CHAPTER 1

Why Clinical Professionalism Matters

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OVERVIEW

- Clinical professionalism is founded on respect for the dignity of each human person.
- Each health professional, health service provider, professional body and regulator should 'first, do no harm' to those in their care.
- Modern professionalism is a partnership of patient and professional in an organisational framework that supports the safety and well-being of both parties.
- A duty of care acts to protect patients from a potentially unequal relationship with healthcare providers and professionals.
- A culture of rudeness and incivility in healthcare fosters cynicism and burnout in healthcare professionals and damages patient care.
- Clinical professionalism underpins safe patient care and addresses the human factors that contribute to clinical errors.

Introduction

We are all human beings. We share the same human condition – we suffer, make mistakes, we fall away from our ideals. Equally, we are all capable of greatness, of excellence and of placing the needs of others above ourselves. Each of us is unique and has a value which can never be ignored or taken away. Our roles in life should not only occupy our time but engage and bring us satisfaction. The ancient Greeks defined true happiness as the full use of one's powers along lines of excellence (see Box 1.1). These concepts have been espoused from ancient times.

We collaborate in communities and societies because it is in our interest and that of our group, because there is a mutual benefit in doing so. Some of us seek to alleviate suffering, to repair others and to improve and extend quality of life. Intervening in the lives of others is a challenge carrying a responsibility, again recognised long ago and addressed by Hippocrates: '*First, do no harm*.'

This starting point of care by health professionals is set out more clearly in the Hippocratic Oath (see Box 5.1). While intended for the physicians of the time, the principles encapsulated in the oath are reflective of the duties of all healthcare professionals and healthcare organisations in the modern era. Though modified for various settings, their essence is essentially unchanged. In the 21st century, the Physicians' Charter, a collaboration of American and European professional bodies, is a derivative of the Hippocratic Oath rather than its replacement (see Box 1.2). In addition, regulatory bodies have developed guidance on values and practice for their own disciplines which also reflect these concepts (see Further reading/resources).

Box 1.1 **An ancient Greek definition of happiness.**

'The good of man is the active exercise of his soul's faculties in conformity with excellence or virtue, or if there be several human excellences or virtues, in conformity with the best and most perfect among them'.

Aristotle (384–322 BCE), Nicomachean Ethics

This was paraphrased by John F. Kennedy as, 'Happiness is the full use of your powers along lines of excellence in a life affording scope'.

Box 1.2 **The physicians' charter.**

Professionalism is the basis of medicine's contract with society.

- Fundamental principles:
  Principle of primacy of patient welfare.
  Principle of patient autonomy.
  Principle of social justice.
- A set of professional responsibilities:
  Commitment to professional competence.
  Commitment to honesty with patients.
  Commitment to patient confidentiality.
  Commitment to maintaining appropriate relations with patients.
  Commitment to improving quality of care.
  Commitment to improving access to care.

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Commitment to a just distribution of finite resources.
Commitment to scientific knowledge.
Commitment to maintaining trust by managing conflicts of interest.
Commitment to professional responsibilities.

Adapted from ABIM Foundation, American Board of Internal Medicine, ACP-ASIM Foundation (2002) American College of Physicians-American Society of Internal Medicine, European Federation of Internal Medicine. Medical professionalism in the new millennium: A physician charter. *Annals of Internal Medicine*, **136** (3), 243–246.

Formation of professions and the duty of care

The concept of medicine as a 'profession' emerged in the late medieval period with the formation of professional guilds. Initially, the term encompassed the standards and codes of conduct of the practitioners themselves and was essentially doctor-centred. In time, the protection of medical practice from other competing professions, as well as rules governing the commercial conduct of practice, evolved the concept further. The socialisation of health services and the development of patient-centred practice in the last half-century has led to a description of professionalism as a contract between doctors and society. This contract addresses questions of funding, resource allocation and consumerism, but most importantly in ensuring that the patient's own views are heard above those of the various parties involved in healthcare. This is what Engel described as not only, '*What was the matter with the patient*', but '*what mattered to the patient*' [Engel, G.L. (1977) The need for a new medical model: a challenge for biomedicine. *Science*, **196** (4286), 129–136]. The process of healing is thus not simply the removal of disease but also the enablement of patients in achieving full use of their powers and potential (see Chapter 3).

The partnership of patient and professional has been expressed as:

> *Patient: I suffer; Professional: I think; Patient and Professional: We will act*
>
> (Skelton, 2002)

Even if truly patient-centred, this partnership is still potentially unequal. The patient must rely on the professional's knowledge and skills and the conscientious application of them. The patient may have insufficient expertise to adequately judge if this is the case, and so must trust his or her healthcare professional to do the right thing. In Law, this is addressed by the 'duty of care' (see Box 1.3). Both individuals and organisations control the means and manner of access to healthcare, and therefore both have a duty of care to their patients.

Box 1.3 **The duty of care.**

'Irrespective of any contract, if someone who is possessed of a special skill undertakes to apply that skill for the assistance of another person, who relies upon such skill, then a duty of care will arise'.

Lord Justice Morris, 1964
Hedley Byrne and Co. Ltd v Heller and Partners

The employment terms and regulatory requirements for healthcare workers rest largely with providers and professional bodies. These bodies set the terms and control the application of these conditions even though professionals engage with them freely. Again, the individual trusts he/she will be dealt with fairly and his/her dignity respected. A duty of care, based on 'first, do no harm', should be firmly embedded in the culture of these organisations, for the professional remains a human being despite his/her role. Similarly, the transparency and duty of candour expected of individuals must be practiced by healthcare providers, professional bodies and other organisations which influence the delivery of healthcare.

Clinical professionalism has therefore social, ethical and legal dimensions. These dimensions serve to define society's expectations of the health professional and the constraints on the scope of clinical practice (see Chapter 9). We promote it as a positive virtue to ensure patient safety (see Chapter 7). Regulatory frameworks are also necessary to define the requirements of entry to a healthcare profession, the monitoring of continuing competence to practice and the identification of situations in which it is no longer appropriate for an individual to have professional registration (see Chapter 11). It is important to appreciate that when regulatory mechanisms are properly and compassionately applied they serve to protect not only patients but also the practitioner. This process reflects the sometime necessities of clinical practice (see Box 1.4).

Box 1.4 **Is Mr Fletcher fit to drive?**

Mr Fletcher is a 79-year-old man who lives independently with his wife. Mrs Fletcher has mobility problems due to rheumatoid arthritis and relies on her husband to drive her to social and healthcare appointments.

One evening at a traffic junction Mr Fletcher accidently goes into the back of another car. A passing Police car stops to assess the accident. There is damage to both vehicles. Mr Fletcher is noticed to be unsteady and incoherent as he gets out of the car and attempts to explain the situation. The officer breathalyses Mr Fletcher and the result is negative. However, the officer remains concerned regarding Mr Fletcher and decides to inform the Driver Vehicle Licensing Authority (DVLA). He advises Mr Fletcher to see his GP for assessment.

On seeing his GP, Mr Fletcher emphasises his need to continue driving due to his wife's needs. His wife is very vocal in her support of him. Their son is, however, concerned by his father's recent deterioration in health, and relates he has also had some problems with urinary incontinence. Mr Fletcher's GP finds him to have significant memory and concentration problems, as well as signs of Parkinson's disease. He advises Mr Fletcher he needs referral to a memory clinic and to a consultant neurologist. He tells Mr Fletcher that for the safety of himself, his wife, pedestrians and other road users, he should not drive until these assessments are complete and the DVLA has declared him fit to do so.

Although very resistant initially, Mr Fletcher and his wife conclude that his health problems do indeed make it unsafe for him to continue driving. With the support of his son, arrangements are

made to provide transport for the couple when required. He surrenders his licence voluntarily. Although the insurance claim against him is on-going and stressful, on reflection he can see this situation was building for some time and perhaps he could have taken the initiative in addressing it earlier. His family and healthcare workers continue to support him in maintaining his health and quality of life as far as possible.

The agencies in this case have cooperated to ensure both Mr Fletcher's safety and that of others. A duty of care existed between each agency and Mr Fletcher to ensure he was not physically or psychologically harmed by this necessary process. These principles should inform transactions between healthcare-related organisations and individual professionals.

So what is 'clinical professionalism'?

Too often professionalism is defined by its absence. We all know when it isn't present: "*He isn't very professional*". However, having characterised the professional–patient relationship as a partnership underpinned by trust, and the professional's duty of care to the patient within a legal and regulatory framework, clinical professionalism is the mechanism by which this partnership is best guaranteed. The acquisition and application of any skill requires individual and organisational self-discipline. A common definition of medical professionalism between the various interested groups has been a work in progress. However, there is general agreement that professionalism includes:

> '*A set of values, behaviours and relationships that underpins the trust the public has in doctors*'.
>
> Royal College of Physicians of London, 2005

The scope of clinical professionalism has been defined by professional bodies worldwide (see Further reading/resources), but what of the public's own expectations?

The public's perspective

An online survey of 953 respondents to a 55-item inventory of professional attributes of doctors found that the public placed importance on the relationship with patients [Chandratilake, M. *et al*. (2010) *Clinical Medicine*, **10**, 364–369]. Doctors were expected to have high values, good behaviour and positive attitudes across personal and professional life. These roles occur in the settings of 'clinicianship', 'workmanship' and 'citizenship' (see Box 1.5). The public expects doctors to be confident, reliable, dependable, composed, accountable and dedicated across all settings. Personal appearance, physical features or social standing may play little or no role in a doctor being considered 'professional'. These attributes are exercised in varying degrees in each professional according to role, but nonetheless they overlap and interact across all settings (see Figure 1.1).

Values of workmanship and citizenship are shared with others in society and 'clinicianship' with other health professionals. Relationships and respect for fellow workers are considered important. We are both the same as other people in society but also defined particularly by our 'clinicianship', or to paraphrase Augustine of Hippo, 'With you I am a worker and citizen; for you I am a clinician'. There is both a status but also a responsibility upon the healthcare professional. While today there is necessary discussion about work–life balance which contributes to

Box 1.5 **Public perception of medical professionalism.**

Clinicianship

- Respecting a patient's autonomy.
- Being empathic when caring for patients.
- Showing compassion towards patients.
- Being attentive to the needs of patients.
- Being accessible to patients.
- Treating patients fairly and without prejudice.
- Acting in a responsible fashion towards patients.
- Providing advice to patients and colleagues when required.
- Behaving in a reliable and dependable way.
- Communicating in a clear and effective manner.
- Showing altruism towards patients.
- Respecting patient confidentiality and privacy.
- Avoiding a cynical approach in one's job.
- Behaving with composure.

Workmanship

- Respecting colleagues.
- Treating colleagues fairly and without prejudice.
- Being attentive to the needs of colleagues.
- Working well as a member of a team.
- Acting in a responsible fashion towards colleagues.
- Treating other health professionals fairly and without prejudice.
- Being accessible to colleagues.
- Working with one's colleagues towards common goals.
- Being adaptable to changes in the workplace.
- Having the skills to train colleagues if required.
- Being able to manage situations where there is a conflict of interest.
- Having a professional attitude towards professional development.
- Showing leadership skills and initiative.
- Reflecting on one's actions with a view to improvement.
- Being receptive to constructive criticism.
- Making effective use of the resources available.
- Being aware of one's limitations as a practitioner.
- Being sensitive to the cultural background of colleagues and patients.
- Acting in a responsible fashion towards society.
- Acting with confidence in one's duties.
- Looking after one's health and well-being.
- Not using professional status for personal gain.

Citizenship

- Adhering to professional rules and regulations.
- Functioning according to the Law.
- Avoiding substance or alcohol misuse.
- Behaving honestly and with integrity.
- Being sound in judgement and in decision making.
- Taking a dedicated approach to one's work.
- Being accountable for one's actions.
- Being punctual.

Reproduced with permission from Chandratilake, M., McAleer, S., Gibson, J. and Roff, S. (2010) Medical professionalism: what does the public think? *Clinical Medicine*, **10**, 364–369.

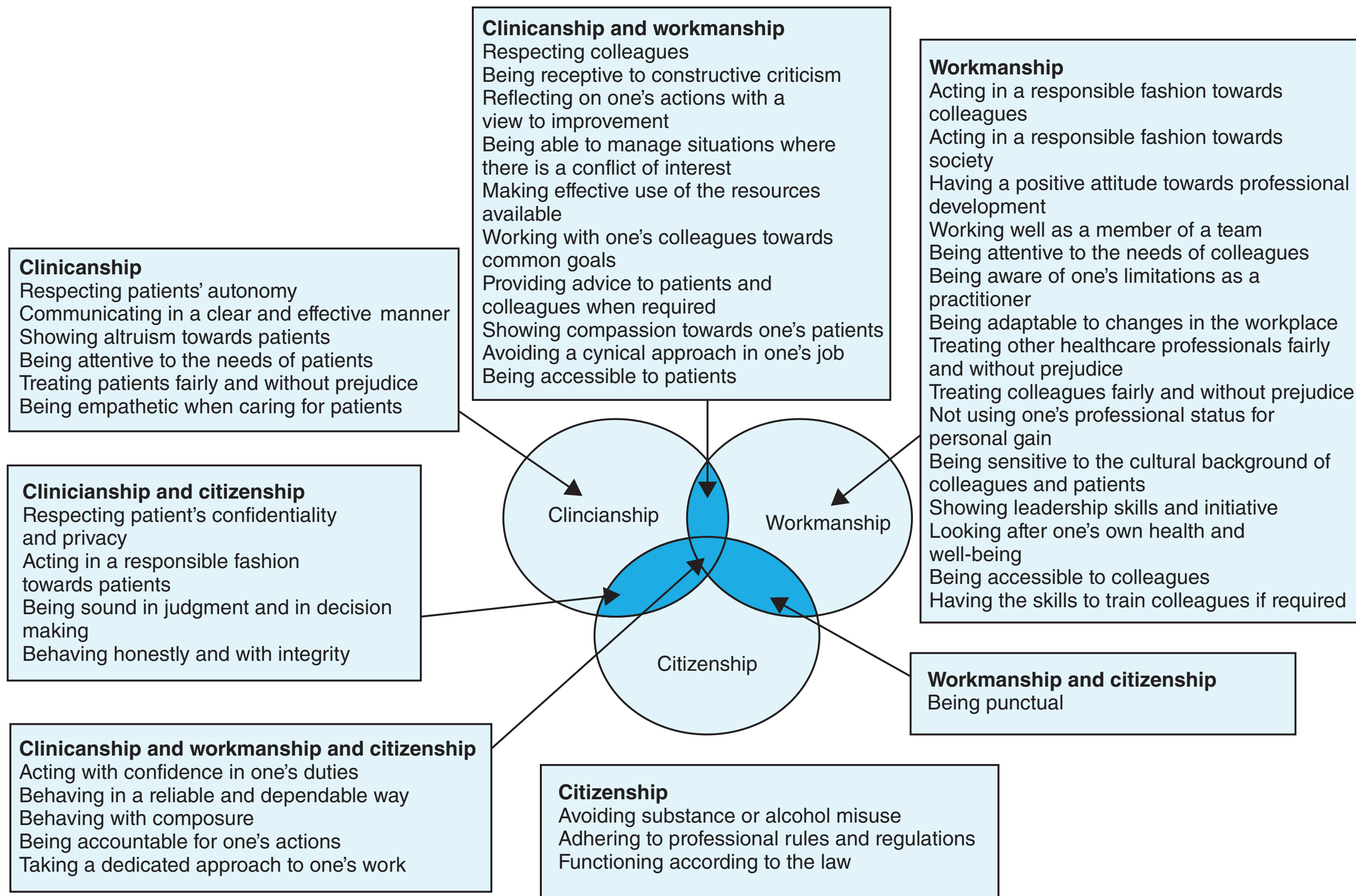

Figure 1.1 Interaction of clinicianship, workmanship and citizenship in clinical professionalism. Reproduced with permission from Chandratilake, M., McAleer, S., Gibson, J. and Roff, S. (2010) Medical professionalism: what does the public think? *Clinical Medicine*, **10**, 364–369.

well-being, the public continues to perceive a vocational element to healthcare (from the Latin – vocare – meaning 'to call'). This is shared with other roles such as teachers and the Police. It suggests our profession is, as William Osler said, a way of life in which our role as workers, citizens and clinicians should inform our thoughts and actions in both our professional and personal lives. Indeed, our personal well-being promotes our professional well-being, and vice versa.

What of students?

Healthcare students find themselves in a position of 'proto-professionalism' – no longer members of the public but also not registered as qualified medical practitioners. They have a unique and valuable perspective on the realities of healthcare delivery, how professionalism is exercised across the three settings identified above, and their own development as professionals (see Chapter 2). Professional difficulties certainly occur during medical school, sometimes in tandem with academic and/or personal difficulty. It is important for patients, students and the profession, that students in difficulty during training are identified and supported, since issues at medical school are predictive of future performance issues [Papadakis, M.A. *et al*. (2005) Disciplinary action by medical boards and prior behaviour in medical school. *New England Journal of Medicine*, **353**, 2673–2682]. The UK's General Medical Council has adapted its guidance '*Good Medical Practice*' for the circumstances of medical students. Professional development begins from the earliest stages of training and is context-driven. Much of this context is provided by contact with clinical teachers and doctors during training. Healthcare curricula increasingly reflect professionalism as a theme, and validated assessment tools have been developed (see Chapter 10).

Role-modelling

The acquisition of professional values is influenced significantly by a student's training environment, and particularly by the healthcare workers encountered in the early years. A role-model is often a clinical teacher (see Box 1.6). Mentioned often in the context of

> Box 1.6 **Definition of role-modelling.**
>
> 'Faculty members demonstrate clinical skills, model and articulate expertise thought processes and manifest positive personal characteristics.'
>
> From Irby, D.M. (1986) Clinical teaching and the clinical teacher. *Journal of Medical Education*, **61** (9), 35–45.

student training, role-modelling applies also post-qualification, is inter-disciplinary, occurs *by* as well as *to* the young, and between individuals and organisations.

Typically, students enter training as idealists. There may be a difference between what students are taught in formal and informal teaching and what they observe happening in practice. This is true particularly in relation to behaviours, attitudes, beliefs and values – all aspects of professionalism. Students develop their own professional behaviours from observations of their own teachers or role models. A perceived difference between what teachers say and what they do is a considerable source of student distress during training. It contributes to the perpetuation of inappropriate standards of professional behaviour among students and clinicians.

Students value any demonstration of 'altruism, responsibility, honour and integrity and respect' from their clinical teachers on the wards, and 'excellence, leadership and knowledge and skills' in the teaching/learning environment [Karnieli-Miller, O. (2011) *Academic Medicine*, **86**, 369–377]. Both, positive and negative behaviours are role-modelled by clinical teachers (see Boxes 1.7 and 1.8).

Box 1.7 **Positive attributes in students' assessment of faculty professionalism.**

- Takes time and effort to explain information to patients.
- Treats patients regardless of financial status, ethnic background, religious preference or sexual orientation.
- Respects patients' dignity and autonomy.
- Respects patients' confidentiality.
- Shows compassion and empathy.
- Actively listens to and shows interest in patients.
- Does not abuse power differential between teacher and student.
- Shows respectful interaction with trainees.
- Provides direction and feedback.
- Shows respectful interaction with other health professionals/other physicians.
- Admits errors or omissions.
- Shows awareness of limitations.
- Maintains appropriate boundaries.
- Avoids derogatory language.

Adapted from Todhunter, S., Cruess, S.R., Cruess, R.L. *et al.* (2011) Developing and piloting a form for student assessment of faculty professionalism. *Advances in Health Science Education*, **16**, 223–238.

Lapses of professionalism

Failing to uphold or meet the standards of behaviour expected constitutes a 'lapse'. Isolated, but significant, events arise for many reasons but require self-examination for continuing personal and professional development. They also require the support of the profession at large. Students observe lapses during their courses. They are made by fellow students, clinical teachers and administrative staff (see Figure 1.2). A consequence is an erosion of ideals and increasing cynicism about training and healthcare (see Box 1.9). This cynicism begins within the first year of training and accelerates during the first clinical (usually third) year in medicine. It falls

Box 1.8 **Positive and negative role-modelling characteristics and behaviour identified by medical students.**

Behaviour identified by students as positive (they would like to emulate in the future)	**Behaviour identified by students as negative (they would not like to emulate in the future)**
Clinical attributes:	
Good knowledge of general Medicine.	Inability to impart knowledge at the student level.
Articulate history taking skills.	Talking about patients without respect.
Able to explain and demonstrate clinical skills at appropriate student level.	Lack of empathy or compassion for patients.
Empathy, respect and genuine compassion for patients.	'Fake' empathy or compassion for patients
Teaching skills:	
Development of a rapport with students.	Lack of time for students within and outside of tutorials.
Provision of time towards the growth of students academically and professionally.	Poorly structured tutorials. Humiliation of students.
Provision of a positive learning environment.	Poor understanding of the curriculum and assessment requirements.
Structured tutorials with clear expectations.	Lack of meaningful feedback. Lack of patient interactions.
An understanding of the curriculum and assessment requirements.	
Immediate and meaningful feedback.	
Provision of patient interaction.	
Personal qualities:	
Respectful interdisciplinary interactions	Lack of preparation for tutorials.
Preparedness for tutorials.	Lack of enthusiasm for teaching.
Punctuality.	Negative regard for other medical professionals.
Enthusiasm for teaching and the subject.	
Demonstration of a passion for their career choice.	

Reproduced with permission from Burgess, A., Goulston, K. and Oates, K. (2015) Role modelling of clinical tutors: a focus group study among medical students. *BMC Medical Education*, **15**, 17.

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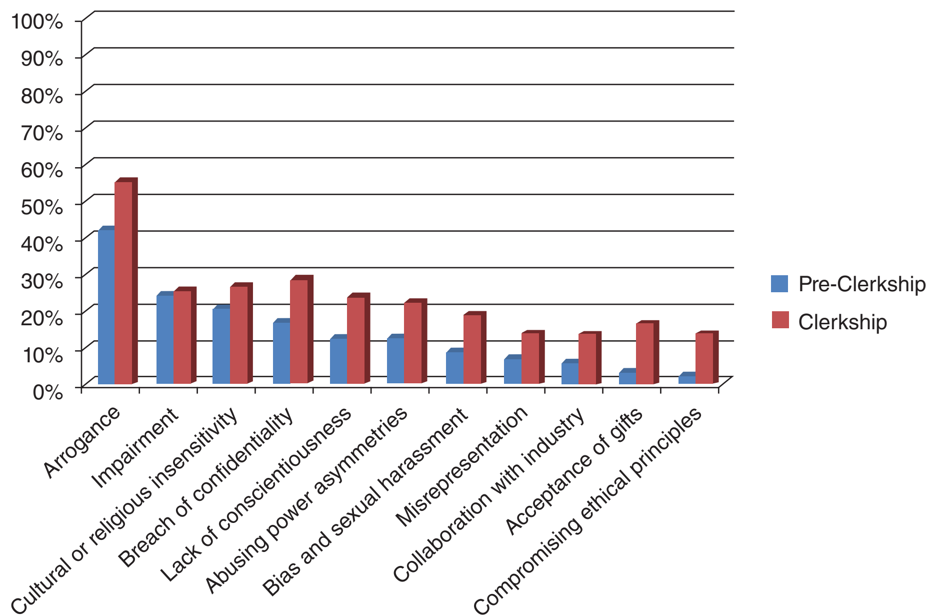

Figure 1.2 Percentage of students observing professionalism lapses (preclinical versus clinical). Reproduced with permission from Hendelman, W. and Byszewski, A. (2014) Formation of medical student professional identity: categorizing lapses of professionalism, and the learning environment. *BMC Medical Education*, **14**, 139. This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly credited.

Box 1.9 **Definition of cynicism.**

'A contemptuous disbelief in man's sincerity of motives or rectitude of conduct, characterized by the conviction that human conduct is suggested or directed by self-interest or self-indulgence'.

It is manifested in healthcare settings by the conduct of individuals, groups and organisations towards patients and to one another.

From Eron, L.D. (1958) The effect of medical education on attitudes: a follow up study. *Journal of Medical Education*, **33**, 25–33.

further in the early years of practice before rising to a more idealistic state as seniority within the profession is achieved.

The nature of lapses has altered with changing lifestyle choices and working practices. The healthcare profession was an early adopter of the internet, and there are undoubted benefits of this (see Chapter 5). In a study among United States surgical staff, 64% of junior doctors and 22% of senior doctors had Facebook pages. Of these pages, 50% were publicly accessible, and 31% of accessible pages contained work-related comments and 14% referred to specific patient situations or patient care [Landman, M. *et al.* (2010) *Journal of Surgery*, **67**, 381–386]. The high-frequency use of social networking sites may have a negative impact on medical professionalism scores, particularly integrity.

The culture of healthcare

Students begin their professional journey arguably as idealists whose professionalism is eroded by the very environment in which they aspire to work (see Chapter 6). While there are many outstanding individuals and organisations delivering exemplary patient-centred care, there is also a toxic element which damages patient care and the individuals caring for them. This toxicity encompasses many strands, but of importance are rudeness, incivility and derogatory comments, humorous or otherwise. These lapses are those which most greatly distress students. Most often derogatory comments are directed towards patients, usually out of earshot – at least of the patient – and towards fellow professionals. While most accept such comments are both disrespectful and dehumanising, at the same time they are deemed an unavoidable feature of working in a pressured environment. The airline industry is often cited as a model for risk management in healthcare. Indeed, it provides a vivid example of the effects of rudeness in healthcare (see Box 1.10).

Box 1.10 **An 'air-rage' incident.**

In 2009, two Northwest Airlines pilots flying an Airbus A320 from San Diego to Minneapolis, with 147 passengers onboard, became so engrossed in a 'heated discussion over airline policy' that they lost situational awareness and overshot the airport by 150 miles before a member of the cabin crew called the flightdeck and they realised their mistake. The flight landed safely after contact with air traffic control was resumed. The airline treated this as a serious safety incident and suspended the two pilots, whose licences were revoked. Whatever caused their lack of attention, the story illustrates the interplay between emotionally charged behaviour, namely arguing or rudeness, and cognitive skills, such as concentration.

Reproduced with permission from Flin, R. (2010) Rudeness at work. *British Medical Journal*, **340**, c2480. DOI: 10.1136/bmj.c2480.

The patient safety movement has made some impact on technological aspects of practice and systems design, but research on relational factors among staff and its impact on patient care is more limited. Among newly qualified nurses, interpersonal conflict significantly affected absenteeism, and retention of staff. Few had received training on conflict resolution or been debriefed following such incidents [McKenna, B.G., Smith, N.A., Poole, S.J. and Coverdale, J.H. (2003) Horizontal violence: experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing*, **42** (1), 90–96]. The Francis Report in the UK attributed poor staff attitudes as contributory to adverse patient outcomes. A randomised controlled trial in a simulated neonatal intensive care unit examining the effect of mild rudeness on diagnostic and procedural tasks found that rudeness alone accounted for 12% of the variance between intervention and control groups. This variance increased once information sharing and seeking help were accounted for in the analysis [Riskin, A., *et al.* (2015) The impact of rudeness on medical team performance: a randomized trial. *Paediatrics*, **136** (3), 487–495].

For safe patient care, civility and respect are resources just as important as anything material or technological, and should be available in abundance. Clinical leaders should promote their positive benefits – particularly the improvement in cognitive function of healthcare staff when courtesy and consideration is practised (see Chapter 9).

Professional burnout and suicide

In 2016, *The Lancet* reported burnout among healthcare workers as having reached 'epidemic' proportions [West, C.P. *et al.* (2016) Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet*, **388**, 2272–2281]. The evidence that those working in healthcare are being damaged by their employment is well established. It is also alarming (see Chapter 4). Despite our technological advances, it calls into question the sustainability of healthcare services, for the main method of delivery remains human to human. Suicide rates in healthcare workers are several-fold higher than in the general population, and rise further among those involved in complaints or regulatory investigations. Patients cannot be completely safe unless the safety of those treating them is also a priority.

Well-being and resilience are not simply the absence of burnout and suicidal ideas but rather 'the full use of one's powers along lines of excellence in a life affording scope' – that is, safe and successful patient care. We cannot compel resilience any more than the parents of a dysfunctional household can order their children be well-adjusted. However, we can promote it and support it both as individuals, colleagues and leaders by the manner of our conduct towards patients and professionals alike. West's systematic review of interventions to reduce burnout identifies an as-yet limited number of strategies. It is clear, however, that successful interventions are both individual-focussed as well as system and organisation-based (see Box 1.11). This implies that healthcare professionals are not the subjects of their organisations but should be working with them as equal partners. Those involved in complaints – and this means all of us at some stage – are particularly vulnerable to burnout and suicide. This should be accounted for in the structure of systems and organisations (see Further reading/resources). While responsibility must be assumed where responsibility lies, exclusive focus on the perceived shortcomings of an individual produces personal and professional isolation for that person with sometimes devastating consequences for the individuals, their family and friends. Attention focussed solely on individuals can overlook the systematic or organisational issues contributing to clinical error, and thus make its repetition more likely [Reason, J. (2000) Human error: models and management. *British Medical Journal*, **320**, 768–770].

Box 1.11 **Possible strategies to prevent and reduce physician burnout.**

- Individual-focussed interventions.
  - Mindfulness
  - Stress management
- Small group discussions or curricula.
- Organisational approaches
  - Duty hour requirements
  - Locally developed modifications to clinical work processes

Adapted from West, C.P., Dyrbye, L.N., Erwin, P.J. and Shanafelt, T.D. (2016) Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet*, **388**, 2272–2281.

Conclusions

The clinician–patient relationship remains the keystone of healthcare delivery. A duty of care occurs at each interaction with patients, but arises also in how professionals relate to one another and how healthcare organisations relate to those delivering services to patients. Civility and respect are fundamental principles of clinical professionalism and essential to increasing patient safety. The alternative is cynicism and burnout, which potentially damages everyone. Clinical leaders should be person-centred and motivated to bring about the full use of professionals' powers along lines of excellence in the best interests of patient care.

Further reading/resources

ABIM Foundation, American Board of Internal Medicine, ACP-ASIM Foundation (2002) American College of Physicians-American Society of Internal Medicine, European Federation of Internal Medicine. Medical professionalism in the new millennium: A physician charter. *Annals of Internal Medicine*, **136** (3), 243–246.

Chandratilake, M., McAleer, S., Gibson, J. and Roff, S. (2010) Medical professionalism: what does the public think? *Clinical Medicine*, **10**, 364–369.

Papadakis, M.A., Teherani, A., Banach, M.A. *et al.* (2005) Disciplinary action by medical boards and prior behaviour in medical school. *New England Journal of Medicine*, **353**, 2673–2682.

Karnieli-Miller, O., Vu, R., Frankel, R.M. *et al*. (2011) Which experiences in the hidden curriculum teach students about professionalism? *Academic Medicine*, **86**, 369–377.

Landman, M., Shelton, J., Kauffmann, R.M. (2010) Guidelines for maintaining a professional compass in the era of social networking. *Journal of Surgery*, **67**, 381–386.

Riskin, A., Erez, A., Foulk, T.A. *et al*. (2015) The impact of rudeness on medical team performance: a randomised trial. *Pediatrics*, **136** (3), 487–495.

West, C.P., Dyrbye, L.N., Erwin, P.J. and Shanafelt, T.D. (2016) Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet*, **388**, 2272–2281.