



## Unprofessional behaviour in medical students: A questionnaire-based pilot study comparing perceptions of the public with medical students and doctors

Susannah Brockbank, Timothy J. David & Leena Patel

**To cite this article:** Susannah Brockbank, Timothy J. David & Leena Patel (2011) Unprofessional behaviour in medical students: A questionnaire-based pilot study comparing perceptions of the public with medical students and doctors, Medical Teacher, 33:9, e501-e508, DOI: [10.3109/0142159X.2011.599450](https://doi.org/10.3109/0142159X.2011.599450)

**To link to this article:** <https://doi.org/10.3109/0142159X.2011.599450>



Published online: 19 Aug 2011.



Submit your article to this journal [↗](#)



Article views: 3824



View related articles [↗](#)



Citing articles: 7 View citing articles [↗](#)

## WEB PAPER

# Unprofessional behaviour in medical students: A questionnaire-based pilot study comparing perceptions of the public with medical students and doctors

SUSANNAH BROCKBANK<sup>1,2</sup>, TIMOTHY J. DAVID<sup>1,2</sup> & LEENA PATEL<sup>1,2</sup>

<sup>1</sup>The University of Manchester, UK, <sup>2</sup>Central Manchester University Hospitals NHS Foundation Trust, UK

## Abstract

**Background:** Evidence suggests that doctors and medical students use different strategies to evaluate unprofessional behaviour. Anecdotal evidence suggests that the public and profession may judge misdemeanours differently.

**Aims:** To explore whether members of the public will judge examples of medical student misconduct more harshly than medical students and doctors.

**Methods:** This was a pilot cross-sectional survey of the public, medical students and doctors. For 10 hypothetical examples of medical student misconduct and one of appropriate conduct in a questionnaire, participants were asked to (1) indicate the level of acceptability and (2) to choose the sanction they considered most appropriate for each.

**Results:** Overall, doctors were harsher than students and the public were harsher than doctors in their choice of sanctions. The most lenient outcomes were selected by students for deception in an examination, nonattendance and dishonesty. The most punitive were chosen by the public for forgery, criminal conviction, misrepresenting qualifications, alcohol and drug misuse and lack of insight.

**Conclusions:** The public judge misdemeanours among medical students more harshly than do medical students and medical professionals. This implies that views of lay members should be sought by medical schools when promoting professionalism and considering cases of medical student misconduct.

## Introduction

Public trust in doctors as well as in the regulation and accountability of the profession are vital for the practice of medicine. Core professional values must be upheld not only by those who are qualified but also by medical students. Unprofessional behaviour at medical school is associated with early academic difficulties (Yates & James 2010), unsatisfactory progress (Bennett et al. 2005) and poor clinical performance (Arnold 2002), and is a predictor of serious misconduct among practitioners (Papadakis et al. 2004). Thus, as the medical practitioners of the future, the standards of behaviours expected of medical students, within as well as outside the learning environment, are different from those of students on non-medical programmes.

In the UK, the General Medical Council (GMC) has provided guidance for medical students and those involved with their education about the professional behaviour expected of these students, and in particular the standards that define whether or not they are deemed fit to practice (GMC 2009). Notwithstanding this, there are wide differences among staff as well as students in how they define professionalism, make judgements about whether a behaviour is or is not acceptable, and thereafter decide on what sanctions,

## Practice points

- Lapses in medical student behaviour may be judged differently by the public, doctors and medical students.
- When promoting professionalism among medical students, the public's perceptions of the medical profession should be taken into account.
- When considering lapses in medical student behaviour, it may be helpful to consider opinions of members of the public, doctors and medical students.

if any, to impose (Hunt et al. 1989; Ginsburg et al. 2000; Green 2009).

A recent study by Roff et al. (2011) showed that students and faculty members largely agreed on sanctions that should be imposed for a variety of misdemeanours; however, there were a cluster of examples in which medical students selected less harsh sanctions than faculty members. When evaluating professionalism, Ginsburg et al. emphasise the importance of operationalising abstract principles into more directly observable behaviours in context (Ginsburg et al. 2002). Through a series of studies (Lingard et al. 2001; Ginsburg et al. 2003a, 2003b), they illustrate that medical students use reasoning

*Correspondence:* L. Patel, Department of Paediatric Endocrinology, Royal Manchester Children's Hospital, Manchester M13 9WL, UK; Tel: 0161 701 1632; fax: 0161 701 1631; email: lp@manchester.ac.uk

strategies that take into consideration principles of professionalism, implications of the action and effect (gut instinct) to interpret and justify actions in hypothetical professional dilemmas (Lingard et al. 2001; Ginsburg et al. 2003b) as well as in professional lapses that they had personally experienced (Ginsburg et al. 2003a).

Faculty members, however, analyse professionalism in different ways – they place emphasis on the behaviour itself, possible explanations underlying it, the likely consequences of students' actions or some combinations of these elements (Ginsburg et al. 2004, 2008, 2009). Additionally, concerns about the welfare and future career prospects for a student, as well as professional accountability to the public, are likely to influence decisions about how best to address problematic behaviour. Consequently, the judgements that medical practitioners make may be ambiguous and lack consistency. For example, what one considers as unprofessional can be viewed as perfectly reasonable by another. Even honesty, the most valued principle, can be applied in disparate ways such that dishonesty, for example in the form of a student not revealing information requested by a patient, may be interpreted as acceptable or unacceptable depending on whether the student's intention was to prevent distress to the patient or to protect his/her own interests (Ginsburg et al. 2009).

Ginsburg et al. (2009) draw attention to the general tendency to make snap judgements from the behaviour that one sees as well as attribution error (Rees & Knight 2008). When not explicitly known, the reasoning behind the behaviour is inferred and is more likely to be attributed to individual factors such as personal values or personality rather than to external factors or the situation. With these varied perspectives with which they view a deviant behaviour, it is therefore not surprising that the choice of interventions, outcomes and sanctions recommended by staff and students may vary radically from condoning the behaviour to unredeemable punitive sanction (Osborn 2000; Smith 2000).

Despite the considerable literature on medical students and staff views about students' misdemeanours (Anderson & Obenshain 1994; Lingard et al. 2001; Rennie & Crosby 2001; Ginsburg et al. 2003a, 2003b, 2004, 2008, 2009), we are not aware of any studies that explored the perceptions of the public. There has, however, been a number of high-profile medical misconduct cases in the recent past and the medical profession has been criticised by the media for rank-closing and self-protection (Bunyan 2004; Jenkins 2004; Laurance 2011). Notably, Dame Janet Smith, the judge who led the Shipman Inquiry, was critical of the GMC and the medical profession as a whole for 'closing rank' (The Shipman Inquiry 2001).

A national survey of doctors' attitudes to unprofessional behaviour in the USA found that less than half of the doctors who reported having observed unprofessional behaviour among their colleagues had reported this (Campbell et al. 2007). Roff and Dherwani (2011) showed that consensus exists between medical educators in relation to how medical students should respond to and report unprofessional behaviour among their colleagues. In a study of medical students, however, it was discovered that only a minority would be willing to 'whistle-blow' on one of their peers (Rennie & Crosby 2002). We theorised that, given this reputation for

protectionism among doctors, the public would judge unprofessional behaviours more harshly. In addition, given doctors' and students' previously documented reticence to report their colleagues, we hypothesised that these groups would judge misdemeanours less harshly.

We expected that the public would approach professional misbehaviour with a different perspective from medical students and doctors, and would judge the action itself at face value without being influenced by principles universally accepted within the profession. Evidence suggests that doctors are the most trusted profession by society and thus doctors have a duty to uphold this trust (Ipsos MORI 2009). Anecdotal reports suggest that any behaviour that appears to undermine public confidence in the profession is likely to be judged severely and addressed with harsher sanctions than might be considered by medical students and professionals (Rapid responses 2000; Smith 2000).

We therefore undertook this study to examine the perceptions and outcome judgements of members of the public compared with those of medical students and doctors to a range of deviant behaviours in hypothetical examples of medical student misconduct.

## Methods

We undertook a cross-sectional pilot study and compared questionnaire responses from members of the public with those from medical students and doctors. This study used a convenience sample for all groups over the same 1-month time period. For members of the public, parents or carers of paediatric patients were approached whilst waiting for outpatient clinic appointments at a single children's hospital site. They were invited to participate in the study whilst waiting to be seen by various healthcare professionals. Education sessions at the hospital were identified for different year groups of medical students and groups of doctors in order to ensure that participants were not recruited more than once. All medical students and doctors who attended these education sessions were invited to participate in the study.

The questionnaire required responses to a series of scenarios (S1–S11), and it was designed, tested and refined before being distributed to study participants. This brief testing was done to ensure that the questions were easy to understand and answer. Through the scenarios, our aim was to present actions of medical students in unambiguous contexts rather than professionally challenging dilemmas. The situations were chosen based on (1) the authors' experiences of misconduct among medical students and (2) a range of behaviours, in addition to cheating, which maps to the GMC guidance about a student's fitness to practice medicine (GMC 2009). The use of some of these scenarios was also supported by their use in previous work surveying attitudes of doctors or medical students to medical student misconduct (Sierles et al. 1980; Rennie & Rudland 2003). Of the 11 scenarios in the questionnaire, 10 were hypothetical examples of misconduct among medical students (Table 1; *Note: Full text of scenarios and questions used are available in Appendix*). One 'dummy' scenario considering an example of appropriate behaviour was also included (S5). This scenario described a medical

**Table 1.** Showing the results of *t*-tests on the responses to question 2 – which sanction was deemed most appropriate.

Scenario	Description of context and behaviour ( <i>Category for unprofessional behaviour</i> )	Public mean	Doctors mean	Medical students mean	Public versus medical students <i>t</i> -test <i>p</i> <sup>a</sup>	Doctors versus medical students <i>t</i> -test <i>p</i>	Public versus doctors <i>t</i> -test <i>p</i>
1	Consulting a textbook in an examination; isolated event ( <i>cheating in examination</i> )	3.1	3.4	3.6	0.02	0.3	0.2
2	Fabricating a blood pressure result in an OSCE ( <i>deception about patient assessment in an examination</i> )	3.2	2.9	<b>1.8</b>	<b>&lt;0.001</b>	<b>&lt;0.001</b>	0.1
3	Making up results in a research project ( <i>dishonesty by falsifying research</i> )	3.2	3.4	<b>2.8</b>	0.02	<b>0.005</b>	0.4
4	Copying written work and not referencing ( <i>plagiarising</i> )	3.6	3.4	3.6	1.0	0.3	0.3
6	Nonattendance and lying about the reason; repeated pattern ( <i>persistent irresponsibility and dishonesty</i> )	3.7	3.6	<b>2.3</b>	<b>&lt;0.001</b>	<b>&lt;0.001</b>	0.9
7	Significant nonattendance and deception by forging a supervisor's signature ( <i>persistent irresponsibility and cheating</i> )	<b>4.5</b>	4.0	3.5	<b>&lt;0.001</b>	0.06	0.09
8	Attending ward teaching whilst drunk ( <i>alcohol misuse and lack of insight</i> )	<b>4.6</b>	3.9	3.1	<b>&lt;0.001</b>	0.03	0.03
9	Defrauding the benefit system and being convicted ( <i>criminal conviction for financial fraud</i> )	<b>5.0</b>	4.9	4.2	<b>0.009</b>	0.05	0.6
10	Impaired ability to study and failing examinations due to heavy cannabis use ( <i>drug misuse and lack of insight</i> )	<b>5.1</b>	4.4	3.9	<b>&lt;0.001</b>	0.06	<b>0.004</b>
11	Introducing oneself as a doctor before examining a patient's breasts ( <i>misrepresenting qualifications</i> )	<b>5.1</b>	4.5	4.0	<b>&lt;0.001</b>	0.2	0.6

Notes: The responses on the questionnaire: 1, no reprimand; 2, reprimand/disciplinary warning only and no punishment; 3, repeating the examinations/essay/project; 4, repeating the year of study; 5, temporary suspension; 6, studies terminated and registration as a student of the University should cease.

Scenario 5 excluded as this was the 'dummy' scenario, i.e. not misconduct.

<sup>a</sup>*p* < 0.01 was deemed significant (represented in bold face).

student stopping to help an injured motorcyclist and thus missing lectures.

For each scenario, two questions were presented with response options on an ordinal scale. The first question was intended to validate our assumptions that 10 of the 11 scenarios represented unprofessional behaviours. It referred to the level of acceptability of the behaviour and participants were required to judge the behaviour to be: (1) 'okay', (2) 'possibly unacceptable' or (3) 'definitely unacceptable'. The second question then asked which sanction the participant deemed most appropriate in the context described. The sanctions were designed on a 6-point scale of increasing harshness. In 5 of the 11 scenarios, one of the options was excluded, as it did not apply to the misconduct described (S5, 8, 9, 10, 11). For example, the scenario in which a student defrauds the benefit system had no direct connection to any single assessment or placement and it was therefore not appropriate to suggest repeating such activities (Appendix). This second question was designed to encompass disciplinary

actions that are commonly used to deal with misconduct among medical students. Before distributing the questionnaire, the scenarios and questions were discussed with a small pilot group composed of doctors, medical students and members of the public. Changes were subsequently made to eliminate ambiguities and ensure comprehension.

The questionnaire was distributed by the primary researcher to 180 participants (61 members of the public, 63 doctors in active practice and 56 medical students), when the primary researcher (SB) was a fourth year medical student at the University of Manchester. This period of time was chosen as it was allotted for independent research projects. No incentives were offered for participating in the study. A covering letter was included, which explained confidentiality measures and that ethical approval had been gained for the study. The questionnaires were completed by participants independently and anonymously. They were returned to the receptionist in the outpatient department or education centre either in person or by mail and collected by the researcher.

Approval for this study was obtained from the Tameside and Glossop NHS Research and Ethics Committee and the University of Manchester Research Ethics Committee.

### Statistical analysis

Advice about statistical analysis was sought from a medical statistician. Responses from each questionnaire were entered into SPSS version 16. To test the validity to our assumption that 10 scenarios represented unacceptable behaviours and one was an example of acceptable behaviour, we examined the responses of each group to question 1 for each scenario: median values are presented as these data were not normally distributed.

For question 2, the data were normally distributed. Before analysing each scenario separately, we first identified whether there was a significant main effect of group for question 2. The rationale for this was that if there were no significant main effect of group then any differences in scenarios were likely to have been due to chance. Therefore, responses were first analysed as a repeated measures ANOVA with scenario (11 scenarios) serving as a within subject factor and group (medical students versus doctors versus the public) as a between subjects factors. As a significant main effect of group was found ( $p < 0.001$ ), responses to question 2 for individual scenarios were then compared using independent samples *t*-tests. Owing to multiple significance testing, *p*-values lower than 0.01 were considered significant.

The mean responses to question 2 revealed a dichotomy with all responses to scenarios 1 to 4 and scenario 6 being  $< 4$ . Therefore, based on a mean response of  $< 4$  or  $\geq 4$  by the public to question 2 (Table 1), we subsequently categorised the behaviours depicted by the scenarios as (1) less serious transgressions warranting relatively lenient action or remediation or (2) serious unprofessional behaviour requiring more severe disciplinary action.

## Results

### Questionnaire response rate

In this study, 130 out of the 180 questionnaires were returned giving a response rate of 72%: 43/56 (77%) medical students, 33/63 (52% doctors) and 54/61 (89%) members of the public.

### Level of acceptability of behaviour in each scenario

The median response of all groups to question 1 for all 10 misconduct scenarios was 3, i.e. that the behaviour was 'definitely unacceptable'. Conversely, median responses of all groups to the 'dummy' scenario were that this behaviour was 'acceptable'.

### Comparison of group responses to the most appropriate sanction for the scenarios

Analysis of responses to question 2 using repeated measures ANOVA showed a significant main effect of group.

Overall, doctors were harsher than students and the public harsher than doctors in their choice of outcomes (Table 1).

Among the three groups, scenarios 2 and 6 (deception about patient assessment in an examination, and persistent irresponsibility and dishonesty, respectively) attracted the most lenient outcomes overall, these being from the medical student group. Of the sanctions chosen, the most punitive (mean  $\geq 4$  to question 2) were by the public and these were for scenarios 7–11 (S7, persistent irresponsibility and forgery; S8, alcohol misuse and lack of insight; S9, criminal conviction for financial fraud; S10, drug misuse and lack of insight; S11, misrepresenting qualifications). Doctors' and students' responses also differentiated three of these more severely (S9, S10, S11) than the other misconduct scenarios.

Sanctions chosen differed significantly between the groups for all but two scenarios (S1 and S4 – cheating in examination and plagiarising; Table 1). Compared with the public and doctors, students' choices were lenient for deception in a clinical examination (S2), and persistent nonattendance and dishonesty (S6). Doctors were harsher than students for falsifying research (S3). The public selected punitive outcomes compared with students for five scenarios (S7–S11). Doctors' choices were only marginally lower for four of these five scenarios. For drug misuse and lack of insight (S10), however, the public were significantly harsher compared with medical students as well doctors.

## Discussion

### Principal findings

From responses to scenarios in a questionnaire, we found that there seemed to be consensus among the public, doctors and medical students about a range of medical student behaviours being 'definitely unacceptable' and one being 'acceptable'. Overall, the public were inclined to be stern compared with doctors, and students were most lenient. Despite this, all three groups consistently judged some behaviours more harshly than others. Thus, criminal conviction for financial fraud (S9), misrepresenting qualifications (S11), alcohol and drug misuse and lack of insight (S8 and S10) were perceived as serious unprofessional behaviours.

Cheating in examination (S1) and plagiarism (S4) appeared to be viewed as mild transgressions by all subject groups, as the outcomes chosen were more remedial than punitive. Unlike the public and practicing professionals, there was a tendency for students to condone dishonesty along with repeated nonattendance (S6), deception in a clinical examination (S2) and falsifying research (S3).

### Explanations for overall differences between the public's perceptions and those of doctors and students

Our findings are consistent with the expectation that the public would approach and judge professional behaviours from a different perspective from doctors and students. As the receivers of health care, members of the public are less able to consider how they might behave if they were in the same



situation as those aspiring to deliver the care. The public expects absolute honesty, trustworthiness and impeccable professional behaviour from current as well as future medical practitioners (Askham & Chisholm 2006). Consequently, any deviation that betrays this trust and compromises public safety would be judged sternly. This is illustrated by the prolific communication in the BMJ that ensued when, in August 2000, a UK medical student was caught cheating in a final long-case examination but no action was taken to punish this student (Smith 2000). A number of doctors and students condoned this behaviour, as in our study (Rapid responses 2000).

A desire for preservation of the profession may lead doctors and students to shelter their colleagues in this way. The few members of the public who responded, however, expressed the opposite opinion that this behaviour is not only unacceptable, but that this episode has wider implications for the trustworthiness of the medical profession, as illustrated by this quotation: 'I must applaud the BMJ for bringing this case to more general notice. The article rightly points out the crucial importance of trust in the practice of medicine - as it is in many other walks of life. If somebody breaks trust it is, and should be, very difficult for them to rebuild it' (Rapid responses 2000).

Perceptions about professionalism and related behaviours have been described to vary among medical faculty (Ginsburg et al. 2004), between faculty and medical students (Anderson & Obenshain 1994; Osborn 2000) and among students (Rennie & Crosby 2001). This is partly because the process by which any individual approaches, interprets and judges another's actions is complex. Whilst some might give more importance to the action itself, others, especially students, are likely to evaluate the nature and context of the behaviour, possible reasons leading to it, whether it is isolated or part of a pattern, and its implications for patients, the student and others (Lingard et al. 2001; Ginsburg et al. 2003a, 2003b, 2004, 2008, 2009).

When awarding an outcome, students appear more likely than doctors to rationalise, make allowances, or even excuse certain behaviours. Doctors and students will also be more aware than the public that medical students have little clinical responsibility and therefore excuse some examples of misconduct. Although teaching and evaluating professionalism in undergraduate education poses major challenges (Hickson et al. 2007; Parker & Wilkinson 2008; Hawkins et al. 2009; Lucey & Souba 2010), it also implies that students have gaps in their learning and development about professionalism, and consequently may not always behave impeccably. In addition, contradictory experiences and messages that students may encounter during their formative years can adversely affect their ethical maturation. Feudtner et al. (1994) described this as 'ethical erosion'.

Although the outcomes chosen by doctors were not as harsh as the public, we believe their choices will have been fairer and more justified. In line with the body of evidence discussed above, they may have applied their complex clinical decision-making skills and the wisdom that comes with enriched experiences in the field of medicine and medical education (Ginsburg et al. 2004, 2008, 2009). Conversely, however, the less harsh responses may have resulted from

doctors, we theorise, 'closing rank' and choosing to protect the medical student in question.

#### Comparatively lenient approach by students to less serious transgressions

The outcomes chosen by our three subject groups suggested that they were able to differentiate some behaviours, notably those prohibited by law (criminal activity and drug misuse), as being more serious than others. The less serious transgressions included dishonesty along with repeated nonattendance (S6), deception in a clinical examination (S2) and falsifying research (S3), and students were relatively lenient about these. It is possible that they did not consider attendance as a core value which reflects on their integrity, did not equate nonattendance with irresponsibility or recognise it as an unprofessional attribute, and this should be formally emphasised to all students. In addition, they may have made allowances for behaviours that occur in artificial settings such as an objective structured clinical examination (OSCE) and research laboratory, and which do not directly impact on patient care. Such reasons did not, however, detract the doctors from indicating disapproval.

#### General agreement about cheating

Within the medical education environment, lapses in behaviour among students and staff are well recognised and some, such as cheating in examinations, are more common (Stimmel & Yens 1982; Anderson & Obenshain 1994; Rennie & Crosby 2001). We found reasonable agreement between the public, doctors and medical students for the outcomes to both scenarios depicting academic dishonesty. Their outcome preferences suggest that they viewed these as pardonable misdemeanours and amenable to remedial actions. Not all forms of cheating and plagiarism are intentional and some can be attributed to students' lack of understanding or confusion about rules for referencing, as reported in a previous study (Rennie & Crosby 2001).

Our results are in keeping with the similar opinions of faculty and medical students to various forms of academic cheating in another questionnaire-based study (Anderson & Obenshain 1994). They contrast, however, with the radically different outcomes proposed by staff and students to a cheating incidence involving two medical students in USA (Osborn 2000). The author presents an insightful analysis of the complex factors that lead to such misconduct and the subsequent outcomes: students seemed to take into account factors such as remorse and the intention behind the action when selecting an appropriate punishment, whereas staff made a judgement based on the action itself (plagiarism, in this example) (Osborn 2000). Although many students deemed plagiarism to be unprofessional, cheating to help a friend was acceptable. In contrast to staff, their value system was not as strict, and helping each other superseded honesty in this context.

## Methodological limitations

As members of the public were recruited from the waiting room of the paediatric out-patient clinic, their positive or negative experiences of encounters with healthcare professionals may have influenced the results. These particular individuals will, more than likely, have had more contact with medical professionals than average for their age. They may even have had first-hand experience of behaviour they deemed unprofessional, either in medical students or doctors.

Only 3 of the 11 scenarios specified whether the behaviour was isolated or repeated. In reality, when there are concerns about student misconduct, a panel will take into consideration information gathered from multiple sources over time. It is unusual for sanctions to be imposed by individual decisions from isolated behaviours.

In the absence of a validated instrument for comparing attitudes in this manner, we designed the questionnaire based on our experiences of student misconduct, GMC guidance about a student's fitness to practice medicine (GMC 2009) and previous work surveying attitudes of doctors or medical students to medical student misconduct (Sierles et al. 1980; Rennie & Rudland 2003). However, the responses in the questionnaire may not have been truly representative of participants' views. For example, all the possible options were punitive, whereas respondents may actually have chosen a remedial action had this been available as a response. A previous study suggested that faculty prefer an official meeting and are less likely to choose suspension and expulsion for hypothetical examples of unprofessional behaviour among medical students (Anderson & Obenshain 1994). For the spectrum of behaviours that arouse concerns, Hickson et al. (2007) propose graded interventions starting with an informal awareness raising discussion and followed by more formal actions. Had we included an informal meeting and supportive intervention to help the student (e.g. through close supervision or counseling) among the potential outcomes, doctors and students may have been more inclined to choose these options. This is particularly pertinent as, in general, doctors undergoing fitness to practice proceedings, for example, due to a substance misuse problem, would be offered the opportunity to access help rather than immediate punitive action. Furthermore, doctors and students may have identified the unprofessional behaviour described, particularly substance misuse, as symptomatic of an underlying psychopathology. Had a patient presented with erratic behaviour and substance misuse to his/her doctor, the search for an underlying cause and appropriate supportive action would certainly be the first response, rather than punishment. These factors may have revealed wider differences when compared with the public.

Similarly, people may have interpreted the sanctions differently to how we had intended, such as believing that 'temporary suspension' may have been a measure used whilst an incident was being investigated and not a final sanction. We attempted to overcome these issues by piloting the questionnaire prior to distribution.

Ginsburg and coworkers presented students and faculty with video scenarios showing actions of students in challenging professional dilemmas (Ginsburg et al. 2003b, 2004).

There was considerable disparity in the way the behaviours were interpreted and consequently judged. Our focus was on outcome decisions for a range of behaviours. Therefore, to eliminate any confusion or controversy in interpretation, the behaviours and contexts presented in the scenarios were relatively unambiguous.

As we did not wish to overwhelm participants, we restricted the number of scenarios and were therefore limited in the number of critical behaviours we could incorporate. From the frequently observed negative behaviours that predict future misconduct, irresponsibility and unreliability were depicted in our 11 scenarios (Papadakis et al. 2001; Teherani et al. 2005, 2009). We did not, however, include two important behaviours: diminished capacity for self-improvement and lack of initiative.

In contrast to the public and medical students, only 50% of the doctors completed the questionnaires. This low response rate may simply have been lack of time as they were all active practitioners. Other possible explanations include resentment at being disturbed during education sessions, apathy about the topic of the research, a reluctance to overtly give opinions on subordinates' behaviours where they are exemplary role models, lack of moral courage and fear of jeopardising the reputation of the medical profession.

## Conclusion

The results of this study are consistent with the hypothesis that members of the public judge misdemeanours among medical students more harshly than do medical students and medical professionals. Where professionals may attempt to rationalise or even excuse the behaviour of their colleagues, the public would expect unfailingly professional behaviour and trustworthiness in their doctor. Whereas the GMC routinely includes lay members on fitness to practice panels, this is not always the case at medical schools and practices vary widely. In the GMC's guidance on medical student fitness to practice, it is suggested that 'in determining panel composition, the school should consider whether it would be practical to include... a student representative who does not know the student being investigated' (GMC 2009). Our study implies that views of lay people, as well as doctors and peers, should be considered in medical student fitness to practice proceedings.

In addition, a wide spectrum of student behaviours may arouse attention, and agreement may not be reached on which behaviour is below the acceptable threshold (Ginsburg et al. 2004). Considerable judgement is required by individual members of staff and medical schools in differentiating appropriate from inappropriate behaviour, making the distinction between a relatively minor transgression and unprofessional conduct, and deciding on whether further action and any sanction is required. Our study suggests that all deviations in behaviour are not perceived by the public and professionals to be serious. In addition, all are not necessarily intentionally immoral. Each transgression is unique in its nature and context and therefore necessitates individual consideration for the welfare of the student as well as accountability to the public. These factors should be considered in medical professionalism education, in order that there is a realisation among medical

students that patients, doctors and peers all consider misconduct differently.

## Acknowledgements

The authors sincerely thank Dr Isla Gemmell, Medical Statistician, The University of Manchester, for advice about statistical analysis.

**Declaration of interest:** The authors report no declarations of interest.

## Notes on contributors

SUSANNAH BROCKBANK, MB, ChB (Euro), was a fourth year medical student at the University of Manchester when this research was conducted. She has since graduated and is currently a foundation doctor at Trafford General Hospital.

TIMOTHY J. DAVID MB, ChB, PhD, MD (Bristol), is a professor of Paediatrics and Academic Lead for Student Fitness to Practise at the University of Manchester, dealing with all serious cases of unprofessional behaviour, misconduct and ill health causing impairment among medical, dental, nursing, pharmacy, psychology and social work students at the University.

LEENA PATEL MB, BS, MD, MRCP (UK), is a senior lecturer in Child Health at The University of Manchester and honorary consultant paediatrician at Central Manchester University Hospitals NHS Foundation Trust.

## References

- Anderson RE, Obenshain SS. 1994. Cheating by students: Findings, reflections, and remedies. *Acad Med* 69:323–332.
- Arnold L. 2002. Assessing professional behavior: Yesterday, today, and tomorrow. *Acad Med* 77:502–515.
- Askham J, Chisholm A. 2006. Patient-centred medical professionalism: Towards an agenda for research and action. Oxford: Picker Institute.
- Bennett AJ, Roman B, Arnold LM, Kay J, Goldenhar LM. 2005. Professionalism deficits among medical students: Models of identification and intervention. *Acad Psychiatry* 29:426–432.
- Bunyan N. 2004. Shipman Judge Attacks GMC Self-Interest [Internet] The Telegraph December 10 2004. [Published 2011 April 24]. Available from: <http://www.telegraph.co.uk/news/uknews/1478680/Shipman-judge-attacks-GMC-self-interest.html>
- Campbell EG, Regan S, Gruen RL, Ferris TG, Rao SR, Cleary PD, Blumenthal D. 2007. Professionalism in medicine: Results of a national survey of physicians. *Ann Intern Med* 147:795–802.
- Feudtner C, Christakis DA, Christakis NA. 1994. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. *Acad Med* 69:670–679.
- General Medical Council. 2009. Medical students: Professional values and fitness to practise [Internet]. London: General Medical Council. [Published 2011 April 24]. Available from: [http://www.gmc-uk.org/education/undergraduate/professional\\_behaviour.asp](http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp)
- Ginsburg S, Lingard L, Regehr G, Underwood K. 2008. Know when to rock the boat: How faculty rationalize students' behaviors. *J Gen Intern Med* 23:942–947.
- Ginsburg S, Regehr G, Hatala R, McNaughton N, Frohna A, Hodges B, Lingard L, Stern D. 2000. Context, conflict, and resolution: A new conceptual framework for evaluating professionalism. *Acad Med* 75:S6–S11.
- Ginsburg S, Regehr G, Lingard L. 2003a. To be and not to be: The paradox of the emerging professional stance. *Med Educ* 37:350–357.
- Ginsburg S, Regehr G, Lingard L. 2003b. The disavowed curriculum: Understanding students' reasoning in professionally challenging situations. *J Gen Intern Med* 18:1015–1022.
- Ginsburg S, Regehr G, Lingard L. 2004. Basing the evaluation of professionalism on observable behaviors: A cautionary tale. *Acad Med* 79:S1–S4.
- Ginsburg S, Regehr G, Mylopoulos M. 2009. From behaviours to attributions: Further concerns regarding the evaluation of professionalism. *Med Educ* 43:414–425.
- Ginsburg S, Regehr G, Stern D, Lingard L. 2002. The anatomy of the professional lapse: Bridging the gap between traditional frameworks and students' perceptions. *Acad Med* 77:516–522.
- Green M, Zick A, Makoul G. 2009. Defining professionalism from the perspective of patients, physicians and nurses. *Acad Med* 84:566–573.
- Hawkins RE, Katsufakis PJ, Holtman MC, Clauser BE. 2009. Assessment of medical professionalism: Who, what, when, where, how, and...why? *Med Teach* 31:348–361.
- Hickson GB, Pichert JW, Webb LE, Gabbe SG. 2007. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. *Acad Med* 82:1040–1048.
- Hunt DD, Carline J, Tonesk X, Yergan J, Siever M, Loebel JP. 1989. Types of problem students encountered by clinical teachers on clerkships. *Med Educ* 23:14–18.
- Ipsos MORI. 2009. Trust in People/Trust in Doctors 2009 [Internet]. [Published 2011 April 24]. Available from: <http://www.ipsos-mori.com/Assets/Docs/Polls/poll-trust-in-professions-topline-2009.pdf>
- Jenkins R. 2004. Shipman: How the Doctors' Watchdog Failed Patients [Internet] The Times December 10 2004. [Published 2011 April 24]. Available from: <http://www.timesonline.co.uk/tol/news/uk/article401420.ece>
- Laurance J. 2011. Doctors Warn That 'Club Culture' Among Surgeons is Costing Lives [Internet] The Independent March 21 2011. [Published 2011 April 24]. Available from: <http://www.independent.co.uk/life-style/health-and-families/health-news/doctors-warn-that-club-culture-among-surgeons-is-costing-lives-2247761.html>
- Lingard L, Garwood K, Szauter K, Stern D. 2001. The rhetoric of rationalization: How students grapple with professional dilemmas. *Acad Med* 76:S45–S47.
- Lucey C, Souba W. 2010. Perspective: The problem with the problem of professionalism. *Acad Med* 85:1018–1024.
- Osborn E. 2000. Punishment: A story for medical educators. *Acad Med* 75:241–244.
- Papadakis M, Hodgson CS, Teherani A, Kohatsu ND. 2004. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. *Acad Med* 79:244–249.
- Papadakis M, Loeser H, Healy K. 2001. Early detection and evaluation of professionalism deficiencies in medical students: One school's approach. *Acad Med* 76:1100–1106.
- Parker MH, Wilkinson D. 2008. Dealing with "rogue" medical students: We need a nationally consistent approach based on "case law". *Med J Aust* 189:626–628.
- Rapid responses to: Smith R. Cheating at medical school. 2000. *BMJ* 321:398 [Internet] Letter. [Published 2011 April 24]. Available from: <http://www.bmj.com/cgi/eletters/321/7258/398>
- Rees CE, Knight LV. 2008. Banning, detection, attribution and reaction: The role of assessors in constructing students' unprofessional behaviours. *Med Educ* 42:125–127.
- Rennie SC, Crosby JR. 2001. Are "tomorrow's doctors" honest? Questionnaire study exploring medical students' attitudes and reported behaviour on academic misconduct. *BMJ* 322:274–275.
- Rennie SC, Crosby JR. 2002. Students' perceptions of whistle blowing: Implications for self-regulation. A questionnaire and focus group survey. *Med Educ* 36:173–179.
- Rennie SC, Rudland JR. 2003. Differences in medical students' attitudes to academic misconduct and reported behaviour across the years – a questionnaire study. *J Med Ethics* 29:97–102.
- Roff S, Chandratilake M, McAleer S, Gibson J. 2011. Preliminary benchmarking of appropriate sanctions for lapses in undergraduate professionalism in the health professions. *Med Teach* 33:234–238.
- Roff S, Dherwani K. 2011. Development of inventory for polyprofessionalism lapses at the proto-professional stage of health professions education together with recommended responses. *Med Teach* 33:239–243.



- Sierles F, Hendrickx I, Circle S. 1980. Cheating in medical school. *J Med Educ* 55:124–125.
- Smith R. 2000. Cheating at medical school. *BMJ* 321:398.
- Stimmel B, Yens D. 1982. Cheating by medical students on examinations. *Am J Med* 73:160–164.
- Teherani A, Hodgson C, Banach M, Papadakis M. 2005. Domains of unprofessional behavior during medical school associated with future disciplinary action by a state medical board. *Acad Med* 80:S17–S20.
- Teherani A, O'Sullivan P, Lovett M, Hauer K. 2009. Categorization of unprofessional behaviours identified during administration of and

remediation after a comprehensive clinical performance examination using a validated professionalism framework. *Med Teach* 31: 1007–1012.

The Shipman Inquiry. 2001. Safeguarding Patients: Lessons from the Past - Proposals for the Future [Internet]. [Published 2011 April 24]. Available from: <http://www.shipman-inquiry.org.uk/fifthreport.asp>

Yates J, James D. 2010. Risk factors at medical school for subsequent professional misconduct: Multicentre retrospective case-control study. *BMJ* 340:c2040.

## Appendix

These are the scenarios used in the questionnaire:

- (1) A final year medical student is found consulting a textbook during an examination (textbooks are not permitted in examinations). The student has not done this before.
- (2) During a practical Pass/Fail examination, a student is asked to take a patient's blood pressure. However, the student does not hear the sounds (with the stethoscope which would indicate the two BP readings) and therefore makes up the BP result.
- (3) During a research project, a student makes up some of the results in order to reach a deadline.
- (4) When writing a literature review (a scientific essay), a student copied about 75% of the work from a review written by another student the year before and did not reference or acknowledge it.
- (5) A second year medical student, who has been on a first aid course, is on her way to the medical school for lectures, when she sees a motorcyclist crash into a lamp-post. She stops and gives first aid to the badly injured cyclist, and accompanies him in the ambulance to hospital, thereby missing two lectures.
- (6) A student takes 2 days off, telling the medical school that he is unwell; however, the student actually uses the time to take a holiday. This is now the third time this has happened.
- (7) A student forges the supervising consultant's signature at the end of a placement to indicate satisfactory completion of the placement. The student has only attended 60% of this placement, the basic requirement being 80%.
- (8) A student attends compulsory teaching on a ward. The student smells of alcohol, has slurred speech and is unsteady.

- (9) A final year student with £30,000 of student debt fraudulently obtains £5000 in benefits to which the student is not entitled. The student is convicted of fraud and given a 12-month suspended sentence.
- (10) A third year medical student fails all the year 3 examinations at the first attempt (students are usually allowed a second attempt to retake failed examinations). It then transpires that the student's ability to study has been impaired by heavy (daily) use of cannabis over a period of 18 months.
- (11) A male medical student tells a woman he is a doctor and then proceeds to examine her breasts.

These are the questions as they were worded in the questionnaire:

Q1. Would you consider this behaviour as:

- (1) OK
- (2) Possibly unacceptable
- (3) Definitely unacceptable

Q2. Which course of action would you deem most appropriate in this situation?

- (1) No reprimand
- (2) Reprimand/disciplinary warning only and no punishment
- (3) (Repeating the examinations/essay/project)
- (4) Repeating the year of study
- (5) Temporary suspension
- (6) Studies terminated and registration as a student of the University should cease

Note: Option 3, represented in brackets, was excluded for some scenarios to which it did not apply.