Comhairle na nDochtúirí Leighis
Medical Council

A FOUNDATION FOR THE FUTURE

GUIDELINES FOR MEDICAL SCHOOLS
AND MEDICAL STUDENTS
ON UNDERGRADUATE PROFESSIONALISM

Comhairle na nDochtúirí Leighis
Medical Council

The Medical Council regulates the medical profession under the terms of the Medical Practitioners Act 2007 ("the Act"). The 25 member Medical Council consists of 13 non-medical members and 12 medical members. It has a statutory role to protect the public by promoting the highest professional standards amongst doctors practising in the Republic of Ireland. This includes the responsibility to "better ensure the education [and] training of medical practitioners…"

The Act entrusts Council with a wide range of complex functions in medical education and training. However, the majority of these functions can be expressed simply, in terms of two overriding responsibilities: to **set** standards, and to **monitor adherence** to those standards.

Among the Council's standard-setting duties is to prepare and publish "…guidelines on the ethical standards and behaviour appropriate for medical students…"

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President's Introduction

As President, I am delighted to introduce '*A Foundation for the Future: Guidelines for Medical Schools and Medical Students on Undergraduate Professionalism'*.

These guidelines reflect the significance Council attaches to professionalism, not just for registered doctors, but for students too. It underlines the importance of fostering professionalism from the very beginning of a future doctor's career. The standards of professionalism expected of students of medicine from the outset are very different to those expected of students in other fields. From a patient's perspective, the interactions they have with those treating them in a clinical setting shape their views of the care they've received. The professionalism of medical students in such environments can be as important as the professionalism shown by the senior treating physician in giving patients confidence that they are being cared for to the highest possible standard.

These guidelines are developed for medical schools and students, to facilitate uniformity in the teaching of professionalism throughout the medical schools and clinical settings where trainee doctors learn their skills. They are another practical expression of Council's commitment to the central aims of promoting high standards of education, training and professionalism, and protecting the interests of the public.

Their development was a collaborative process, with the view of medical schools, medical students and key partner organisations sought during a consultation process. The numerous submissions received proved an invaluable resource in producing these guidelines and promoting professionalism at the heart of the patient-doctor relationship. I would like to thank everyone who provided feedback to help better the guidelines, particularly Dr Anne Keane, for her energy, dedication and enthusiasm.

The professional behaviours developed at an early stage of a doctor's training are likely to be continued throughout their career. Through the development of these guidelines we look forward to working with medical schools and trainees to ensure there is clarity on the standards the Medical Council expects throughout a doctor's working life, from student to specialist.

Professor Freddie Wood

President

Executive Summary

Professionalism is central to sustaining the public's trust in the medical profession; it is at the core of the doctor-patient relationship. Doctors are justifiably trusted by an overwhelming majority of the public. Medical professionalism is the set of intrinsic values, expressed as extrinsic behaviours which underpin and justify that trust.

The Council is committed to fostering a supportive learning environment to enable good professional practice and since it views professional development as a continuum, this also includes providing guidance to educational bodies and future doctors. The guidance is intended to assist medical schools in the fostering of professionalism, to support them in addressing professional deficits in undergraduates, and to provide guidance on professionalism to medical students. Good practices are already evident in these areas: the guidance is intended to complement existing processes within schools and promote consistency.

Embedding professionalism in the undergraduate medical curriculum, and developing it in medical students who are right at the start of their medical career, is an investment that will pay dividends: dividends for patients, their relatives and friends, medical students themselves, members of the clinical team that will work alongside doctors, future generations of students who will be taught by doctors with high standards of professionalism who are role models, Irish medical education and training, and the health care system in Ireland.

These Guidelines are in two parts. The first part focuses on the development of high standards of professionalism, including: the principles of teaching professionalism and the "seven Rs"; methods for assessment; becoming a professional and the importance of culture and example in this process; professionalism in the context of clinical sites and among the clinical team; online professionalism; and the preparation for transition to medical practice.

The second part focuses on dealing with potential professional deficits, and Student Fitness to Proceed/Fitness to Graduate. It focuses on the importance of medical schools dealing with professional deficits in the interests of patient safety; the importance of resources for Student Fitness to Proceed/Fitness to Graduate; informal support for students; and the two stages of the Student Fitness to Proceed/Fitness to Graduate process. It establishes a fundamental principle: when students do not (because they will not or cannot) demonstrate professionalism, they should not be allowed to graduate with a medical degree even if they demonstrate satisfactory academic outcomes.

Medical schools already give the development of professionalism a high profile in the undergraduate medical curriculum, and there are many examples of good practice in the area. The vast majority of medical students are also conscious of the importance of being professional, and this is reflected in their professional values and behaviour. These Guidelines are intended to support medical schools and students in maintaining momentum in this area.

The practical development and maintenance of high standards of undergraduate professionalism requires the collective efforts of many stakeholders including medical school academic leaders, teachers and trainers, clinical training sites, students, and the medical profession both as individuals and collectively. The Council's development and promotion of these Guidelines, and its subsequent monitoring of their implementation, is intended to underpin and reinforce medical students evolving professionalism.

1.   PREFACE

1.1 Objectives

These Guidelines have three main objectives:

♦   **To assist approved bodies in fostering professionalism among medical students**

♦   **To provide medical students with Guidelines on professionalism**

♦   **To support approved bodies in their handling of student deficits in professionalism.**

The Guidelines reflect the significance Council attaches to professionalism, not just for registered medical practitioners but for students too. It underlines the importance of fostering professionalism from the very beginning of a future doctor's career. The Guidelines are another practical expression of Council's commitment to the central aims of promoting high standards of education, training and professionalism, and protecting the interests of the public.

1.2 Terminology

The use of the term "Guidelines" reflects the reference in the Medical Practitioners Act 2007 for Council to "prepare and publish…guidelines for [approved] bodies on ethical standards and behaviour appropriate for medical students…"

In five cases, the body approved by the Medical Council for the purposes of the award of a basic medical qualification (an undergraduate degree) is a university: University College Cork (UCC); University College Dublin (UCD); National University of Ireland (NUI), Galway (NUIG); University of Dublin, Trinity College (TCD); and University of Limerick (UL). In the sixth case it is the Royal College of Surgeons of Ireland. However, the term "medical school" is generally used in these Guidelines in the interests of readability and because it is widely understood by the intended audience. Statutory responsibility for implementing the Guidelines remains with the relevant university and with the Royal College of Surgeons of Ireland.

The positive term "professionalism" is used to incorporate both an attitude and demonstrated professional behaviour. The term "professional deficit" is generally preferred to "unprofessionalism" or "unprofessional behaviour", as "professional deficit" recognises that there are gradations in departures from expected behaviour.

The term Student Fitness to Proceed (SFTP) is used throughout. As students are not practising medicine in the sense of being registered and delivering clinical care, the focus of the Guidelines is their fitness to proceed to the next stage of the programme, and ultimately their fitness to graduate (the term Fitness to Practise has a statutory meaning and registration implications under the terms of the Act and is avoided).

1.3 Relationship of these Guidelines to organisational guidelines

These Guidelines are not intended to replace the policies and processes of universities and of the Royal College of Surgeons of Ireland which apply to all students. These bodies have well established policies and processes that cover issues of academic performance and ethical shortfalls including plagiarism and cheating in examinations and those will continue to apply to medical students as to every other student. The Guidelines reflect that there is a particular requirement for medical students (in common with other health and social care students) to demonstrate a professionalism that is congruent with their role as apprentice practitioners. The Guidelines are intended to supplement the generic policies and processes of universities and of the Royal College of Surgeons of Ireland.

Medical schools have also developed medical student–specific policies and processes to reinforce professionalism and deal with any instances of professional deficit. These Guidelines are not intended to replace those policies and processes. They are intended to support, complement and reinforce them.

However, it is important that the policies and processes of medical schools are consistent with these Guidelines, in terms of the development of good professionalism and the principles, policies and processes for dealing with professional deficits. Medical schools should review the relevant principles, policies and processes to ensure compatibility with these Guidelines.

1.4 Applicability

These Guidelines are intended for approved bodies which deliver approved programmes of undergraduate (basic) medical education leading to a primary medical qualification. They apply irrespective of whether the bodies and programmes are approved or approved with conditions attached. They apply to approved bodies and programmes within Ireland; they also apply to approved bodies and programmes outside the jurisdiction which award Irish primary medical qualifications. They apply to all years of basic medical programmes (although the application of the Guidelines is likely to reflect the changes occurring as the stages of the programme roll out).

1.5 Relationship of these Guidelines to Guidelines for Medical Schools on Ethical Standards and Behaviour appropriate for Medical Students

Guidelines for Medical Schools on Ethical Standards and Behaviour appropriate for Medical Students were previously produced by the Council and addressed the areas of competence, confidentiality, personal and professional interactions, dress, and health. Those Guidelines are still extant and should be taken in conjunction with these Guidelines.

1.6 Relationship of these Guidelines to the Guide to Professional Conduct and Ethics for Registered Medical Practitioners

The Medical Council has for many years produced a *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, which is periodically revised to ensure that it remains current. This document on pre-registration professionalism reflects the Ethical Guide's emphasis on professional conduct, responsibilities to patients, confidentiality, consent, and professional practice. It shares the Ethical Guide's emphasis on the importance of integrity, compassion and concern, sensitivity and understanding, judgment and communication. Laying a firm foundation of professionalism at the pre-registration stage is intended to assist doctors in dealing with the sometimes challenging and complex ethical and professional issues they will face post-registration.

The "Ethical Guide" states that "medical students should be familiar with and adhere to the principles of this Guide". Medical schools frequently use the Guide as a teaching tool. This approach is still relevant.

2.   INTRODUCTION

2.1 Trust

Professionalism is central to sustaining the public's trust in the medical profession; it is the essence of the doctor−patient relationship. While there is a perception in some of the literature that public trust is waning, research by the Medical Council (captured in *Talking about Good Professional Practice*) found that doctors were still trusted by an overwhelming majority of the public. Medical education and training and its role in fostering and maintaining professionalism has a key role to play in ensuring that this trust is justified, and is demonstrated by students right from the start of their medical career. Embedding early professionalism is an investment that will pay dividends for:

♦   **Patients treated by doctors with high standards of professionalism**

♦   **The relatives and friends of patients**

♦   **The individual medical student in terms of their competence, success, and avoidance of future disciplinary processes**

♦   **The members of the clinical team that will work alongside doctors**

♦   **All future colleagues**

♦   **The school, in terms of the quality of its programme(s), the impact on accreditation, and the effect on its reputation**

♦   **Future generations of students who will be taught by doctors with high standards of professionalism who are role models to emulate**

♦   **The health care system in Ireland**

♦   **The reputation of Irish medical education and training in a global workforce.**

2.2 Ethos of Guidelines

The Guidelines are intended to be positive and constructive. The Medical Council accreditation cycle has demonstrated the progress that has been made by medical schools over recent years in making professionalism an integral part of the medical curriculum. Students' understanding of the importance of professionalism is deepening. Medical Schools are also very conscious of the need for them to deal effectively with students with professionalism deficits.

The Guidelines are intended to support medical students and medical schools in maintaining this upward trajectory by reinforcing the good practice already evident in many areas. Momentum has been built up. The Medical Council wants to support the medical schools in undertaking their key responsibility in development and consolidating professionalism; and in their determination to deal appropriately with any professionalism deficits.

2.3 The need for Guidelines for students

One of the underlying principles of these Guidelines for students is that professionalism develops as part of a spectrum or continuum of progression, with an understanding and demonstration of professionalism deepening and broadening as the doctor develops. However, three major factors distinguish medical students from doctors, and therefore make a separate guide on undergraduate professionalism appropriate:

- ♦ **Students are not registered with the Medical Council: there is no provision under the Act for such registration**

- ♦ **Students do not provide clinical service to patients; clinical placements are an integral part of their education and training, but students are on the clinical site for the purposes of their education and training**

- ♦ **As they are not registered medical practitioners, students are not and cannot be subject to the Medical Council's Fitness to Practise processes.**

These differences and their student status also alter the balance of responsibility from the individual to the approved body. Registered medical practitioners may work in an environment which challenges their professionalism and may face challenges in maintaining that professionalism. But the primary responsibility for maintaining their professionalism rests with them. Medical students are adults, and also have a personal responsibility to maintain professionalism. However, in accordance with the Act, and its reference to "…guidelines for bodies…" there is a specific requirement for an organisation–wide approach to fostering student professionalism and dealing with professional deficits. There is certainly an onus on approved postgraduate bodies to foster professionalism and on employers to facilitate it. But the one-to-one relationship of the individual practitioner with the Medical Council in cases of breaches of unprofessionalism marks a significant difference. The Medical Council's relationship with individual students in this regard is an indirect and vicarious one, mediated via the medical school; and the medical school plays the pivotal part in fostering professionalism and tackling professional deficits. The medical schools' central role in fostering professionalism and tackling professional deficits will continue.

2.4 Practicality

There has been a very significant amount of research into undergraduate professionalism, reflected in the volume of published material; this research is very welcome. Medical schools should offer appropriate opportunities for their own staff to contribute to developing this evidence base, and should aim to incorporate relevant research findings into their curriculum development and delivery processes.

These Guidelines are informed by the evidence base but their focus is a practical one. In providing Guidelines for medical students and medical schools on professionalism and dealing with professional deficits, it aims to provide a framework for action.

2.5 Relationship with accreditation

The extent to which a body demonstrates adherence to standards determines Council's accreditation decision under the Act. For programmes and bodies, the decision may be approval; or approval with conditions; or the amendment or removal of previous conditions attached; or withdrawal of approval. For bodies only, Council has the option to refuse approval.

The Council has previously monitored medical schools' implementation of the *Guidelines for Medical Schools on Ethical Standards and Behaviour Appropriate for Medical Students*, and students' awareness of them. It will continue this process with these new Guidelines, factoring medical schools' implementation into Medical Council processes for accreditation, including into the Annual Return.

2.6 Health issues

Health problems may underlie behaviour which is unprofessional, but a health problem is not unprofessionalism. These Guidelines are not intended to deal with deficits due to a health problem (whether short-term or chronic) or a particular psychological trauma (such as bereavement).

Medical students, like all students have the right to access services that support their well-being and provide for the prevention of illness and treatment of medical and psychological conditions. However, medical schools must be aware of the particular relevance of effective management of medical students with relevant medical and psychological conditions. Medical schools must take action if there is evidence that a student's medical or psychological condition is adversely affecting a student's conduct and behaviour and, in particular, is affecting or may affect patient well-being and safety.

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PART ONE

DEVELOPING HIGH STANDARDS

OF PROFESSIONALISM

3.   DEFINING MEDICAL PROFESSIONALISM

There is no single, universally accepted and over-arching definition of medical professionalism. Definitions vary by person, place and time. The perspectives of individuals and groups shape and frame the understanding of medical professionalism. The exchange and interplay of these different perspectives - discourse - involves concepts of:

♦   **Individual professionalism; professionalism as an individual personal attribute, or set of attributes**

♦   **Interpersonal professionalism; professionalism as a feature that emerges through social interaction**

♦   **Collective professionalism; professionalism as an attribute or set of attributes relating to the "contract" between the medical profession and society**

♦   **Complex professionalism; professionalism as a dynamic construct which shifts over time.**

The purpose of these Guidelines is basically a practical one: providing guidelines on developing and reinforcing professionalism, and dealing with professional deficits, which are useful to medical schools and students. A definition is necessary to drive the agenda forward. The working definition of professionalism that underpins these Guidelines is therefore as follows:

Medical professionalism is the set of intrinsic values, expressed as extrinsic behaviours which justify the trust between patients and good doctors, and between the public and the medical profession.

These values and behaviours include:

♦   **Respect for patients demonstrated by patient–centred practice**

♦   **Ethical standards including honesty, integrity, empathy and altruism demonstrated by ethical practice**

♦   **Reflection/self-awareness demonstrated by reflective practice**

♦   **Personal responsibility for actions demonstrated by responsible behaviour, including safeguarding one's own health and well-being**

♦   **Teamwork commitment demonstrated by effective communication and teamwork, including, where appropriate, acting as the leader of a team**

♦   **Social responsibility demonstrated by commitment to the health of the community.**

The attributes of professionalism are in most cases applicable to all stages of a doctor's career, from the first day in medical school until the day they retire from active practice. The context in which the attributes will be demonstrated will change. The issue of online professionalism, for example, is included in these Guidelines. The range of ways in which professionalism can be demonstrated will evolve; working as a very junior member of the clinical team is very different to being the leader of the team, but both require team-working skills. Students will inevitably be at a formative stage of understanding and demonstrating professionalism. Professionalism will evolve and it will adapt as global, national, local and individual circumstance adapt. Indeed, appropriate adaptation to changing circumstances is part of being a professional, as is a commitment to lifelong learning and personal and professional development. At its core, however, professionalism will continue to be based on key attributes. For the purposes of these Guidelines the key objectives are for students to demonstrate the level of professionalism appropriate to their place on the continuum of competence, and to demonstrate commitment to the maintenance and further development of their professionalism.

4. PRINCIPLES FOR TEACHING AND LEARNING PROFESSIONALISM

The Guidelines are intended to stimulate innovation, not stifle it, and the Guidelines are not prescriptive. Medical schools are best placed to assess best practice and the needs of their students in light of the type of curriculum, the ethos of the medical school, and available resources, and to make decisions about the details. However, some principles should be incorporated into these decisions, including the "seven Rs":

Professionalism should be:

Recognised as a key competency of medical practice
This core value is reflected in modern medical curricula and promoted in these Guidelines. Any perceptions among students that professionalism is an optional extra or a "soft" subject should be tackled (including via assessment). Schools should encourage research into the teaching of professionalism.

Reality-based and rooted in clinically-oriented situations
Early professionalism can appear to students to be rather abstract and hypothetical when the majority of their time is spent in lecture theatres, tutorial rooms, laboratories and libraries. Medical schools should maximise the relevance of early professionalism; students on clinical placements tend to appreciate at that stage the benefit of the grounding they were given.

Real-patient focused
This is particularly appropriate during and after major clinical placements. Participation of patients enriches teaching.

Reflective
Students need "space" to reflect on their own professionalism or professionalism generally, through professionalism journals, narratives, reflective pieces, in group discussions, as part of the feedback process with teachers and in other ways. They need a safe environment in which they can explore issues that have engaged them, troubled them or distressed them, including the issue of the inevitable limitations on their capacity to heal.

Respectful
Patients allow students privileged access to them (even in their own homes). Medical schools should stress the importance of respect in student/patient interactions, including appropriate examination of patients, appropriate boundaries, good communication, confidentiality, and dignity. Students demonstrating high standards of professionalism will encourage patients' willingness to participate in teaching.

Reinforced
While professionalism should run like a thread throughout the curriculum, there are key milestones where medical schools should be particularly aware of opportunities to reinforce it, particularly before extended clinical placements and pre-internship.

Related to other subjects
There are many opportunities for schools to discuss and promote professionalism outside of formal, "badged" professionalism teaching, and to foster dialogue about professionalism issues arising in relation to a particular topic.

5.   PRINCIPLES FOR ASSESSMENT OF PROFESSIONALISM

These Guidelines are not prescriptive. Once again, medical schools are best placed to assess best practice and the needs of their students and to make decisions about the details. Assessment should focus not only on students knowing about professionalism but also on students being professional.

Some principles should be incorporated into medical schools' assessment policies and procedures, and assessment methods should:

♦   **Be framed so as to emphasise the centrality of professionalism to the undergraduate curriculum and its parity with knowledge and clinical skills**

♦   **Be correlated to curriculum content and transparent, defined learning outcomes**

♦   **Be framed so as to assess interpersonal and situational professionalism as well as individual professionalism**

♦   **Use a variety of different assessment methods and tools**

♦   **Balance formative and summative assessment, continuous assessment and assessment by examination**

♦   **Integrate the findings of assessment into the teaching and learning and assessment process**

♦   **Encourage students to reflect and self-evaluate, on scenarios and real issues**

♦   **Maximise participation by clinical supervisors, junior doctors, other healthcare professionals, peers, and patients.**

Feedback to students (including face-to-face feedback) on their performance should be routinely available and should not be seen as an event that only takes place where there is deficit. While feedback on professional deficits is an initial step in tackling underperformance (dealt with in the second part of these Guidelines), effective feedback also recognises and reinforces good professionalism. Face-to-face feedback in particular is time-consuming for teachers, but appreciation of feedback by students, and their hopes for more, was a constant theme of the Council's dialogue with students at accreditations, with particular reference to professionalism in the predominantly clinical years.

In this regard, schools should support staff development in the assessment of professionalism, and facilitate research into the assessment of professionalism.

6. BECOMING A PROFESSIONAL

6.1 The hidden curriculum

Formal teaching and learning of professionalism is only part of the process of becoming professional. There is a powerful "hidden curriculum" (sometimes more accurately a semi–hidden or informal curriculum) of tacit norms, values, and beliefs, implicit and unspoken, which embed or erode the formal messages of the overt curriculum.

While the hidden curriculum is often used in a pejorative way, it should be noted that it can also be a very positive subliminal influence. To use a simple medical analogy, compassion and empathy, honesty and integrity, respectful behaviour, and good communication are infectious, as is the opposite. They are adopted and perpetuated by means of a cycle of "cultural reproduction" when students become doctors and teachers themselves.

In a medical education structure that still has echoes of the traditional apprenticeship system, this process is inevitable. The hidden curriculum is likely to be particularly influential in the clinically-focused parts of the programme, where impressionable medical students are surrounded by new and unfamiliar experiences. The clinical environment is an ideal one for doctors to deliver messages by diffusion or "osmosis", with the student subconsciously assimilating the lessons and mirroring the attitudes and behaviour that they themselves experience and that they observe.

Students absorb the message that this is how "real doctors" act in the "real world": act as individuals, with their medical peers, with trainees, with students, with others in the clinical team, with managers and above all with health service users and the wider public.

Schools need to:

♦ **Ensure that there is general awareness among staff and students of the issue of the hidden curriculum and its impact (it is important that the message to staff acknowledges that most staff are committed and receive little reward, with much teaching still reliant on goodwill)**

♦ **Develop an informal curriculum that consistently reinforces the values of the formal curriculum**

♦ **Provide advice on ways in which a positive message can be sent via the hidden curriculum, reinforcing messages about professionalism and the importance of professional behaviour that is provided in the formal curriculum**

♦ **Involve students in identifying and evaluating elements of the hidden curriculum as they are manifested from time to time**

♦ **Consider that there may be variations in the culture and therefore the hidden curriculum of different medical specialties**

♦ **Remind students that although it may be difficult, and there may be pressure to conform, they have a responsibility to address unprofessionalism that they experience or observe, particularly in the clinical environment, initially by seeking advice.**

6.2 Role models

Role models play a major role in delivering the hidden curriculum. Key elements of professionalism are "contagious": susceptible to being strengthened or weakened by good or poor role models. Role modelling may be the single most important component of the medical school experience as it relates to professionalism and the development of professional identity.

Good role models embody and manifest good professionalism and are emulated by students. They lead by example. Role models are not exclusively senior medical staff: senior students have recognised that they themselves can be role models for more junior students. But there is a particular onus on senior medical staff to be good role models. The Council's experience in accreditations shows that the majority of students have good insight into the importance of role modelling: they highlight best professional practice and recognise and are disappointed by its opposite. It is certainly unfair to apply to students the principles, polices and processes contained in guidelines if notably poor behaviour is being exhibited, and not tackled, among those who should be exemplars of good professional practice.

Schools should also do everything that they can to develop good role models – including via staff development – and to ensure student exposure to them. Schools also need to identify and remediate poor role models, and student feedback can play an important part in this.

There is a particular onus on those in formal or informal teaching leadership positions to ensure that their own standards of professionalism are high, and that they "cascade" this approach to other teachers and trainers.

It is recognised that medical schools do not have a contractual relationship with teachers who are not university employees. Any deficits arising therefore cannot be addressed in the same way as they would be in a formal employer/employee relationship. However, the onus on accredited medical schools to provide a high quality learning environment requires appropriate standards of professionalism among educators, irrespective of the employment status of the teacher. Standards of professionalism among staff should be factored into the clinical placement decisions that medical schools make. The establishment of governance structures to provide for regular meetings between medical school and training site representatives is also helpful in this respect.

6.3 Identity

Identity can be said to differentiate a student's view of themselves as "practising medicine" in future to "being a doctor"; not doing, but being. This is linked with the hidden curriculum and with role models. The informal and hidden curricula have a very significant influence on identity formation. Role models play a central role in developing and shaping the identities of the individual students and groups of students. Students adapt to and adopt characteristics associated with the individuals and the environment that they interact with.

There are certainly benefits to developing a strong sense of self-identity and of shared identity. Identification with and emulation of role models is discussed above, with reference to the student identifying themselves with role models and reflecting that identification in their values and behaviour. Students are part of many different intersecting professional groups, including those of the wider body of students; medical students; students in a particular medical school, at a particular stage in the programme of that medical school; in a particular placement, or on a particular clinical team. If the group norm is a positive one, then – in keeping with the importance of role models - that is a major advantage for the student(s) and for their future practice. It is entirely appropriate for medical students to take pride in being future doctors.

But there are risks in group norms too, if that norm is one that tacitly or explicitly endorses poor professionalism and embodies it. Identity can promote valid conformity to positive values and behaviour; or inappropriate conformity, a reluctance to appropriately challenge and question, a fear of harming professional relationships, of being perceived as not being a "team player". The aim of developing an appropriate identity is not to instil an automatic conformity with explicit or implicit values and behaviours: acting professionally in some cases may require exactly the opposite.

Medical schools have a responsibility to do everything that they can to make students' formation of identity a positive one.

6.4 White coat ceremonies

Even in integrated programmes the second part of the programme is distinguished by the amount of time that students spend in clinical placements. Transitions are a key feature of a medical career, and some medical schools mark the transition to major clinical placements by means of a white coat ceremony. Students taking an oath or pledge or giving an undertaking is often part of the ceremony.

A white coat is a powerful symbol of clinical practice and the ceremonies are intended to mark the transition from a student with some interaction with patients to a situation in which the student is an apprentice member of the clinical team.

It is for medical schools as to whether they have a white coat ceremony. If a ceremony is held it is important to avoid any suggestion that the ceremony is distancing the medical student cohort or excluding others: the emphasis must be on the medical students' future obligations and role in the service and safety of patients.

The ceremony does provide an opportunity to reinforce the importance of professionalism but this may be done in other ways, and the ceremony by itself is not enough. It is the reinforcement of professionalism before the major clinical placement that is the key. Whether this reinforcement takes place in a specific pre-clinical attachment "block" or as an integral part of the curriculum is again for medical schools to assess and determine.

7.   SOME KEY THEMES

7.1 Patterns of unprofessionalism

Schools should consider whether to record student attendance, including at clinical sites, and enforce minimum attendance as an indicator of professionalism, with consequences (e.g. exclusion from examinations) for an unsatisfactory attendance level. There should be clear specification as to what constitutes acceptable reasons for absence.

A balance should be struck between the fact that all medical students are adults and are expected to take responsibility for their own behaviour; and the apparent link between future disciplinary problems and irresponsibility, e.g. unjustified absenteeism.

Research in other jurisdictions suggests that an unremediated deficit in professionalism as a student is predictive of future poor performance as a qualified doctor, with serious ethical breaches in a doctor's career preceded by a history of poor professionalism that began at the undergraduate level. The Medical Council has in recent years emphasised the spectrum or continuum of competence. The potential implications of this reverse continuum of professional deficit continuing unremediated are obvious.

The evidence underlines the need for medical schools to act during the early formative stages of medical education and training before habits become ingrained and when behaviour may be more malleable.

7.2 Professionalism on clinical sites

Clinical sites play a key role in encouraging or discouraging professionalism. Students generally have early exposure to patients. The second part of the programme is spent predominantly on clinical training sites, ranging in size from small general practices to major urban teaching hospitals, and various stages in between. Site ethos has significant potential to enhance or undermine successful development of professionalism.

Major clinical placements introduce a new dimension into the education and training process and into professionalism. Students are becoming part of a clinical community. There is the personal dimension for the student: they are now spending significant time in a new and unfamiliar environment away from the campus that has been their "home". Depending on the rotation, they may or may not be with their classmates. They are in an environment which, however committed to education and training it may be, has a different primary focus than a medical school: the delivery of clinical care, with all the pressures that entails on those delivering it. Students will have greater exposure to junior doctors and to the most senior doctors and to other members of the healthcare team. Above all they will have greater exposure to patients and to patients' relatives and friends.

There are challenges inherent in this transition to "practical professionalism". One of them is maintaining professionalism in a new context. The entry into major clinical placements is when the pre-clinical foundations laid in the earlier part of the programme should pay dividends, and where reinforcement tailored to the clinical context should be provided by the school.

In many instances the content of these Guidelines is equally applicable to the campus and to the clinical site (and indeed to the electronic environment). But medical schools should be particularly aware of the relevance to clinical sites of:

- ♦   **Students' professional interaction with patients**

- ♦   **Role models and the hidden curriculum**

- ♦   **The need for informal support and advice on professionalism**

- ♦   **The need for continued access to pastoral support: that is, support for students' mental, emotional and physical wellbeing, and for their general welfare.**

There must be encouragement and support for students to come forward if they believe they may have witnessed an event with patient safety implications. In discussions with students during accreditations, reports of witnessing such events are uncommon, but students generally understand that they must put patient safety first, and would discuss concerns with their supervisor, mentor, or trusted other.

Other partners in the education and training process - primarily the Health Service Executive - should provide familiarisation for students on generic and site-specific policies and procedures. Effective interaction between medical schools and healthcare bodies - including in the form of contracts, Memoranda of Understanding and formal liaison committees – promotes mutual organisational understanding of expectations. Medical schools, assisted by healthcare bodies, should foster an awareness of these Guidelines among teachers on clinical sites.

Medical schools policies and procedures should address and promote immunisation compliance by students. The promotion of immunisation compliance by medical schools not only protects the health of the individual/student but also the health of patients and their families, colleagues and all those participating in or consuming health care. Conscientiousness demonstrated by the immunisation compliance of students and healthcare professionals positively correlates with professionalism and contributes to their ability to serve as role models.

Many students are eager to become immersed in the clinical environment and to apply on sites the professionalism they have learnt and applied to some extent in the earlier part of the programme. While there are new challenges there are also new opportunities for students to translate theory into practice, in an environment that supports and nurtures their growing professionalism.

7.3 Inter-professional professionalism

When students become doctors they work as members of a health care team. Learning about, with, and from students and teachers from a range of healthcare disciplines can enrich the curriculum and prepare students for future interdisciplinary multi-professional practice. "Practical inter-professionalism" in the clinical training environment can be especially rewarding, and allows students to access the good professional practice and positive role models of other disciplines. Working collaboratively in teams is an essential part of modern medical practice and requires an understanding of and respect for their roles. Developing inter-professional professionalism should be an aim for every medical school. There is already significant commitment (from students as well as from staff) and implementation of this to build upon.

There are challenges involved - infrastructure and resources, an already intense medical curriculum, the logistics of dovetailing of curricula content, scheduling and timetabling, and assessment - involved in expanding inter-professional teaching and learning opportunities. However, the accreditation process found a consensus among the students that they would welcome more opportunities to interact and collaborate with nurses and other healthcare professionals. The Council commends this as good practice.

7.4 Well–being and professionalism

As well as being crucial for the individual student, student well-being appears to be positively correlated with professionalism. Support is needed at every stage of the student lifecycle: but it is particularly important on clinical sites. There, students are facing the challenges outlined above, and may also be dealing with the hidden curriculum, any shortfalls in the standards of role modelling, and being emotionally challenged by their exposure to patients and possibly critical incidents. There must be clear structures in place for students on sites as well as on campus to access advice and support, which should include opportunities for reflection, feedback and discussion about their experiences. Clear information about what to do in the event of an ethical dilemma is important.

Reinforcing professionalism as students' progress through the clinical environment is essential. The development of professionalism does not have an inevitably upward trajectory: it may "hit a ceiling" and halt, it may plateau or it may even regress as a student moves through the programme. It has been hypothesised that students on the primarily clinical part of medical

programmes undergo a decline in empathy, resulting in a "hardening of the heart"; and that this may be linked with a life event, with student distress due to other causes, or with "burnout" - emotional exhaustion, depersonalisation and low sense of personal accomplishment. Encouraging the development of resilience among students has a role to play here. It can also be hypothesized that burnout is a result of exposure to a covert curriculum which conflicts with the overt curriculum that has been the focus of the earlier stages of the programme.

In any case, empathy underpins the doctor–patient relationship and more empathetic students may also be more clinically competent students. Certainly empathy is part of the professionalism portfolio, and even the potential for its decline is a further reason to ensure that professionalism has the necessary prominence.

7.5 Online professionalism

Social media use has expanded exponentially over the past decade. The demographic of students, including medical students, predisposes to widespread use of social networks. It is safe to assume that nearly all medical students have a social media presence. The high level of use – time spent online - must also be factored in. Its use is not confined to students: all medical schools in Ireland now have a Facebook page.

There are positive and potentially negative implications and applications of the practically universal use of social networking technology. Positive applications include using it as a resource for learning, promoting collaboration, its student–generated content possibilities, promoting peer learning, enabling informal study groups, allowing sharing of narratives in an anonymised and respectful way, and developing capacity for reflection.

The importance of students maintaining professionalism when they are online -"e-professionalism" - is a prime example of the need to apply professionalism to new scenarios. Patients need to have confidence that future doctors will be appropriately professional in the virtual as well as the real environment, and there is a need for medical schools to support students to develop and maintain online professionalism.

It should be noted that in many cases, online professionalism requires the same standards and practices of professionalism as are required in any setting. In its intent and effect on the bullied individual for example, cyber–bullying does not radically differ from other forms of bullying. But the scope and the reach of the technology and potential for viral spread of content creates a new dimension.

The Medical Council is aware that social networking sites are at the intersection of students' personal and professional identity. Guidance in this area requires the right balance between maintenance of professionalism and the right of the student to a private life and freedom of expression. The Medical Council does not expect medical schools to "police" individual student's sites. It does expect schools to foster good online professionalism among the student body as part of its wider remit to develop awareness and adherence to professionalism.

There is an onus on medical schools to ensure that any material that originates from or represents a recognised student society or student group is congruent with appropriate standards of professionalism.

Medical schools should:

♦   **Foster student awareness of the importance of online professionalism**

♦   **Develop principles for online professionalism based on consultation and broad consensus, including among the student body**

♦   **Develop guidance to support students' online professionalism**

♦   **Consider providing specific guidelines on online behaviour that is inconsistent with professionalism, for example:**

◊   **Violations of patient confidentiality (recognising that even when patients are not named, sufficient details may be disclosed to enable identification)**

◊   **Use of offensive or derogatory language**

◊   **Depictions of intoxication**

◊   **Sexually suggestive material.**

The Medical Council intends to produce Guidelines on social media for the profession, and in due course medical schools should review these to ensure congruency with their guidance.

The issue of deficits in online professionalism is dealt with in part two of these Guidelines. Procedures for dealing with professional deficits are applicable to online activity.

7.6 Preparation for internship

Intern training is a crucial formative stage in the development of doctors. It is the final year of Basic Medical Training which most doctors will complete immediately following the award of their Primary Medical Qualification. It will be spent in a number of training rotations in a range of specialties approved by the Medical Council, and at a training site which is inspected and approved by the Medical Council.

Despite the exposure to clinical practice that occurs in modern undergraduate medical programmes, the change from medical student to intern is still very significant. It brings fresh challenges and opportunities. Although internship is the final year of Basic Medical Training, interns are registered doctors and contribute towards the provision of clinical care and service. They are required to adhere to the Medcial Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners. As there is no statutory distinction between registrants in this regard, interns are subject to Fitness to Practise procedures.

Strengthening professionalism at undergraduate level should ease this transition from student to intern. The growing emphasis on ethics in the undergraduate curricula of medical schools that award an Irish degree has already familiarised students with professionalism: learning about professionalism, seeing professionalism in action, and learning how to be professional themselves. Furthermore, if SFTP is effective, students with severe professional deficits will not become interns.

Schools should provide opportunities for reinforcing professionalism immediately pre-internship, and assess the viability of sub-internships, completion modules, shadowing and comprehensive inductions with an emphasis on practical professionalism as well as practical clinical skills.

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PART TWO

DEALING

WITH PROFESSIONAL DEFICITS

8.   INTRODUCTION

8.1 The importance of dealing with unprofessionalism

Assessing professionalism in terms of students knowing about professionalism is not enough. Undergraduate medical educators have an educational and societal obligation to ensure that their graduates possess the attributes of professionalism requisite for practicing medicine. Despite the generally high standard of student professionalism, and the efforts made by medical schools, there will inevitably be cases of students who are falling below the standard required. In addition to fostering good practice in student professionalism, medical schools need to take practical steps to deal with instances or patterns of professional deficit.

Dealing effectively with unprofessionalism is necessary primarily in the interests of the patients whose well-being may be compromised by the unprofessionalism of the individual involved. But it is also necessary in the interests of the student's peers; to maintain the quality of the graduates being produced; and to protect the integrity of the programme as a whole.

There must be opportunities within the medical school to identify as early as possible students who have professional deficits, and to act appropriately. Not detecting professional deficits at the earliest possible stage is a missed opportunity for an institutional effort to provide remediation. So too is detecting the deficit but not dealing effectively with it. Either runs counter to the interests of the individual student, the student body, the medical school, the wider community and most importantly the health and well-being of patients. A "failure to fail" where failure is justified is unacceptable.

It should be emphasised that the Medical Council is not expecting perfection in medical students' professionalism. That is unrealistic at any stage, and still less when students are maturing into their future role. It is the seriousness of an isolated but major incident, the cumulative impact of a series of deficits, persistence of deficit, and the approach of the student to overcoming that deficit that are significant in this context. There is an ethical imperative to protect the public.

8.2 Current situation

Medical schools are commendably keen to ensure that students who continue to display major deficits in professionalism, despite the best efforts of the school, are not allowed to graduate with a medical degree. Medical schools have therefore developed policies and processes to tackle student unprofessionalism.

In June 2014 the Medical Council asked all medical schools (in Ireland and overseas) that awarded an Irish degree to complete a survey on developing and maintaining undergraduate professionalism, which included questions about their student fitness to proceed/graduate procedures. The results showed that there was a considerable amount of good practice in Irish medical schools that can be built on using these Guidelines as a framework. One of the clear messages from the survey was that the schools were keen to see Guidelines on this issue from the national regulator to support the work the schools are doing. This is one of the major aims of the Guidelines.

The Guidelines are intended to promote consistency in decision-making within schools and between different schools, and are predicated on the principle that the Medical Council and medical schools need to take a joint approach to reach a common goal of ensuring the professionalism of graduates and registrants.

8.3 Medical Council role in Student Fitness to Proceed

The Council will have no direct role in SFTP. There is no statutory foundation for such an involvement by Council. Council's role in this context is one of providing Guidelines to approved bodies and assessing the way in which those bodies are implementing the Guidelines, and taking any action necessary in regard to the medical school as part of Council's quality assurance activity. It has no part to play in a medical school's SFTP in an individual case, and all stages of the process, including appeals procedures, will take place within a medical school and/or university framework.

8.4 The role of the university

Where a medical school is part of a university, it is crucial that university procedures should reflect the fact that medical students (in common with students from other clinical disciplines) have a particular responsibility to be professional, and that the organisation tackles any instances of unprofessionalism accordingly. Medical schools should reinforce the Council's message that university authorities should ensure that their processes reflect these Guidelines.

9. FRAMEWORK AND RESOURCES

9.1 Framework

Medical schools should formally adopt:

- **Clear and patient-centred SFTP principles**

- **SFTP policies that support those principles**

- **SFTP processes that support those policies**

Polices and processes should be robust, fair and understandable.

Principles, policies and processes should be accessible and actively disseminated and promoted to:

- **Students in all years of the medical programme**

- **Medical school staff, academic and administrative**

- **University staff, academic and administrative**

- **Staff on clinical training sites, clinical and administrative**

- **Anyone involved with the formal advice and support activity and / or panel activity discussed below.**

In addition:

- **Students should be made aware of the principles, policies and processes, which should be presented in a sensitive way that fosters understanding of the rationale as well as the mechanisms.**

- **This knowledge and understanding should be regularly reinforced.**

- **Medical schools should review principles, policies and processes on a regular basis.**

- **Principles, policies and processes should be congruent with these Guidelines.**

9.2 Resources including staff

Schools should ensure that:

- **Appropriate resources are available to support an effective SFTP process**

- **Staff involved in dealing with students with professionalism deficits are equipped and supported to perform this important role**

- **Staff involved in dealing with students with professionalism deficits feel that their contributions are valued and respected**

- **Staff taking an active part in SFTP should be seen by medical schools as making a positive commitment to quality assurance, and performing a key a mainstream activity.**

10. INFORMAL ADVICE AND SUPPORT

Informal advice and support are not part of the SFTP process. They are part of the normal interaction between the medical school and its students. All those involved in teaching and administrative support should be aware of the informal advice and support available. Students should be enabled of their own volition to discuss their professionalism within a context of informal advice and support.

It is appreciated that this will require a significant degree of insight on the part of the student; that students with professionalism deficits may be the least likely to have this insight; and that a degree of courage is needed for students to reveal such issues to those "in authority". Nevertheless, there should be information and opportunity for students to raise issues related to their own potential professional deficits.

There must be parallel information and opportunity for students to raise issues related to potential professional deficits in others.

In the case of relatively minor professional deficits, informal advice and support would normally be the most appropriate first step and the initial "default" position. Some students who seek informal advice and support may simply need reassurance that they are acting professionally. In many cases resolution may result from indicating the need for improvement and providing advice and support on the achievement of a positive outcome.

Informal advice and support may be given as a part of "unplanned" feedback; following a routine formative or summative assessment; or during a meeting arranged by the student or member of staff to discuss a particular issue arising.

It is recognised that in many cases a teacher will themselves directly advise a student, and in many cases this is the most appropriate course of action. But teachers should bear in mind that in some cases informal advice and support is best provided by (an)other(s) and should - with the student's consent – refer accordingly.

Informal advice and support should also be available for students whose deficits have been addressed via the more formal mechanisms set out in these Guidelines: those students should be able subsequently to access informal advice and support to reinforce professionalism and maintain the progress they have made in addressing any deficits.

Where informal advice and support does not achieve the desired outcome, formal advice and support should be commenced. In cases of more serious deficit, direct referral to formal advice and support including remediation is indicated. There is no onus on the school to offer informal advice and support first in such cases.

Where students have specific concerns, triggered by their personal or observed experiences or otherwise, there should be clear polices and processes for addressing them. In many cases, a student's initial need is for discussion with a trusted other, and for advice. Students must be able to share and explore their experiences and perceptions and concerns in a safe and confidential environment that will encourage them to come forward.

11. STAGE ONE SFTP : FORMAL ADVICE AND SUPPORT INCLUDING REMEDIATION

This is the first stage of a formal SFTP process. While it may be the student's decision to seek informal advice and support in the first instance, the decision to provide formal advice and support including remediation will normally be a medical school decision.

Formal advice and support is normally appropriate when the student demonstrates:

♦ **A continuing pattern of minor deficits which when viewed in isolation may seem insignificant but when seen cumulatively indicate an issue which has not been resolved by informal advice and support**

♦ **An isolated (but not gross) lapse from previously high standards.**

Formal advice and support including remediation therefore may, depending on the nature of the deficit, be based on the outcome of initial informal advice and support, which was found to be insufficient to produce the necessary improvement, or may be the first recourse.

All those involved in teaching and administrative support should be aware that there is a framework and clear channels for referral of a student for formal advice and support including remediation. This is particularly important when students are on extended clinical placements.

The Medical Council is not prescriptive as to the composition of the group that undertakes Stage One of the STFP process. Medical schools are best placed to decide on the requisite level of seniority, experience and competency that an effective evaluation group would comprise. Consideration should be given however as to whether it is appropriate for an individual who has been involved in providing informal advice and support to a particular student to participate in formal advice and support for the same student: it may be that these roles are best played by different individuals.

While a number of individuals are likely to be involved in the process, an individual should be identified as the focal point for liaison with the student regarding their identified deficit.

They should, after appropriate consultation, including with the student, draw up an action plan intended to address and resolve the student's professionalism deficit(s).

The action plan should be a joint commitment between the student and the identified focal point of the Stage One group and should be:

♦ **Relevant to the student and the issue(s)**

♦ **Transparent in terms of timescale and expected outcome(s)**

♦ **Realistic**

♦ **Measurable in terms of evaluation of the students' progress and the scope for attainment of the plan.**

An action plan could include commitments regarding:

♦ **Attending remedial teaching**

♦ **Attending a support service**

♦ **Additional mentoring or supervision**

♦ **Adhering to specified behaviour(s)**

♦ **Discontinuing a specified behaviour.**

An action plan is appropriate only if there are grounds to believe that the student will comply with it: e.g. because they take responsibility for their own actions; demonstrate an apparently genuine understanding/acceptance/regret about the deficits; are willing to enter into remediation; have already made attempts to overcome the deficits; and where there is a reasonable chance of remediation being successful.

The medical school should ensure appropriate record-keeping and monitor progress. If there is a positive outcome, there should be a sign off to this effect by the student and the school. The student may be advised to use informal support and advice to maintain that improvement.

12. STAGE TWO SFTP: THE SFTP PANEL

12.1 Referrals

Students can be referred to Stage Two following unsuccessful remediation at Stage One. It is anticipated that in many cases attempted remediation via an action plan will be tried as a first option, and that it is only if that attempt is unsuccessful that the student will be referred to Stage Two.

However, it must be emphasised that there is no onus on the medical school to take this course of action. If the nature of the professional deficit is such as to make it appropriate, then the student should be directly referred to Stage Two, without first going through Stage One. This would be the normal course of action in the case of a potential gross breach of professionalism.

Definitions in these Guidelines of what constitutes a potential gross breach cannot be too prescriptive. Thresholds will always inevitably be open to interpretation. Action must be taken by the school on a case-by-case basis.

However, deficits which fall into categories 1 (criminality), 2 (attitudes and behaviour towards patients), 3 (abuse, aggression, threat of violence, use of violence) or 7 (alcohol or substance misuse) of the Annex to these Guidelines indicates that the course of action that should normally be taken by the medical school would be direct referral to Stage Two. Deficits in other categories may depending on the nature of the deficit indicate direct referral.

In particular, the medical school should always consider the possibility of a gross breach, and direct referral to Stage Two, where the deficit includes but is not limited to:

♦ **Potential significant compromising of patient safety, dignity or well-being**

♦ **Potential significantly compromising of the safety, dignity or well-being of fellow students, medical school / university staff, or staff on clinical training sites**

♦ **Potential or actual criminal activity (including online).**

In the case of potential significant compromising of the safety, dignity or well-being of others, or of potential or actual criminal activity, the referral to Stage Two would normally be accompanied by suspension from the programme pending the outcome of Stage Two; or by curtailment of the student's activities so as to remove the opportunity for further potential breaches, e.g. by removal of the student from clinical placement and their restriction to academic activity not involving patient contact, or to private study.

12.2 Corporate governance

The term pool is used to denote a group from whom members of each panel are drawn.

The process for formation of the pool and the panel should be clear and comply with good practice in equality and diversity.

There should be clear Terms of Reference detailing the composition, remit and responsibilities of the pool and the panel. The panel's reporting arrangements within the medical school and the university should be clear, including the various levels of approval that are required post-panel, and the appeals process. The relationship between this process and other codes, policies and processes within the school or university should be clear.

There should be generic timelines which are intended to apply to all stages of all cases. If for good reasons the school cannot meet the anticipated milestones, this should be clearly communicated to the student. The school should be prepared to adjust timelines if the student presents reasonable grounds for that adjustment.

12.3 SFTP pool and panel members

Medical schools should consider establishing a joint pool of assessors with members drawn from each medical school.

Panels for particular cases should be established from within the pool. The majority of the members of each panel should be from the student's own medical school, but each panel should have at least one external member.

Due consideration should be given to potential conflict of interest issues. Members of staff who have been closely involved in providing informal or formal advice and support to a particular student should not be members of the panel hearing that student's case.

12.4 Competencies of pool and panel members, including appeal panel members

The core competencies expected of each member should include:

- ♦ **Prioritising patient safety**

- ♦ **Adherence to high personal ethical standards**

- ♦ **Commitment to equality and diversity**

- ♦ **Maintaining confidentiality, impartiality and objectivity**

- ♦ **Making decisions based on analysis of evidence and on logic**

- ♦ **Knowledge and understanding of third-level healthcare education in Ireland or in another jurisdiction**

- ♦ **Interpersonal and communication skills**

- ♦ **Ability to understand and absorb complex information**

- ♦ **The appropriate level of seniority/experience**

- ♦ **Comprehensive knowledge and understanding of the relevant internal polices and processes and their application and (in due course) comprehensive knowledge and understanding of these Medical Council Guidelines.**

As well as medical school staff, schools should also consider whether the following should be included in the pool:

- ♦ **Externs from outside the State**

- ♦ **Nominees from patient representative groups**

- ♦ **Nominees from healthcare organisations**

- ♦ **Students**

- ♦ **Those with legal qualifications/experience**

- ♦ **Those with counselling qualifications/experience.**

12.5 Panel members' training

All panel members should receive training for their role. If a pool of assessors is jointly established by the schools, consideration should be given to joint training of assessors. Collaboration among schools in the training of members of SFTP panels would have resource implications in terms of economies of scale. It would also tend to promote consistency of approach among panel members and thereby consistency in the decision-making process, both within medical schools and among medical schools.

Training should include developing comprehensive knowledge and understanding of the relevant internal polices and processes and their application and (in due course) comprehensive knowledge and understanding of these Medical Council Guidelines.

12.6 Proceedings

The Panel reviewing the case should consider the evidence and determine the appropriate outcome.

Proceedings should be fair and transparent and, among other things, the process should:

♦   **Provide the student in advance with the information upon which the Panel will adjudicate**

♦   **Advise the student in advance of their right to representation and/or support**

♦   **Ensure that the conduct of meetings is in line with best practice**

♦   **Ensure that the student (if they chose to attend) has an opportunity to make their case**

♦   **Make their decision on the grounds of balance of probability**

♦   **Prescribe an appropriate course of action**

♦   **Provide a report to both parties that clearly specifics the decision and the reason for it**

♦   **Maintain all relevant records are kept of all panel deliberations, confidentially and in line with university policies and relevant data protection legislation.**

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Action

Student Fitness
to Proceed
Outcome

Student Fitness
to Proceed
Panel

Formal Advice, Support
and Remediation

Informal advice and support
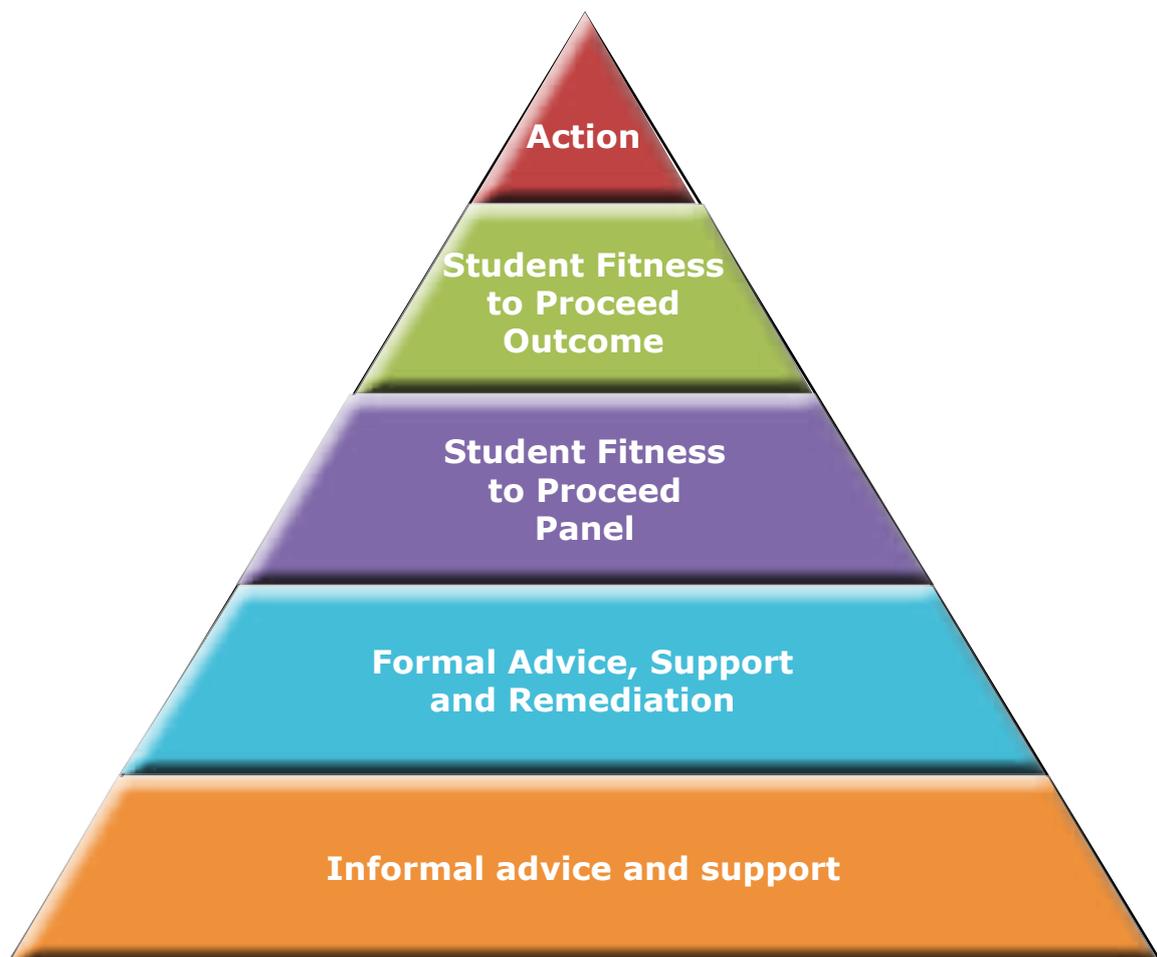
13. POTENTIAL OUTCOMES OF SFTP

13.1 Range of options

As always, patient safety and well-being and the interests of the public should be paramount in the decision-making process.

The range of options open to the panel should be specified, and normally include:

♦ **No deficit (no action required, informal advice and support may be indicated)**

♦ **Some deficit, such as to warrant a course of action not amounting to exclusion from the programme, which may include:**

  ◊ **An admonition/reprimand and/or**

  ◊ **A requirement to undertake an additional course of study/period of study, or to repeat a period of study, or undertake some other prescribed action and/or**

  ◊ **Restitution and/or**

  ◊ **Suspension for a specified period.**

♦ **Deficit such as to render the student unfit to proceed, with exclusion from the programme.**

The finding of some deficit should be reserved for cases where the Panel believes that there is at least the potential for the student to be remediated, and where the student is willing to take the action required. In a finding of some deficit, the action taken should:

♦ **Be appropriate for the specific case and the issues that prompted the Panel meeting**

♦ **Include a timescale and an expected outcome that can be measured and used to benchmark progress**

♦ **Be proportionate, realistic and achievable.**

The school should monitor progress towards required the outcome(s).

In all cases, the outcome should be communicated to the student in a timely manner.

13.2 Appeals Processes

There should be a fair and transparent process for appealing the findings of the SFTP Panel. This should be heard by an Appeals Panel. The process for formation of the pool and the panel should be clear and comply with good practice in equality and diversity. Those who have been closely involved in informal or formal advice and support for a particular student, and those who served on the panel that considered that student's case, should not sit on the Appeals Panel.

There should be clear Terms of Reference detailing the remit, responsibilities and composition of the Appeals pool and the panel.

The Terms of Reference should include:

♦   **The grounds on which an appeal may be made, including extenuating circumstances that may be taken into account**

♦   **The student's representation at the appeal panel**

♦   **Admission or otherwise of fresh evidence**

♦   **The powers of the appeal panel**

♦   **The reporting arrangements of the appeal panel**

♦   **The potential outcomes, e.g. appeal upheld, sanction(s) amended, appeal rejected.**

As always, patient safety and well-being and the interests of the public should be uppermost in the decision-making process.

The outcome should be communicated to the student in a timely manner.

All panel-related information, including the outcome, should be dealt with in a confidential manner, in line with university policies and in accordance with relevant data protection legislation.

13.3 Exclusion from the medical programme

This course of action is obviously the most the most serious that can be taken by a panel. It reflects a decision that is taken based on all the evidence available, the student is not fit to proceed to the next year of the programme or to graduate as a doctor. If the panel finds that exclusion is the only way of protecting patients, peers, staff or the public, then it is the appropriate action to take.

Schools will have to strike the balance between allowing a student the time and opportunity to benefit from the framework that is in place for formal advice and support including remediation, and prolonging the student's career beyond the point at which improvement is feasible, which benefits neither the student, the school, patients nor the public.

It is not possible to provide a definitive list of professionalism deficits that provide grounds for expulsion. However, the severity of a single transgression, or a pattern of repeated and apparently intractable transgressions of a less serious but still significant nature, should be taken into account. Some potential grounds for exclusion are that the student has:

♦   **Behaved in a way that is fundamentally incompatible with being a doctor**

♦   **Shown a reckless disregard for patient safety**

♦   **Done serious harm to others, patients or otherwise, either deliberately or through incompetence, particularly when there is a continuing risk to patients**

♦   **Abused their position of trust**

♦ **Violated a patient's rights or exploited a vulnerable person**

♦ **Committed offences of a sexual nature, including involvement in child pornography**

♦ **Committed offences involving violence**

♦ **Been dishonest, including covering up their actions, especially when the dishonesty has been persistent**

♦ **Put their own interests before those of patients**

♦ **Persistently shown a disregard or lack of insight into the seriousness of their actions or the consequences.**
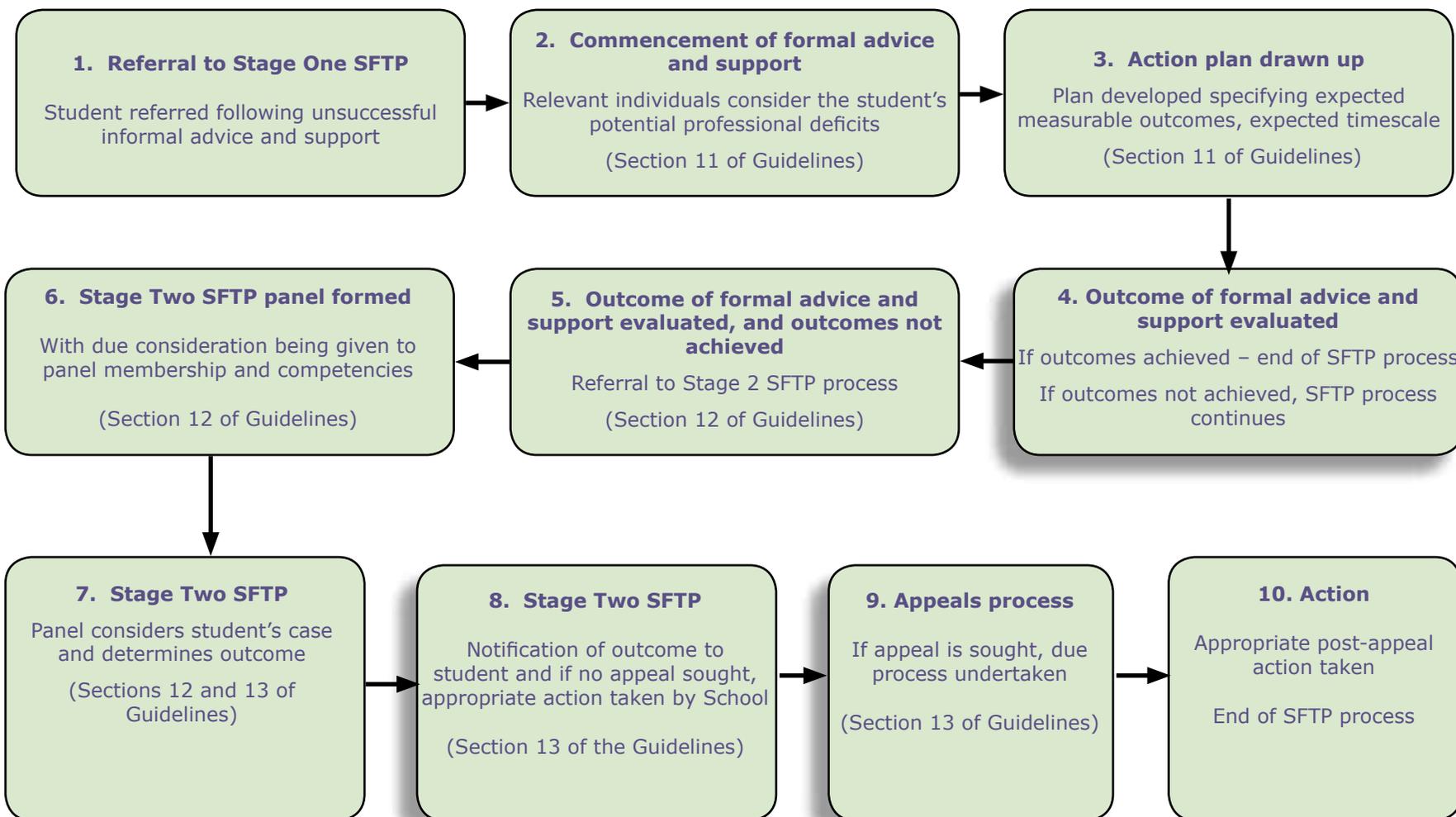
Possessing insight (having or showing an accurate and deep understanding; being perceptive) is not a panacea. A student may have an awareness of the underlying cause(s) of their unprofessionalism, and an awareness of the impact of that on others, without being willing or able to address it. To be truly useful, insight must be a springboard to action, and must be followed by a discernable change in behaviour. But insight is at least a starting point and normally an essential basis for cooperation by the student and for real progress.

In some cases it may be possible to assist excluded medical students to transfer to another course within the university. For students in the later stages of a medical programme, there may be the opportunity to graduate with a non-medical degree (the so-called "honorable exit"). The nature of the deficit and the student's behaviour is a major determinant and this may mean that graduation with any degree is not appropriate. The panel may make a recommendation in this regard.

It is accepted that exclusion from the programme is unfortunately likely to be distressing for the student and their family and friends. However, standards of acceptable and unacceptable professionalism must be set and implemented in the interests of the quality and integrity of medical education and training in general and the relevant programme and its graduates in particular. But the primary aim of exclusion is the protection and well-being of patients, peers, staff and the public. The Council's quality assurance and enhancement activity is undertaken under the provisions of the Act, an act "for the [purpose of better protecting…the public ….and for that purpose …to better ensure the education [and] training of medical practitioners". Approved bodies have an obligation to support the approving body – Council – in the fulfilment of this key part of its remit. Medical schools should be conscious of this obligation in all their SFTP principles, polices and processes, but particularly so when the level and/or frequency of professional deficit has reached the stage at which exclusion is a possible option.

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Student Fitness to Proceed 2015 - Process Flowchart

1. Referral to Stage One SFTP

Student referred following unsuccessful informal advice and support

2. Commencement of formal advice and support

Relevant individuals consider the student's potential professional deficits

(Section 11 of Guidelines)

3. Action plan drawn up

Plan developed specifying expected measurable outcomes, expected timescale

(Section 11 of Guidelines)

6. Stage Two SFTP panel formed

With due consideration being given to panel membership and competencies

(Section 12 of Guidelines)

5. Outcome of formal advice and support evaluated, and outcomes not achieved

Referral to Stage 2 SFTP process

(Section 12 of Guidelines)

4. Outcome of formal advice and support evaluated

If outcomes achieved – end of SFTP process

If outcomes not achieved, SFTP process continues

7. Stage Two SFTP

Panel considers student's case and determines outcome

(Sections 12 and 13 of Guidelines)

8. Stage Two SFTP

Notification of outcome to student and if no appeal sought, appropriate action taken by School

(Section 13 of the Guidelines)

9. Appeals process

If appeal is sought, due process undertaken

(Section 13 of Guidelines)

10. Action

Appropriate post-appeal action taken

End of SFTP process

14.   ESTABLISHING A FUNDAMENTAL PRINCIPLE

It is intended that the informal and formal advice, support and remediation provided for students will enable many of them to raise their standards of professionalism to acceptable standards. In cases where students struggle to do that, Stage Two SFTP highlights the seriousness with which major professional deficits are viewed and provides a further framework for overcoming deficits.

However, when students do not (because they will not or cannot) demonstrate professionalism, they should not be allowed to graduate with a medical degree even if they demonstrate satisfactory academic outcomes.

This is not a decision that medical schools and universities will make lightly. However, the career aspirations of an individual cannot be allowed to outweigh the interests of patients. The Council's statutory duty to better ensure the education and training of medical practitioners is specifically linked to the protection of the public; it is "for that purpose". The conferral of a medical degree is a de facto assurance from the medical school to the Medical Council that the graduate has demonstrated to the required level the competencies required to be a doctor. A high standard of professional behaviour is a key part of those competencies. If a student has been advised, supported and remediated in line with the Guidelines contained in this document, yet continues to display major deficits in professionalism, or if they commit a gross breach of professionalism, it is not appropriate for them to be conferred with a medical degree which enables them to register and practise.

15.   CONCLUSION

The safety of the public is at the centre of the Medical Council's remit, and is the ultimate purpose of all Council activity. Developing and maintaining high standards through education, training, and professional competence plays a key role in protecting the public. This is particularly important in an environment of rapidly changing scientific knowledge, high patient expectations and increasingly sophisticated health care delivery systems. Patients and the public rely on education and training to produce the high quality doctors that they need and deserve.

The responsibility to ensure these high standards of medical education and training is a shared one:

♦   **The Medical Council as the regulator has the statutory authority to set standards and monitor their delivery, and to make the accreditation decisions appropriate to its findings**

♦   **Medical schools as the deliverers have a duty to ensure that professionalism is fostered and embedded, and that deficits in professional behaviour are appropriately dealt with**

♦   **Doctors – irrespective of whether they have formal teaching commitments or not- have a duty to encourage students to achieve their potential and to provide role models that can be admired and emulated**

♦   **Managers of clinical sites have a responsibility to facilitate the education and training of medical students**

♦   **Last but not least, students themselves have a responsibility to be active participants in their own professional development and to be professional.**

Annex: Examples of professional deficits

Areas of concern	Indicative examples
1. Criminality (caution or conviction)	a) Sexual offences (including child pornography offences) b) Threatened/actual physical violence c) Dangerous driving d) Robbery/theft / burglary e) Fraud/deception f) Controlled drug offences (including cultivation or manufacture, possession for sale or supply, possession) g) Criminal damage h) Public order offences i) Road and traffic offences
2. Professional deficit in attitudes or behaviour towards patients	a) Inappropriate examinations of patients b) Other breach of apprpriate boundaries in patient interaction c) Poor communication skills, including rudeness or lack of respect d) Breaching patient confidentiality e) Deceiving patients about their care or treatment f) Deceiving a patient about one's student status, including the inappropriate provision of medical advice
3. Abuse, aggression, threat of violence, use of violence	a) Verbal abuse b) Intimidation c) Bullying d) Persistent harassment (including sexual harassment) e) Assault f) Incitement to violence (all irrespective of whether legal proceedings are involved)

Areas of concern	Indicative examples
4. Poor interaction (including with other students, staff members, the public, and the clinical team)	a) Poor communication skills b) Persistent rudeness or lack of respect c) Disruption of teaching and learning d) Persistent failure to work as a member of a clinical team or other group or team e) Unfair or unlawful discrimination on the grounds of gender, race or other factors
5. Academic professional deficit	a) Persistent poor attendance b) Cheating in examinations, logbooks or portfolios or other assignments (including plagiarism) c) Passing off others' work as one's own d) Forging a teacher's or supervisor's signature on assessments e) Falsifying research undertaken or research results
6. Other dishonesty or fraud	a) Financial fraud b) Producing fraudulent documentation c) Misrepresentation of academic attainments or qualifications d) Misrepresentation of medical student status in the clinical environment

Areas of concern	Indicative examples
7. Alcohol or substance misuse	a) Misuse of controlled drugs or substances (including cultivation or manufacture, possession for sale or supply, possessing or misusing illegal drugs) b) Alchohol or substance consumption impacting on the health of patients, the student, or those working in the academic or clinical environment c) Driving under the influence of alcohol or drugs (all irrespective of whether legal proceedings are involved)
8. Professional deficit in use of information technology (including the internet and social media)	Use of information technology to support potentially unprofessional activity in oneself or others including: a) Criminal activity b) Substance abuse c) Threatening, abusive, rude or lewd behaviour d) Falsification and dishonesty e) Breaches of patient confidentiality or dignity
9. Poor management of one's own health	a) Not declaring health or disability issue b) Demonstrable lack of insight into health concerns and their potential impact c) Failure to seek necessary medical treatment or other support d) Refusal to follow medical advice or care plan in relation to maintaining/regaining fitness to proceed

Documents referenced

1.   *Medical Practitioners Act 2007.*

2.   *Guidelines for Medical Schools on Ethical Standards and Behaviour Appropriate for Medical Students.* 2011. Dublin: Medical Council.

3.   *Guide to Professional Conduct and Ethics for Registered Medical Practitioners (7th Edition).* 2009. Dublin: Medical Council.

4.   *Talking about Good Professional Practice: views on what it means to be a good doctor.* 2014. Dublin: Medical Council.

THE "SEVEN Rs"

PRINCIPLES OF TEACHING AND LEARNING PROFESSIONALISM

RECOGNISED AS A KEY COMPETENCY OF MEDICAL PRACTICE

REALITY-BASED AND ROOTED IN CLINICALLY-ORIENTED SITUATIONS

REAL-PATIENT FOCUSED

REFLECTIVE

RESPECTFUL

REINFORCED

RELATED TO OTHER SUBJECTS