chapters have presented thematic analysis findings of a document produced by the UK national dental regulator for registrants, and document and thematic analysis findings of documents produced for education providers by a range of UK national regulators. The intention in this chapter is to consider these further and to highlight the potential consequences of the current portrayal of professionalism in documents describing curricula requirements from regulators. From here, to provide evidence-based recommendations for future development, I have further interpreted my findings and presented an idealised construct of professionalism, as implied within regulator documentation. The objectives of the chapter are:

- To consider the challenges with the current presentation of professionalism from the perspective of the provider of undergraduate training.
- To consider the potential (unintended) consequences of the current approach adopted by regulatory bodies.
- Based on the findings in this study, to develop recommendations for future articulation of curriculum requirements of professionalism for education providers and regulators, and future iterations of current documentation produced by the dental regulator in the UK.

7.1 The Journey

Initially considering the scope and desired outcome of this research, the focus was the development of an assessment instrument for professionalism at the undergraduate dental student level. The assessment of professionalism was recognised as essential for inclusion in the curriculum, based on guidance from the UK dental regulator, but it was also something that presented challenges to education providers in terms of demonstrable attainment. Those challenges included the range and breadth of content; how to implement assessment in a meaningful way; consideration of fairness, consistency and transparency. The latter three elements being features which any assessment should be able to withstand under scrutiny. Consequently, the ability to develop a robust assessment of professionalism must have meaningful impact on curriculum delivery.

The research was initially planned as an exploration of the influence of personal judgements in assessing the development of professionalism, with the aim of examining how clinical teachers and examiners form a judgement of ‘professionalism’ in undergraduates. The

rationale at this point was to understand what factors influence those who make determinations of professionalism. The development of a conceptual model of factors in judgement of professionalism by those who examine dental students which could be utilised when designing assessments was then envisaged. Four strands of investigation were planned to aid understanding of the nature of professionalism: a literature review; consideration of governance documents; consideration of curriculum documents; exploration of the viewpoint of members of the 'profession'.

However, the literature review identified multiple challenges arising from the complexity of the professionalism concept. These included those inherent when working with complex phenomena, but also with the literature itself. The 'definition' of professionalism is a much debated issue in the literature, with recognition that one unifying descriptor is unlikely to either feasible or desirable. Therefore focus on the group or institution using it has been proposed (Cruess, 2006, O'Sullivan et al., 2012a, O'Sullivan et al., 2012b). There is currently no widely acknowledged or implemented 'common' shared understanding of 'what' professionalism is, and what it includes within the scope of UK undergraduate dental education. This would therefore present a challenge in terms of developing assessment if agreement is not first achieved on aspects of a descriptor.

There is consensus in the literature in terms of a number of aspects related to assessment of 'professionalism'. These include that assessment: should be longitudinal (Goldie, 2013, Hodges et al., 2011, van der Vleuten and Schuwirth, 2005); is likely to use surrogate markers (McLachlan et al., 2009); it is a 2nd order competence (Zijlstra-Shaw et al., 2012); observable behaviours are often utilised, but may not always confirm attitudes (Aguilar et al., 2011, van Mook et al., 2009).

In addition to these challenges, the literature itself presented challenges. The majority of articles published are 'opinion' pieces and often contain abstracted definitions or virtues and values which are difficult to translate into observable actions (Ginsburg et al., 2004, Stern et al., 2005). There is also an Anglo-Saxon basis to much of the published literature (Hodges et al., 2011) which may not be appropriate to translate into other cultural settings (Park et al., 2017, Tsugawa et al., 2009).

With these multiple considerations and a better understanding of the subject area, it was recognised that the broad scope of the initial research question was unrealistic. In addition, the intention of developing an assessment was unlikely to be successful as too many areas earlier in the process (understanding of content, purpose, methods) were not unpicked, and

this work would be needed prior to any future consideration of judgements. The focus of the research therefore changed toward a need to concentrate on understanding the underpinning themes surrounding professionalism in undergraduate dental education, before any future attempts to 'build' an assessment or assessment strategy. In order to improve the understanding of these underpinning details, the decision was made to focus on exploration of 'known' elements, i.e. elements that have known influence on undergraduate dental education.

7.2 Aim of this project

The aim of this project was therefore to better understand professionalism from the perspective of the education provider via the requirements produced by a regulator.

7.3 The 'curriculum' and document selection

In terms of influences on the undergraduate professionalism curriculum of UK dentistry, when applying the lens of an education provider in relation to the learner, it was first important to consider what a curriculum actually is, and what it comprises. A Dictionary of Education has defined a curriculum as *'the content and specifications of a course or programme of study'* (2015). A 'curriculum' is therefore broad in terms of scope and defining/contributing factors. It includes the attendance, standards of expectation and behaviours of the students on that programme. It also encompasses the assessment strategy, the resources, staff and the learning experienced and evaluation processes (Prideaux, 2003, Manogue et al., 2011). The elements that support the development of the learner in education include the 'formal', 'informal' and 'hidden' curriculum. These have been much discussed in the literature both generally and in regard to medical education (Hafferty, 1998) and specifically in relation to professionalism (Hawick et al., 2017, Cruess, 2006, O'Sullivan et al., 2012b, Cohen, 2006).

The regulatory influence of the GDC on education providers, in their role of Inspecting, Quality Assuring and approving programmes which deliver a registrable qualification has the inherent result that GDC curricular documentation will inevitably contribute to informing the institutional view of professionalism. Working with and having an awareness of how professionalism has been conceptualised in the GDC curricular document is therefore necessary for those using that knowledge. By adopting a pragmatic approach in this research, two aspects were addressed:

1. acknowledgement that education providers must work with the curriculum requirements produced by the regulator;
2. the research aimed to provide practical recommendations and insight garnered from documentation in terms of thematic content, which could be distilled and contribute to practical application and the design of aspects of professionalism curricula including demonstration of attainment.

In considering this in relation to curricula requirements for undergraduate dentistry, there were two main foci included for analysis in this research. Both were GDC documents of direct relevance to education providers in relation to undergraduate dental students: the undergraduate curriculum document 'Preparing for Practice: Dental team learning outcomes for registration (2015 revised edition)' (General Dental Council, 2015a); and the GDC 'Standards for the dental team' (General Dental Council, 2013c) which is a more widely applied document, relevant to both undergraduate students and registrants.

In 'Preparing for Practice', the GDC document states with regard to professionalism that it sets out *'the knowledge, skills and attitudes/behaviours required to practise in an ethical and appropriate way, putting patients' needs first and promoting confidence in the dental* team' (General Dental Council, 2015a p.6). Whilst 'Preparing for Practice' may have been an unequivocal choice, the rationale for inclusion of 'Standards for the dental team' may be less clear to some when considering the lens of an education provider in relation to a student. There were however numerous justifications for inclusion, primary of which was the explicit reference made to the 'Standards' in 'Preparing for Practice' regarding its relevance to students:

> *'The GDC expects professionalism to be embedded throughout dental education and training. All students must have knowledge of Standards for the Dental Team, and its associated guidance, and demonstrate their own professionalism.' (General Dental Council, 2015a p.8)*

The reason the GDC has produced the 'Standards' document is to outline the standards of conduct, performance and ethics that govern dental professionals (General Dental Council, 2013c). Thus in preparing future registrants education providers must be mindful of the expectations facing them on registration, and be active in ensuring they are prepared to meet these requirements.

Other documents could have also arguably been included for analysis. These may have included the 'Student Professionalism and Fitness to Practise' documents prepared by the GDC for both students and education providers (General Dental Council, 2016b, General

Dental Council, 2016c). However, these documents do not denote what 'professionalism' should be and are therefore not fundamental in education provider's planning of the professionalism curricula. Instead, they contain the processes that should be applied if a concern of a breach of professionalism has been raised.

An additional facet of the research was added following the analysis of the 'Preparing for Practice' professionalism domain content. Challenges were noted in the presentation format of requirements which could impact on the ability of education providers to implement (work with) these requirements. However as already noted, providers *must* work with them. So even accepting the thematic coverage, questions arose as to whether there was a better way to present requirements for education providers to aid utility. This further altered the course of this research to extend beyond dentistry, to investigate how other regulators have approached professionalism requirements for those in training to join the profession and whether any recommendations could be made following collation of these analyses.

7.4 Should educational attainment requirements be set by a regulator?

Getting the right 'end product' i.e. the desired doctor or dentist at the end of clinical education, has had a significant impact on the literature pertaining to the design of curricula. In terms of the literature, this has included consideration of whether the admissions process can predict future academic success (McAndrew et al., 2017, Mercer et al., 2013, Rich et al., 2012, Ballard et al., 2015) or 'professional behaviour' (Stern et al., 2005, Adam et al., 2015). Links have also been explored between disciplinary action taken against qualified physicians and previous unprofessional behaviour at medical school (Papadakis et al., 2004, Papadakis et al., 2005). There is also currently a resurgence in interest and publication concerning the 'preparedness' of new dentists as they enter practice (Gilmour et al., 2018, Oxley et al., 2017, Gilmour et al., 2014).

Who should be influencing curriculum content and determining the 'end product' is also important to consider, and the question of whether regulators should be the ones to set educational attainment requirements is an interesting debate, but seen as a moot point by others. The profession has previously been self-regulating, and since 1956, the General Dental Council has been the named regulating body for UK dentists. The Council itself has undergone several changes in constitution in that time, from a large group of dental practitioners forming the Council, to the most recent changes in 2013 which now means that of the twelve Council members, six are lay members and six are registrants (from a number of different registrant groups). The regulator has taken the lead in determining aspects of

education, including setting and assuring quality requirements for dental education and training programmes (for all registrant groups and for specialty training), and inspecting pre-registration programmes to ensure requirements are being met. In terms of outcome requirements for programmes leading to registration, they have clearly stated in 'Preparing for Practice' the perception of their role in setting educational requirements:

> *'Our responsibility is therefore to define the outcomes required, and to make sure they are met through the education, training and assessment process by future registrants.' (General Dental Council, 2015a p.4)*

Is the regulator producing these requirements because it is a regulator, or would any responsible body charged with defining or quality assuring educational standards adopt a similar approach? Considering the potential rationale for adopting this approach is an obvious starting point. Justification for the regulators producing this type of documentation for education providers could include: attempting to ensure consistency from education providers by providing a set of requirements against which Quality Assurance can be achieved, or potentially to be outwardly 'seen' to be producing the guidance. If the current educational requirements have been produced as a way of supporting quality assurance, then adopting an 'outcome' format approach may have been considered to be most functional in this regard. If this were the case, a measure of 'success' in terms of format could be whether from an education provider's perspective, the document content offers genuine 'utility', as opposed as purely a mechanism or external quality assurance.

Accountability is one of the advantages promoted for outcome based education, which in turn has an influence on quality assurance (Harden et al., 1999). Morcke et al. (2013) in their reflection of outcome (competency) based education, suggested that in relation to implications for practice, outcome based education is more appropriate for some aspects of medical undergraduate education than others. This group of researchers went on to highlight the rationale behind a number of key works supporting outcome based education, for example they specifically mention those of Hodges (2010) and Cooke et al. (2010) in terms of assessment and accountability (Morcke et al., 2013). Hodges (2010) discusses the implications of both professional and social accountability when comparing two different models of competence development in medical education, one being a time-based model and the other being an outcome-based model.

To respond to the question posed in the sub-heading, I believe that educational attainment requirements should be set, and that the regulator, with its influence over stakeholders, is in the best position to set these requirements. However, development of attainment

requirements first requires an understanding of the associated challenges in doing this, and secondly should be informed by input from relevant stakeholder groups. I believe that attainment requirements are necessary to ensure an appropriate standard is applied across educational institutions and for quality assurance purposes. Any body/group could 'create' requirements, but they would only have universal influence if that body/group was recognised and compliance was mandatory. For example, an individual school could set requirements, but other schools would not necessarily be aware of them and would not need to adhere to them. All education institutions training dental professionals in the UK must be aware of and comply with GDC requirements. When setting requirements the GDC should engage with: patients and the public (recognising expectations); education providers (those who work with requirements); the wider profession (ensure requirements blend with expectations on the continuum of education and the lived experience).

7.5 Understanding gained from this research

7.5.1 Approaches in portraying requirements

In terms of format, aspects that make some of the educational goals written for professionalism challenging for education providers to work with have been identified. These included:

- Outcomes which are broad or have multiple constituent elements. This has the challenge of either not being able to include all of the content or elements in a single episode of assessment. This then leads to the potential of inconsistent recording of attainment by education providers which would potentially influence quality assurance mechanisms applied across providers.
- Outcomes where content is unclear or there was lack of clarity as to what would constitute attainment. Again this has the potential to mean application is inconsistent between education providers.
- No obvious assessment means (established tool) to measure what has been listed in the requirement, for example if attitudes or beliefs are the foundation of the requirement.
- Challenges related to working within a supervised environment and within the scope of an undergraduate student, within a larger organisation. Difficulties here include ensuring an equity in provision of opportunities for each student and elements where they have limited control or influence, for example taking responsibility for dental teams to operate effectively.

Therefore, utilising this understanding, advice could be given on how educationally acceptable 'learning outcomes' could be prepared and written. This would likely mean recommendations of shorter, more concise outcomes which specifically identified attainment and indicated the means of assessment. However, this could lead to an inappropriate conceptualisation of the complex and context dependant world of 'professionalism'. The challenges experienced by education providers with the format in which educational goals are currently expressed is most likely a reflection of the nature of this complex phenomena rather than the failure to conform to accepted educational formats. Putting elements together that ***can*** be measured may therefore be inappropriate and instead indicate that we should be working with the information from this analysis and in the literature, acknowledging this isn't a simple phenomenon that can be neatly characterised and written.

This presents an argument for why an outcomes based approach may not be appropriate for complex phenomena such as professionalism. Whitehead (2010) concisely articulates how an outcomes-based approach would 'work':

> *'Outcomes-based education hypothesizes that if the desired product can be defined, and appropriate assessment tools developed to ensure that the trainees have achieved these competencies, then the job will be done' (Whitehead, 2010 p.1673).*

If this rationale was applied in the consideration of 'professionalism education', as defining the end product (professional behaviour and attributes) is not straightforward and established assessment tools are contested, then an outcomes-based approach may not be currently appropriate. On reflection, research in this study suggests that some elements of professionalism are only demonstrated by an absence of certain behaviours, for example an absence of evidence of unprofessional behaviour suggests that the 'outcome' has been attained.

Does having a combination of different education attainments matter?

It could be argued that how document statements are described doesn't matter, and if something is inaccurately labelled an outcome when it might be better described as a different style of educational goal is inconsequential. Equally, whether there are a combination of styles used in various documents. From undertaking this research I would argue that in some important areas it does matter and giving statements a particular 'name' confers a particular status that has connotations which affect the way in which they are i) used and ii) viewed.

If the statements are believed to be 'outcomes' and therefore considered to have the qualities and educational 'power' of an outcome, there is fundamental misconception over the purpose

and utility presented. Following this research I also believe that it is important that the regulators and clinical educators understand and acknowledge the complexities and challenges associated with phenomena such as professionalism in learning programmes.

Can we have 'outcomes'?

Considering the component qualities of an 'outcome' it is perhaps unsurprising that the statements associated with Professionalism do not consistently display all of these qualities. The findings of this study suggest that it is 'probably not' possible to develop a list of outcomes which conceptualise the concept of 'professionalism' given the amorphous, multi-faceted, context dependant nature of the phenomenon. So what then is an effective alternative?

Whether all elements of an undergraduate curriculum can (or should) be described in comparable terms is an additional consideration. Where Clinical and Communication skills are likely to be amenable to the format of 'learning outcomes' and opportunities for skills assessment to demonstrate attainment can be developed by education providers, alternatives need to be considered for some complex phenomena.

If not 'outcomes', how else could professionalism be approached?

For 'Professionalism' a series of 'standards' outlining the approach that should be applied to all activities undertaken (as a professional) may be more appropriate, whilst still providing an indication of the appropriate level which is expected to demonstrate achievement. This would reflect a similar approach to that taken by the GDC with registrants i.e. 'Standards for the Dental team'. If written appropriately, a 'standard' would provide the approach which should be adopted, together with an indication of the level which would be deemed appropriate. This threshold level which could be used by education providers to provide the basis of investigation and follow-up if a shortfall was suspected.

If this approach was considered, a further deliberation would be whether the 'standards' could or should be determined by an individual regulator, for example the GDC, or whether it would be achievable or desirable to determine an overarching set of 'professionalism' standards for undergraduate clinical education agreed by a number of different regulators of healthcare professionals. These would likely need to be a group or 'country-specific' regulators, those who already have links and can consider the local population expectations and values. This may still have challenges when considering multi-cultural diversity within countries, generational differences and changes in trends of expectations. An example of this

type of challenge may be the conflicting societal changes in respect of environmental waste. A number of items used within dentistry are single-use, designed to optimise patient safety, so is there a conflict in terms of environmental impact which may need consideration? Would it then be unprofessional to use them, even if they are the only alternative to use for the benefit of a patient? A further area for future work would be consideration of the impact of cultural diversity on requirements/expectations. Whether the practicalities of achieving agreement across professions would prove too challenging, or whether generic principles are transferable across professions would be the key considerations in determining 'success' of this approach. There is already evidence, shown in this research (Figure 6.12), of commonality of the elements included in terms of the content by regulators so this may not be an unrealistic option. There is recent evidence of increasing engagement and collaboration across regulators. This can be seen in the way Chief Executives of a number of UK healthcare regulators produced a joint statement of support about the benefits of being a reflective practitioner (2019) and the work being done to further the principles of 'shared decision making' which includes the General Dental Council and the General Osteopathic Council (General Dental Council, 2018b).

There would also still be an ability to quality assure this approach, if a similar method was adopted to that used when 'Standards for Education' (General Dental Council, 2015d) is addressed during GDC Annual Monitoring processes and Education Programme Inspections. By not having specific listed 'outcomes' the apparent 'utility' of documents produced for education providers may be considered by some as superficial at best or disingenuous at worst. There may be concerns over the ability to map requirements to the curriculum and of how to design assessments. In actuality however, the situational reality and genuineness of what is being monitored is likely to be increased and ultimately may give what is *really* wanted in terms of the skills, knowledge, attitudes and behaviours of the new graduates. That of complex integration, application and responsiveness to individual situations and subsequent reflection, learning, development and adaptation.

A further consideration would be whether standards for undergraduate students would need to be different from those of registrants and whether 'new' standards would need to be written, or whether using the current 'Standards for the dental team' would be appropriate. Potentially the current standards document could provide a foundation, these are not 'specifically' professionalism, but maybe an indication of the rounded approach with which 'being a professional' should be viewed. However, clarification may be needed in terms of how to manage and apply the interplay of the principles, standards and guidance which appear in the

document. The GDC are currently initiating a review of the 'Standards for the Dental Team' document and there is a perception that the current document content is too prescriptive and possibly that through providing a significant amount of detail to sections, there may be unintended consequences in terms of individuals actions in response to these standards as they are currently written.

This area is complicated and clear examples are not easy to explain. It is conceivable that GDC Standard 6.3 '*You must delegate and refer appropriately and effectively'* (General Dental Council, 2013c) could create internal conflict for some practitioners when faced with elements of complexity in a patient's treatment needs. The guidance points in Standards for the Dental Team states at 6.3.3 '*You should refer patients on if the treatment required is outside your scope of practice or competence*' and at 7.2.2 '*You should only deliver treatment and care if you are confident that you have had the necessary training and are competent to do so. If you are not confident to provide treatment, you must refer the patient to an appropriately trained colleague.*' How may this be applied in a situation when a practitioner is fairly confident they are able to undertake a specific extraction or restorative intervention which may have additional complexity? Do they attempt it or choose to refer it just in case it goes adversely? Guidance point 1.7.6 is '*When you are referring patients to another member of the dental team, you must make sure that the referral is made in the patients' best interests rather than for your own, or another team member's, financial gain or benefit.*' Would it be in the patient's best interests not to attempt treatment at all and miss the opportunity of success or refer onwards? These are judgements which need to be made on an individual basis taking into account context. Concerns raised that new graduates are risk averse could be considered from a different perspective in that they may just be doing 'exactly' what they have been told to do.

7.5.2 Thematic coverage of professionalism

The way in which professionalism has been conceptualised by each regulator supports the position in the literature of a complex phenomenon which is multi-faceted with overlapping and interlinking component parts (van Mook et al., 2009, Zijlstra-Shaw et al., 2013, Burford et al., 2014). There were elements of commonality in thematic content and therefore the way different regulators have conceptualised professional attributes. Overarching themes identified in this research from the regulatory documentation were: Patient/service user focus; Regulatory focus and; Practitioner focus. These overarching themes have aspects of alignment with previous findings where professionalism has been investigated. Van De Camp et al. (2004) reported uncovering three themes when reviewing medical

professionalism literature: interpersonal professionalism, public professionalism and intrapersonal professionalism. An International Ottawa Conference Working Group on Professionalism used discourse analysis and presented three approaches to professionalism: individual, inter-personal, societal–institutional (Hodges et al., 2011). Van De Camp et al. (2004) in the 'Interpersonal professionalism' theme included interactions between practitioners and patients and/or practitioners with other healthcare professionals. There were parallels with some of the associated elements they listed with those identified in the 'patient focus' theme of the current study. These included aspects of respect for patient's individuality and values, and engagement with processes which contribute to effective patient care. Similarly, parallels could be drawn between the 'Public professionalism' theme which Van De Camp et al. (2004) described as societal demands on medical professionals, with the 'Regulatory focus' overarching theme in this study. Whilst '*adherence to guidelines*' is an example of such a parallel, there were aspects in the Van de Camp study which overlapped with the 'Patient focus' theme in the current study. Examples here could include where I have identified aspects related to ensuring safe and effective patient care in the 'patient focus' theme, and Van De Camp et al. (2004) found '*commitment to continuity of patient care'* and '*deliverance of quality'*.

Intrapersonal professionalism included the individual aspects associated with meeting the demands of being a medical professional (Van De Camp et al., 2004). In this study this had parallels with the 'focus on the practitioner' overarching theme. Overlapping aspects appeared to be those associated with aspects of internal self-management and self-regulation.

A number of the sub-themes identified in this research were common across all regulators in the document sections analysed to explore pre-registration 'professionalism' (Figure 6.12). These were:

- Individuality and values
- Safety
- Legal and Regulatory policies
- Development and Training
- Personal actions / Health / Integrity
- Management of self
- Interplay of roles / collegiality

A similar approach for each of the clinical professions considered in this research (Doctor, Nurse, Dentist, Osteopath) had also been adopted, that of a 'domain' structure, where one domain was aspects of professionalism. This could demonstrate a shared rationale of addressing the primary function of each of these regulators – that of 'protecting patients'.

What could be done by knowing the thematic coverage, are there potential risks?
As with any research and considering the pragmatic approach adopted here, another question is how utility can be drawn from recognising that content encapsulated under 'professionalism' is consistent across a number of professions. It could be that it reinforces the potential and opportunity for a group of regulators to develop a concept of professionalism which shares common features. Understanding of the sub-themes and overarching themes identified could permit development of a framework which could influence the curriculum structure used by education providers. Consideration could be given to identification of cross-cutting themes within programmes and longitudinal 'courses'. Effectively the sub-themes identified in this research could be viewed as highlighting the key areas of coverage that should be addressed through learning and assessment in any curricula.

Throughout this, it has been recognised that there are challenges with this approach in relation to some aspects of education, specifically whether some aspects of learning can or should be reduced in a mechanistic format to discrete pockets of knowledge or observable behaviours. This brings us back again to the challenges of an outcome based approach to considering a complex phenomenon such as professionalism. In conclusion of their 'Sociological interpretations of professionalism' article, Martimianakis et al. (2009) wrote:

> *'There is a growing awareness that professionalism is too complex and nuanced a construct to be reduced to a simple checklist of individual characteristics and behaviours' (Martimianakis et al., 2009 p.834)*

Findings in this research would support this and demonstrate that the essence, richness and interplay between component elements can be lost or lose value when attempts are made to itemise and quantify elements related to 'professionalism'.

7.6 Recommendations for regulators preparing documents which contain professionalism requirements

Regulators should firstly consider the specific intent of the professionalism statements they have included in any document. Why have they included the statements, what is the expected

attainment from their inclusion and how is the intended audience of the document expected to work with the requirements.

If regulators are including requirements associated with professionalism in a document which also has requirements in other areas (for example clinical or communication skills), to consider the format used. Be aware that the format used for other areas may not be appropriate for 'professionalism' and consideration should be given to utilising the most appropriate format for the context of the type of requirement.

Regulators should consider how statements are labelled in their documents and ensure this labelling is consistent with the format used. For example, if something is labelled as a 'learning outcome', ensure that it has the characteristics expected of a learning outcome. If use of the term 'outcome' is continued in documents intended for use by education providers, statements will require modification to align the accepted educational expectations associated with the use of outcomes.

In terms of the expression of educational goals, a further recommendation for regulators would be the adoption of a 'standards' format, which many already have in some guise for registrants. Although not widely used in education, it appears more appropriate for describing professionalism requirements. We recognise this would require wider collaboration in determining guidance for how providers may work with these standards to demonstrably satisfy quality assurance processes.

A further recommendation is involvement of educators with a background in educational goal preparation when revising or developing new curriculum requirements. This is not about determining content, that is a separate consideration, but rather ensuring education providers can constructively engage with regulator requirements. This means that the format must permit utility for the provider. A result of the utility would be more consistent engagement and therefore demonstration of attainment across providers, itself an aim for regulators when considering quality assurance mechanisms.

In terms of content of professionalism requirements, engagement across professional groups should be considered in addition to within at stakeholder events. Education providers need to highlight any challenges they have when working with requirements and work together, with the regulator, to develop solutions.

7.7 What 'the professional' may encapsulate

In interpreting the findings of this research, an idealised construct of professionalism, as implied within regulator documentation, was developed. A 'construct' was considered the most appropriate representation of 'being the professional', as constructs are ideas or theories which comprise several conceptual elements, however they are not explicit nor based on empirical evidence. The complex phenomenon of professionalism has overlapping influences which are context dependent, therefore it is not possible to represent it as dichotomous options or explicit facets for many aspects, or algorithmic pathways. This therefore led to consideration that it was more appropriate to adopt a subjective approach at representation, incorporating the multiple elements identified in this research.

The construct (Figure 7.1) was developed by considering elements of commonality across regulators in relation to thematic content of professionalism requirements. It considers the relationships of the key participants, together with the conceptual aspects identified as fundamental. The figure is 'idealised' as it represents what happens when a system is working well.

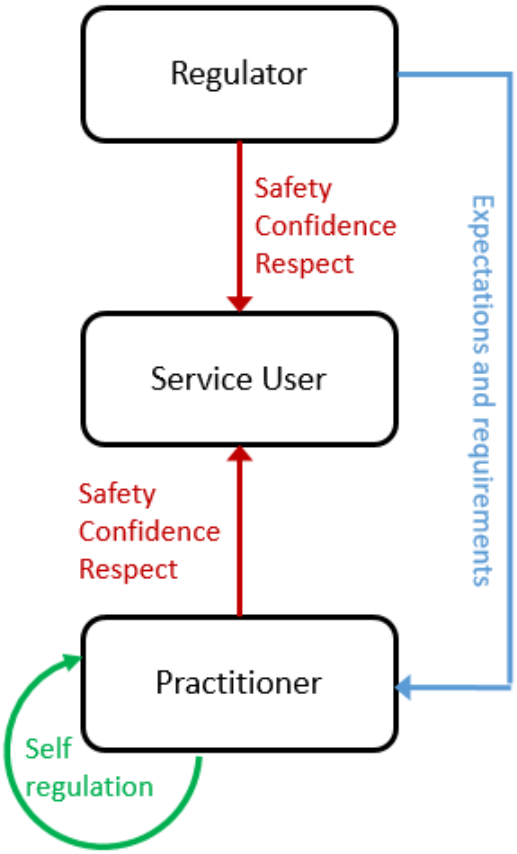

Figure 7.1 An idealised construct of professionalism as implied within regulator documentation

The arrows in the construct indicate the directional influence and impact of the key participants and is suggested to be put into action as follows.

- The regulator
    - Has influence on the practitioner through setting out expectations and requirements, which must be observed by the practitioner.
    - The over-riding purpose of regulator activity is to have a positively assuring impact for service users. This includes ensuring service users are treated safely, that they gain and maintain confidence in the practitioner managing their care (and thereby confidence in the wider profession) and that they themselves are respected as individuals.
- The practitioner
    - Is influenced by the regulator; they must observe the expectations and requirements set in order to practice in their chosen profession.
    - Is internally influenced by elements of self-regulation.
    - Their actions have an impact on the service user, the over-riding focus of influence by the practitioner is delivery of care safely, promotion of the service user's confidence in the practitioner, and ensuring service users are treated with respect.

If all aspects of influence and impact proceed as intended (the idealised construct), the service user receives safe care, their confidence in the person delivering care is optimal and they are managed with respect. Further detail/expansion of the construct of regulator expectations and requirements and practitioner self-regulation is shown in Figure 7.2. This detail has been derived from sub-themes that have become apparent through this research.

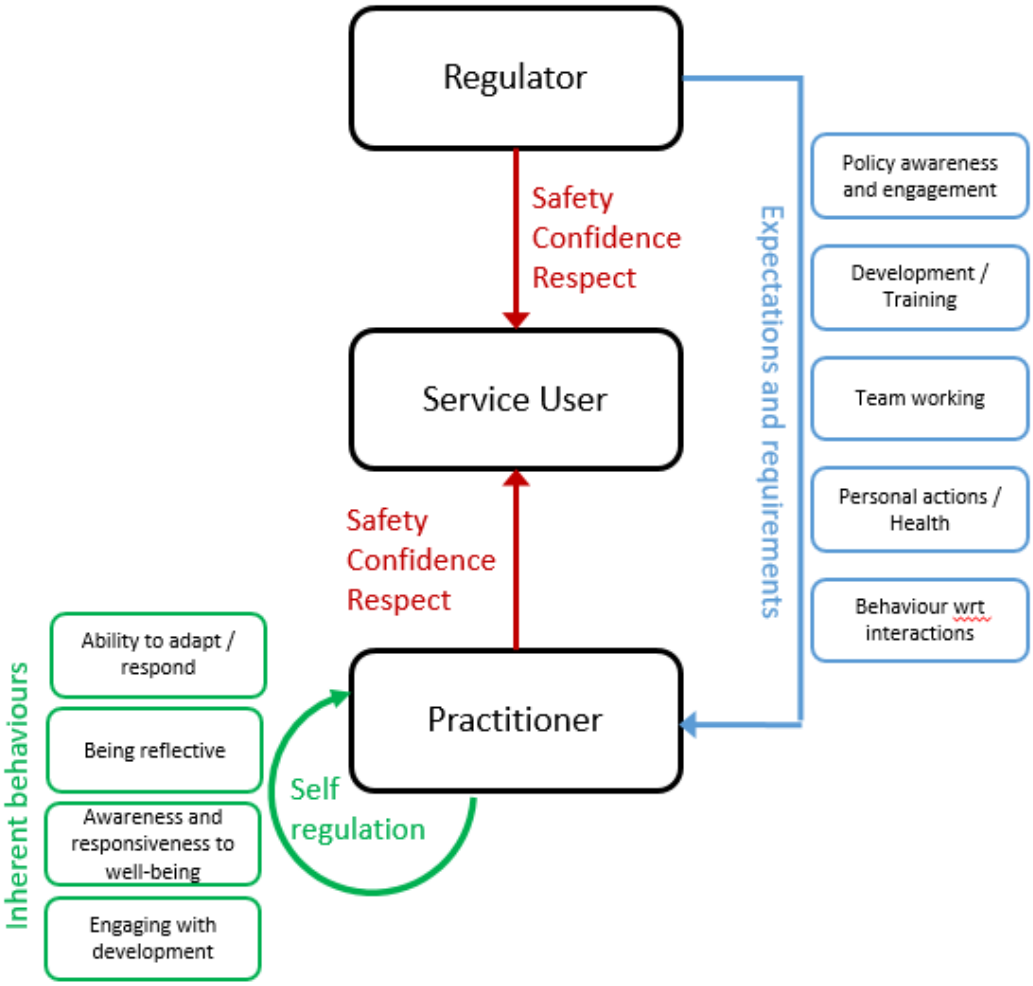

Figure 7.2 An idealised construct of professionalism as implied within regulator documentation (detail)

7.7.1 Regulator expectations and requirements

The expectations and requirements set by regulators, and their influence on individual practitioners, are captured in Figure 7.2. Aspects identified as common across regulators in relation to professionalism included:

- Policy awareness and engagement. Awareness of standards governing individual professions, adherence to relevant laws, for example equality and diversity legislation and having appropriate policies in place to support patients, i.e. complaints. This will result in safe service user care as well as ensuring service users are 'treated with respect'.
- Development / training. Statements requiring practitioners to engage with development and training opportunities and requirements to ensure they are appropriately trained/skilled for the activities they undertake. This often includes requirements to engage with, record and declare certain types/quantity of continuing professional development. The ultimate purpose is delivery of safe care for the service user.

- Team working. Requirements to work effectively as part of a team (within profession and wider healthcare arena) to ensure safe and effective care of the service user.
- Personal actions and health. Practitioners must ensure their actions promote service user confidence in both individual practitioners and the wider profession.
- Behaviour with respect to interactions. Practitioner interactions must ensure that the service user is treated with respect and that their confidence in the individual practitioner and the wider profession is promoted.

7.7.2 Practitioner self-regulation

There are a number of common self-regulation qualities and attributes across regulators in relation to professionalism. This regulation is internal to the individual, rather than 'self-regulation' in the context of a profession being regulated by a group of practitioners from that profession. The later meaning of self-regulation for many professions is now not appropriate as the role of lay or non-registrant members in committees and councils is now required. Self (internal) regulation encompasses elements of inherent behaviours that promote personal well-being, good team-working and the ability to respond and adapt to situations:

- Being a reflective practitioner (a skill currently being promoted across a number of professions) incorporates reflective consideration of personal actions and skills and development needs. Proactive engagement with development activities is also part of this process.
- The ability to adapt and respond to situations applies to clinical scenarios and interactions with service users and team members. It links with being a 'reflective practitioner' and engagement with self-development. Practitioners should have an armamentarium of skills permitting synthesis of contextual information and appropriate response to foresee and/or manage situations as they arise.
- Awareness and responsiveness to well-being incorporates engagement with activities that promote well-being and safety (both of the practitioner and the service user). This may include simple health and safety adherence to aspects of reflection and use of effective feedback (both giving and receipt). If aspects are noted which raise concern, recognising the need for intervention and then appropriate management and follow-up.
- Engaging with development could be because it is a registration requirement, but is intended to be most productive when carried out in conjunction with personal

development planning and reflection. Developing the armamentarium to adapt to situations will also promote well-being in the individual.

7.7.3 When it goes 'wrong'

The construct described in Figure 7.1 and Figure 7.2 is idealised, depicting what happens when systems work in the way they were designed/intended and all proceeds well. However, progress is not always as intended and on occasion, aspects within the construct are either not actioned in the way intended or there is a perception that they have not been demonstrated. There is an assumption of causal relationships in the previous figures where some attributes have been presumptively linked to having a positive impact. An example of this could be the inclusion of 'being reflective'. There is literature describing reflection (Plack and Greenberg, 2005, Johns, 2017, Schn, 2016) and the benefits of being a reflective practitioner (General Medical Council, 2018b, NHS Employers, 2019), but there could be potential negative connotations dependant on how an individual employs that reflection, for example a practitioner may become negatively introspective, affecting their ability to move forward and constructively develop. Awareness and responsiveness to well-being has positive implications if a practitioner uses this to support improvement of their own health and also acts to ensure their well-being doesn't have a negative impact on their patients, colleagues etc. However, it could be looked at in another way if a practitioner does not act appropriately in responding to their own concerns and patients and other team members may be adversely affected.

Figure 7.3 depicts the potential indicators and impact of a failure to comply, or achieve, professional expectations and requirements.

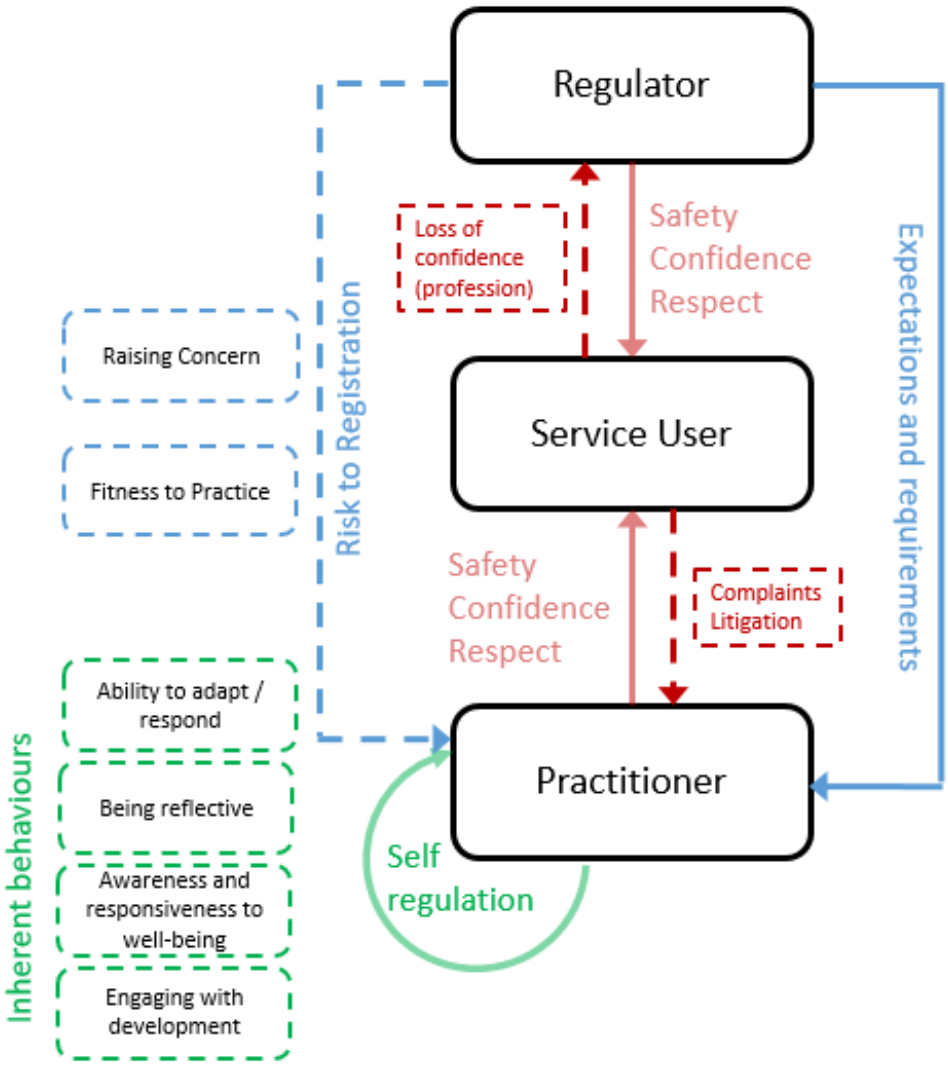

Figure 7.3 Potential impact of failure to comply or achieve professional expectations and requirements

The 'indicators' depicted in the figure are the means by which loss of the ideal situation is detected, and the impact is what may result from the deficit and who is affected.

- Complaints and litigation initiated by a service user will directly impact the individual practitioner. This has the potential to be a result of an actual or perceived loss of confidence by the service user and/or concern that safe care delivery or respect has not been maintained.
- When concerns are raised, or fitness to practise instigated, there is a risk to the individual practitioner's registration. The initiation of these processes is likely to be a result of demonstrable failure in compliance with the expectations and requirements set by the regulator.
- A diminished ability to self-regulate could be both a contributory factor in failure of an ideal system, resulting in complaints, litigation and loss of service user confidence, or a

consequence of a practitioner receiving complaints or concerns. It could also result in a practitioner having to work under conditions, so potentially a practitioner could be temporarily placed in a position where they are not trusted to self-regulate, by having conditions placed, it could be viewed that someone is doing some of that regulation for them. Either way, there is a question to consider on whether this has an adverse effect on the well-being of the individual practitioner and potentially affect their ability to engage with self-regulation activities and adversely impact the care they deliver to service users.

A survey of over 2000 UK dentists by the British Dental Association found there were high reported levels of stress, burnout and low well-being. The most common causes of stress were related to the threat of complaints/litigation and dissatisfied patients (Collin et al., 2019).

- Loss of the service user's confidence in the profession is an adverse outcome which impacts on the regulator. Public confidence in a profession is a key priority for regulatory bodies and loss of this could potentially result in review or reinforcement in systems of expectations and requirements which are in place.

7.8 A changing landscape

One of the key elements of the undergraduate dental curriculum is that the new graduate is a 'safe beginner', defined by the GDC in their 'Preparing for Practice' document. This 'safe beginner' knows their limits and raises concern when appropriate. Dental educators are aware of this in terms of the 'end product' or new graduate, but have faced criticism of this approach from the Dental Foundation Trainers and wider dental workforce in terms of the clinical experience and standard of new graduates (Oxley et al., 2017, Gilmour et al., 2018). Whilst these concerns are not directly related to professionalism attributes and centre more on clinical skills, it illustrates that the undergraduate curricula has implications for a wider group. This signifies the importance of inclusion/involvement, or at a minimum information dissemination, to that wider group regarding changes in undergraduate requirements; this would include those related to professionalism elements of the curriculum.

The impact of anxiety, stress, burnout and resilience in the profession, together with potential 'defensive dentistry' are frequent topics in the popular dental literature (Chipchase et al., 2017, Al Hassan, 2017, Collin et al., 2019). There are systems in which all professionals work and the human factors and societal factors cannot be removed from these as they are integrally linked. It is necessary to be mindful that these are appropriately represented in undergraduate training and that the new graduate enters practise equipped with the skills needed to withstand the pressures they will encounter.

The need to review, reflect and revise elements associated with undergraduate training has been recognised by the UK dental regulator, particularly with reference to shifting societal expectations:

> *'The learning outcomes should be responsive to changes in public expectations and evolve in the light of such changes' (General Dental Council, 2015a p.5)*

These factors support recommendations for multiple stakeholder input in regulatory professionalism requirements including: patients; the public; education providers; representation of the profession. In education requirements inclusion of 'educationalist' input benefits in terms of promoting formats which align utility for the education provider in applying requirements with quality assurance requirements of a regulator. The ultimate aim is providing the best for patients, who view those who provide their healthcare as professionals.

7.8.1 Areas for future work

Throughout this study avenues for further investigation have been identified. Some of these are directly linked to the research, which has been undertaken, others are the result of thinking more widely and include areas at the periphery of the current work.

The challenges of developing professionalism requirements have been acknowledged and the necessity to represent societal expectations acknowledged. What is not understood is the challenges of setting requirements, which satisfy the needs and expectations of diverse societal groups which may include inter-generational expectations and exploration of the impact of cultural diversity on developing professionalism-related requirements.

A topic peripherally touched on in this discussion is the interplay of societal changes in environmental considerations and the way the profession approaches aspects such as materials usage.

It has been noted in previous chapters of this thesis that there have been revisions to the documents analysed in this study. This includes updated versions of NMC and GMC documentation. The regulation of Social Workers in England is moving away from the HCPC and a new regulator, Social Work England, is being established. Revisiting the changes in new versions of documents would be interesting, investigating whether thematic content or emphasis changes and whether there is a change in the style of presenting requirements.

A final avenue of future work could result from the discussion surrounding which aspects of self-regulation are affected when failure to comply, or achieve, professional expectations and

requirements occurs. This may focus on personal inherent behaviours contributing to self-regulation which are most affected, and the impact of this.

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Appendix A

Document mentioned in Chapter 4 (section 4.3.1). Each statement in the 'Standards for the Dental Team' (General Dental Council, 2013c) document was mapped by identified sub-theme. One excel worksheet was created for each of the nine Principles within the 'Standards' document. An example of the sub-theme spreadsheets that were developed is presented below.

Financial sub-theme

Principle	Type	Must	Should	Statement
1	Pt Expec			That their interests will be put before financial gain and business need.
				Redress if they suffer harm during dental treatment.
	Standards			1.7 Put patients' interests before your own or those of any colleague, business or organisation.
				1.8 Have appropriate arrangements in place for patients to seek compensation if they suffer harm.
		X		1.7.1 You must always put your patients' interests before any financial, personal or other gain.
		X		1.7.2 If you work in a practice that provides both NHS (or equivalent health service) and private treatment (a mixed practice), you must make clear to your patients which treatments can be provided under the NHS (or equivalent health service) and which can only be provided on a private basis.
		X		1.7.3 You must not mislead patients into believing that treatments which are available on the NHS (or equivalent health service) can only be provided privately. If you work in a purely private practice, you should make sure that patients know this before they attend for treatment.
		X		1.7.4 If you work in a mixed practice, you must not pressurise patients into having private treatment if it is available to them under the NHS (or equivalent health service) and they would prefer to have it under the NHS (or equivalent health service).
		X		1.7.5 You must refuse any gifts, payment or hospitality if accepting them could affect, or could appear to affect, your professional judgment.
		X		1.8.1 You must have appropriate insurance or indemnity in place to make sure your patients can claim any compensation to which they may be entitled (See our website for further guidance on what types of insurance or indemnity the GDC considers to be appropriate).

Principle	Type	Must	Should	Statement
2	Pt Expec			To know how much their treatment will cost before it starts, and to be told about any changes.
	Standards			2.4 Give patients clear information about costs
	Guidance	X		2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must: • explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and • give full information on the treatment you propose and the possible costs.
		X		2.3.7 Whenever you provide a treatment plan you must include: • the proposed treatment; • a realistic indication of the cost; • whether the treatment is being provided under the NHS (or equivalent health service) or privately (if mixed, the treatment plan should clearly indicate which elements are being provided under which arrangement).
		X	X	2.3.8 You should keep the treatment plan and estimated costs under review during treatment. You must inform your patients immediately if the treatment plan changes and provide them with an updated version in writing.
		X	X	2.4.1 You must make sure that a simple price list is clearly displayed in your reception or waiting area. This should include a list of basic items including a consultation, a single-surface filling, an extraction, radiographs (bitewing or pan-oral) and treatment provided by the hygienist. For items which may vary in cost, a 'from - to' price range can be shown.
		X		2.4.2 You must give clear information on prices in your practice literature and on your websites - patients should not have to ask for this information.
3	Standards			3.1 Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.
	Guidance		X	3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include: • options for treatment, the risks and the potential benefits; • why you think a particular treatment is necessary and appropriate for them; • the consequences, risks and benefits of the treatment you propose; • the likely prognosis; • your recommended option; • the cost of the proposed treatment; • what might happen if the proposed treatment is not carried out; and • whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.
		X		3.3.5 If you think that you need to change a patient's agreed treatment or the estimated cost, you must obtain your patient's consent to the changes and document that you have done so.
4	Guidance		X	4.4.2 In some circumstances you can charge patients a fee for accessing their records. The maximum you can charge depends on whether the records are paper copies or held electronically. You should check the latest guidance issued by your national Information Commissioner's Office.
5	Guidance		X	5.3.9 If a complaint is justified, you should offer a fair solution. This may include offering to put things right at your own expense if you have made a mistake.