

# Towards a practical definition of professional behaviour

Wendy Rogers,<sup>1</sup> Angela Ballantyne<sup>2</sup>

<sup>1</sup>Department of Philosophy, Macquarie University, Sydney, Australia

<sup>2</sup>Department of Primary Health Care & General Practice, University of Otago, Wellington, New Zealand

## Correspondence to

Dr Angela Ballantyne, Department of Primary Health Care & General Practice, University of Otago, PO Box 7343, Wellington South 6242, New Zealand; [angela.ballantyne@otago.ac.nz](mailto:angela.ballantyne@otago.ac.nz)

Received 21 December 2009  
Accepted 28 January 2010

## ABSTRACT

**Context** Professionalism remains a challenging part of the medical curriculum to define, teach and evaluate. We suggest that one way to meet these challenges is to clarify the definition of professionalism and distinguish this from medical ethics.

**Methods** Our analysis is two staged. First, we reviewed influential definitions of professionalism and separated elements relating to (a) ethico-legal competencies, (b) clinical competence and (c) professionalism. In reference to professionalism, we then distinguished between aspirational virtues/values and specific behaviours. From these, we develop a working definition of medical professional behaviour consisting of six domains of behaviour: responsibility; relationships with and respect for patients; probity and honesty; self awareness and capacity for reflection; collaboration and team work; and care of colleagues. Second, we tested this working definition against empirical data concerning disciplinary action against practising doctors using (a) sources in the literature and (b) an original analysis of complaints received by the Medical Board of South Australia.

**Conclusion** Our empirical analysis supports the relevance of four of the six potential domains: responsibility; relationships with and respect for patients; probity and honesty; self awareness and capacity for reflection. There are additional reasons for retaining 'collaboration and team work' in the medical professional behaviour curriculum but 'care of colleagues' may be better addressed in the ethico-legal curriculum. Our definition of professional behaviour is consistent with the theoretical literature, captures behaviours that predict future complaints against practitioners and is consistent with current complaints about professionalism in South Australian practitioners. This definition can further the teaching and assessing of professional behaviour in medical schools.

## INTRODUCTION

Medical professionalism remains a topic that is difficult to define, teach and assess.<sup>1 2</sup> The importance of effectively teaching and assessing professionalism is not in doubt: medical schools have a social responsibility to the community to ensure that their graduates have high standards of professional behaviour. Unprofessional behaviour causes harm to the public, individual patients and the careers of doctors.

Nevertheless, various and conflicting accounts of professionalism have been proposed in the literature and many medical schools continue to struggle with how to teach these concepts effectively.<sup>3</sup> Professionalism is recognised as one of the most challenging of the USA Accreditation Council for Graduate Medical Education Competencies to define, teach and evaluate.<sup>4</sup> It is particularly problematic that professionalism is often conflated with medical ethics and is intermingled with clinical competencies. Both

teachers and students require a medical professionalism curriculum that is clear, assessable and, where possible, evidence-based.

In this paper we present an account of medical professional behaviour. Our working definition comprises six domains of behaviour and is derived from an analysis of influential accounts of professionalism. We assess and refine this account according to (a) published empirical literature linking student behaviour to disciplinary action against practising doctors and (b) unprofessional behaviours leading to complaints at the Medical Board of South Australia (MBSA).

## Theoretical definitions of medical professional behaviour—ethics, law, clinical competence and professionalism

In this section we examine key theoretical accounts of medical professional behaviour to identify elements that are both distinct to medical professional behaviour and assessable. The wide variety of definitions of medical professional behaviour in the literature reflects the challenges in defining this element of medical practice. We classify the following examples, which are typical of the literature, as broad and aspirational definitions of medical professional behaviour because they include behaviours and ideals, values, virtues and motivations that doctors are supposed to embody. These aspirational elements can be particularly difficult to translate into an assessable curriculum.

- ▶ 'Professionalism aspires to altruism, accountability, excellence, duty, service, honour, integrity and respect for others.'<sup>5</sup>
- ▶ 'Four attributes commonly recognised as essential to professionalism: subordination of one's self-interests, adherence to high ethical and moral standards, response to societal needs and demonstration of evincible core humanistic values.'<sup>6</sup>
- ▶ 'Professionalism is placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health.'<sup>7</sup>
- ▶ 'We contend that medical professionalism is rooted in attitudes [which] should lead to intentions to engage in appropriate professional behaviours. These behaviours may include ethical and moral actions, clinical competence, communication skills, sensitivity to diverse populations and acts of social responsibility.'<sup>8</sup>

First, these and similar definitions commonly include three elements that can be usefully distinguished: clinical competence, ethico-legal competence and professional competence. Such broad definitions are difficult to operationalise in terms of an assessable curriculum. We believe that there are

several reasons for favouring a narrower definition that focuses solely on medical professional behaviour. Overly broad definitions of professionalism lead to redundancy by unnecessarily repeating other well accepted elements of the medical curriculum. Clinical competence is assessed throughout medical school so that there is no need to refer to it as an element of medical professionalism. If a student is not clinically competent he or she should not qualify to practice, making any further consideration of professional behaviours irrelevant. Likewise, ethico-legal competence is widely taught in medical schools. This part of the curriculum is the appropriate place for discussing complex and nuanced questions concerning the role of ethics, morality and law in medicine. Clarity would be better served by keeping clinical competency, medical ethics and professionalism as distinct components of the medical education process.

A second concern with the definitions cited above is that they include reference to aspirational virtues and values—including clinical and personal excellence; altruism and selflessness; and community advocacy for social justice. These are qualities that we would all like our personal physicians to have, but these are not appropriate standards for assessing medical students. One can be a competent and professional medical practitioner without these qualities; therefore it seems hypocritical to demand a standard of students that is not required of practitioners. We discuss each of these aspirational values in turn.

#### Clinical and personal excellence

The American Board of Internal Medicine includes a commitment to clinical excellence as a component of professionalism: 'The elements of professionalism required of candidates seeking certification and recertification from the [American Board of Internal Medicine] encompass: a commitment to the highest standards of excellence in the practice of medicine and in the generation and dissemination of knowledge.'<sup>5</sup> We have already indicated that reference to clinical skills is redundant as clinical knowledge is assessed repeatedly throughout medical school. Here we point to a different problem. Teaching standards should be set to measure competence rather than excellence. Excellence is relative and refers to the 'cream of the crop'. By definition the majority of students cannot all be excellent. Students should not be expected to display either clinical or personal excellence to be certified as doctors, rather the assessment standards should reflect the required level of competence.

#### Altruism

Altruism is stressed in some influential accounts of professionalism, which require the physician to subordinate their interests to the interests of their patients or to society more generally.<sup>7</sup> Complex values such as altruism are hard to identify and assess in students. Furthermore, it is unrealistic to expect medical schools to require altruism from their students, particularly in current medical contexts where proceduralists with strong technical skills are consistently rewarded more than doctors who display virtues such as compassion in their practice, or who spend time with patients. A medical professional behaviour curriculum demanding standards that are not required for successful practice runs the risk of alienating students and being seen as hypocritical.

#### Community advocacy

Although some authors argue that ethics should be a component of professionalism teaching,<sup>9</sup> we contend that ethics is distinct from professionalism and that the value of explicitly including professionalism in medical curricula lies in focusing on unique professional behaviours not captured elsewhere. Wynia *et al* note

that the term professionalism comes from the Latin, 'speaking forth'. They define patient and public health advocacy and activism as a core component of medical professionalism. This can range from internal advocacy for healthcare values, internal organisational criticism through to whistle-blowing and direct professional disobedience.<sup>10</sup> We agree with Wynia *et al* that topics such as conflicts of interest, whistle-blowing, patient advocacy and healthcare values are important components of medical school curriculum, but argue that they are more appropriately situated as part of the ethico-legal components of medical courses. In particular, medical ethics provides a forum for students to discuss the values and virtues that characterise medicine and to debate topics such as conflicts of interests and social justice.<sup>11</sup> Students are not, and should not be, assessed as to whether they *are* altruistic or adopt a certain philosophy of social justice and advocacy.

#### Six proposed domains of medical professionalism

Not all accounts of professionalism in the literature include aspirational components.<sup>12</sup> Davis *et al*, for example, recently attempted to provide a bottom-up, behaviour-based account of professional behaviours based on survey data of patient preferences.<sup>13</sup> We align ourselves with these efforts to develop an empirically-derived and behaviour-based account of medical professional behaviour.

Having reviewed the theoretical literature and excluded elements of definitions that refer to ethico-legal or clinical competence, and that were aspirational in nature we were left with six potential domains of professional behaviour. These formed the basis of our working definition of medical professionalism:

1. Responsibility (eg, conscientiousness, record keeping)
2. Relationships with and respect for patients
3. Probity and honesty
4. Self awareness and capacity for reflection
5. Collaboration and working with colleagues
6. Care of colleagues

In the second part of our analysis, we tested these domains against, first, published empirical studies addressing professional behaviour and, second, complaints regarding unprofessional behaviour submitted to the MBSA.

#### EVIDENCE-BASED: EMPIRICAL RESEARCH INTO PROFESSIONALISM

One powerful source of evidence to inform the definition of professional behaviour comes from the recent research linking student behaviours with subsequent disciplinary actions against medical practitioners. This data is important because the ultimate aim of medical professional behaviour curriculum is to train doctors who practice in accordance with established social standards, in particular those that are acceptable to patients. In this section we draw on data from four studies in America and Australia.

Papadakis *et al* identified two specific unprofessional behaviours in medical school that are most predictive of subsequent disciplinary action against practising physicians. These were: (1) severe irresponsibility (eg, unreliable attendance and/or not following up on assigned tasks); and (2) severely diminished capacity for self-improvement (eg, failure to accept constructive criticism, argumentativeness and/or display of poor attitude).<sup>14</sup>

These results are supported in the study by Stern *et al* of student professionalism in an American medical school. These authors found two predictive characteristics. First, failure to demonstrate conscientious behaviour (eg, not completing

## Teaching and learning ethics

evaluations and/or submitting records of immunisations) and second, failure to display humility in self-assessments (eg, overrating their performance in patient interaction tests relative to the examiner's evaluation) were predictive of future unprofessional behaviour.<sup>12</sup>

Likewise, Teheranhi *et al* identified, in a retrospective case-control study, three critical domains of professionalism during medical school associated with future disciplinary action. These were poor reliability and responsibility, lack of self improvement and adaptability, and poor initiative and motivation.<sup>15</sup>

Consistent with the American results, Parker *et al* assessed the reasons for 711 reports submitted to the Personal and Professional Development Committee in an Australian graduate-entry medical programme. Note that this study does not link student unprofessional behaviour to subsequent disciplinary action of practicing doctors. Of the reports, 420 (55%) cited students' unsatisfactory attendance and 291 (45%) cited other concerns: most of these (51%) related to 'responsibility/reliability' and 'participation' combined; 12% related to 'honesty', 'discrimination' and 'doctor-patient relationship'.<sup>16</sup>

This research consistently demonstrates that some combination of lack of responsibility, unreliability, lack of self-awareness and diminished capacity for self-improvement are problematic areas for students' professional development and are linked to disciplinary action at practitioner level. These empirical studies therefore lend support for three of our six proposed domains of medical professionalism.

1. **Responsibility (eg, conscientiousness, record keeping)**
2. Relationships with and respect for patients
3. **Probity and honesty**
4. **Self awareness and capacity for reflection**
5. Collaboration and working with colleagues
6. Care of colleagues

In the second stage of our empirical analysis we further refined our proposed definition using complaints data from the MBSA. The MBSA publishes a summary of complaints received against medical practitioners in its *Annual Report*, listing them by primary allegation.<sup>17</sup> The value of using this data for refining our definition lies in the fact that the complaints reflect what the community actually objects to in practice, and therefore provides an important insight into the relevant and appropriate topics for medical professional behaviour curricula.

For our comparison, we first reclassified the 190 MBSA complaints using a three part division into clinical, ethico-legal and professional competence. In all, 54% of complaints related to clinical competence issues, 15% to ethico-legal issues, and the remaining 31% related to medical professional behaviour or fitness to practice concerns and these are outlined in table 1. The subclassifications of medical professional behaviour complaints are those used by the MBSA.

We omit medical fitness from our account of medical professional behaviour. We recognise that problems with medical fitness or ill health can manifest as unprofessional behaviour and/or lead to complaints. However, responding to practitioner ill health raises issues that are distinct from those raised by unprofessional behaviour or clinical incompetence that are not health related. There are many forms of practitioner ill health or medical unfitness (such as drug or alcohol dependence, mental illness or discrete physical disabilities) that may require monitoring or support but do not lead to unprofessional behaviour, therefore it seems appropriate to treat the issues separately.

This process left us with five behaviours as defined by the MBSA under the classification of 'unprofessional behaviour',

**Table 1** Sub classification of 31% of Medical Board of South Australia complaints 2007–2008 relating to medical professional behaviour

Classification	%
Practice management	9
Doctor's manner	8
Medical reports/records	8
Inappropriate behaviour	2
Advertising	2
Medical fitness	2
Total	31

which accounted for a significant proportion of total complaints (29–41% of all complaints from 2004–2005 to 2007–2008).<sup>17</sup>

We then requested from the Medical Board of South Australia a more detailed description of the 2007–2008 complaints in the five areas we had classified as unprofessional behaviours. The detailed descriptors of the types of complaints are presented in table 2. Descriptors were provided by the senior officer in the Professional Conduct and Performance Services who reviewed the 2007–2008 complaints and provided the level of detail shown in table 2. We did not have access to the original complaints as this data is confidential.

Finally, we provided the MBSA with our proposed six domains of student medical professional behaviour and asked them to map each 2007–2008 MBSA complaint to the domain that best captured the main element of the complaint. This analysis is shown in table 3.

During this period no complaints were received regarding relationships with colleagues or in relation to failure to take care of impaired colleagues. The greatest number of complaints related to issues of responsibility, 23 (45%) and problems relating to relationships with patients, 20 (39%).

This mapping exercise is an inexact process and there are a number of places in which the classifications may be challenged. For example, inappropriate comments and intrusive

**Table 2** Detailed description of Medical Board of South Australia (MBSA) professionalism complaints

MBSA unprofessional behaviours	Detailed descriptor
Medical reports/records	Inaccurate, invalid or improper medical certificates Inadequate or inaccurate medical records Failure to transfer medical records/information Inaccurate, inadequate or delayed reports or failure to provide reports
Doctor's manner	Doctor's manner (not further described) Abuse to patients
Practice management	Breach of infection control Lack of service availability Refusal to attend Failure to follow-up
Inappropriate behaviour	Inappropriate/intrusive questions Inappropriate comments (sexual nature) Unnecessary/inappropriate exam (sexual nature) Inadvertently offensive Intoxicated Psychological incapacity Other inappropriate behaviour (not related to patient care)
Advertising	Advertising

**Table 3** Mapping the six proposed domains of medical professional behaviour against Medical Board of South Australia (MBSA) complaints

Proposed domains of medical professional behaviour	2007–2008 MBSA professionalism complaints (51)
Responsibility (conscientiousness, record keeping)	23 Medical reports—7 Failure to transfer records—5 Refusal to attend—4 Medical certificates—3 Inadequate medical records—1 Breach of infection control—1 Lack of service availability—1 Failure to follow up—1
Relationships with and respect for patients	20 Doctor's manner—13 Inappropriate comments—2 Unnecessary/inappropriate exam—2 Abuse to patients—1 Inappropriate/intrusive questions—1 Inadvertently offensive—1
Probity and honesty	5 Advertising—3 Other inappropriate behavior—2
Self awareness and capacity for reflection	3 Psychological incapacity—2 Intoxicated—1
Working with colleagues and collaboration	0
Caring for colleagues	0

questions could be classified as a problem with self awareness, or failure to follow-up as a breach of respect for patients. Likewise, intoxication or psychological incapacity may well reflect an underlying health problem rather than a lack of professionalism per se. Nevertheless, this mapping exercise demonstrates that at least four of the six domains of professional behaviour that we derived from the literature correspond to problems with professional behaviour that lead to current complaints to an Australian medical regulatory body. This stage of the empirical analysis confirmed the three domains that had previously been supported by the Papadakis,<sup>14</sup> Stern,<sup>12</sup> Teherani<sup>15</sup> and Parker<sup>16</sup> studies (responsibility, probity and self-awareness) and in addition provided empirical support for a fourth category (relationships with and respect for patients).

1. **Responsibility (eg, conscientiousness, record keeping)**
2. Relationships with and respect for patients
3. **Probity and honesty**
4. **Self awareness and capacity for reflection**
5. Collaboration and working with colleagues
6. Care of colleagues

## DISCUSSION

In this project we have used a process of theoretical and empirical investigation to develop a clearly defined set of professional behaviours suited to forming the basis for assessable curricula in professionalism. Our analysis of the MBSA complaints data, combined with the published research linking student behaviours to subsequent disciplinary processes, gives us confidence that our circumscribed definition of professional behaviour will be of value in identifying and assessing potentially problematic behaviours in medical students.

Two of our theoretical domains, (5) collaborating and working with colleagues, and (6) caring for colleagues, were not supported by the empirical analysis. Should these therefore be

included as core professional behaviours subject to assessment in medical schools?

Caring for impaired colleagues is certainly a significant responsibility of medical practitioners. Whereas prior to the 1980s it may have been considered unprofessional conduct to criticise a colleague, it is now accepted that doctors have an obligation to report impaired colleagues.<sup>18</sup> In Australia, for example, Section 71A of the New South Wales Medical Practice Act has introduced a new concept of 'reportable misconduct', placing an obligation on doctors to report certain types of misconduct to the Medical Board.<sup>19</sup> Caring for impaired colleagues can fit comfortably within both the ethico-legal curriculum, as it has a clear legal basis grounded in the duty of care to patients who may be harmed by an impaired doctor, and the medical professionalism curriculum. As we found no support for this domain in our empirical analysis of patient complaints we removed it from our working definition of medical professionalism and conclude that it should be addressed in the ethico-legal curriculum.

In relation to collaboration and working with colleagues, the lack of complaints in this domain in the MBSA data may be explained by the source of complaints, 61% of which came from patients or relatives who are likely to be unaware of, or not complain about, their doctor's working relationships.<sup>19</sup> This may also be a factor in the empirical studies that we reviewed which also relied upon complaints to medical regulatory bodies. We believe that competence in collaborating and working with colleagues should be retained as a core domain in professionalism. It is widely recognised that competence to practice medicine includes the ability of physicians to manage effectively relationships with other physicians, colleagues in the healthcare system, society and oneself.<sup>20</sup> Parker and colleagues' study was the only one that did not rely on patient complaints and this study also found that issues to do with participation led to a significant number of reports submitted to the Personal and Professional Development Committee.<sup>16</sup> Working with colleagues is not an obvious or essential part of either clinical or ethico-legal competence, so will not be covered by existing curricula in these areas, and we therefore retained this in our account of medical professional behaviour.

Thus, we propose that these five domains of behaviour form the basis of professionalism curricula in medical schools:

1. Responsibility (eg, conscientiousness and record keeping)
2. Relationships with and respect for patients
3. Probity and honesty
4. Self awareness and capacity for reflection
5. Collaboration and working with colleagues

Relative to the influential definitions that we presented at the beginning of this paper, this represents a narrow account of medical professional behaviour. This narrow approach is practically useful because it focuses on behaviours that can be observed and recorded—it is relatively easy to ascertain whether or not a student is punctual, reliable or functions as a team member in group activities, and recent work has highlighted innovative programmes for fostering student self reflection.<sup>21</sup> Setting standards for and assessing specific behaviours avoids some of the difficulties of attributing motives<sup>22</sup> or devising a scale for assessing qualities such as altruism.

## Limitations of this analysis

This analysis is limited in a number of ways. First, due to confidentiality concerns the MBSA analysis of complaints was conducted by only one person. We could therefore not use inter-rater reliability to assess the validity of this classification.<sup>23</sup> However, our empirical analysis was multipronged and this

limitation does not undermine the overall utility of our proposed definition.

Second, our theoretical and empirical analysis has generated a concise account of medical professional behaviour, but this requires translation into a formal curriculum and needs to be tested through implementation.<sup>24</sup> We recommend further studies testing the predictive validity of this definition of medical professional behaviour, including longitudinal data collection, and its use as part of formal evaluation systems.

Third, while behaviours are easier to assess than attitudes or motivations, there remain challenges in assessing student behaviours.<sup>25</sup> Raters vary in which behaviours they attend to during assessment, how behaviours are evaluated and the behaviours they consider when providing global evaluations of professionalism.<sup>26</sup> However these limitations in assessing behaviour apply to other aspects of the medical curriculum, for example, communication skills, and are not specific to professionalism. Furthermore, many authors<sup>26</sup> have argued that improving assessment of professionalism requires, in part, greater clarity in the definition of professional behaviours and our narrow account goes some way to responding to this call.

## CONCLUSION

We offer a practical definition of medical professional behaviour that builds on the existing theoretical literature, reflects our current knowledge about medical student behaviours linked to future disciplinary actions, and has some face validity in relation to current complaints about medical practitioners in South Australia. The next step to progress this work is to use this definition of professional behaviours as the basis for medical school curricula and develop longitudinal studies to evaluate its utility in teaching and assessing future practitioners.

**Acknowledgements** We thank the Medical Board of South Australia for their assistance with this project and in particular, Mr Brad Williams for his time in reviewing the complaints classifications.

**Funding** This research project was funded by monies awarded to Wendy Rogers for an Australian Carrick Teaching Award (2007) for excellence in medical ethics education at Flinders University. Information regarding the award is available at <http://www.altc.edu.au/carrick/go/home/awards/pid/59>.

**Competing interests** None.

**Contributors** WR conceptualised the research project, gathered the complaints data from the Medical Board in South Australia, developed the complaints classification table for organising the Medical Board data, determined the research goals and designed the outline of the paper, reviewed and edited the final manuscript. AB performed the literature review, drafted the initial manuscript and contributed to revisions of the final manuscript.

**Provenance and peer review** Not commissioned; externally peer reviewed.

## REFERENCES

1. **Quaintance JL**, Arnold L, Thompson GS. Development of an instrument to measure the climate of professionalism in a clinical teaching environment. *Acad Med* 2008;**83** (Suppl 10):S5–8.
2. **Stern DT**. *Measuring medical professionalism*. New York: Oxford University Press, 2006.
3. **Wagner P**, Hendrich J, Moseley G, *et al*. Defining medical professionalism: a qualitative study. *Med Educ* 2007;**41**:288–94.
4. **Joyner BD**, Vemulakonda VM. Improving professionalism: making the implicit more explicit. *J Urol* 2007;**177**:2287–90.
5. **American Board of Internal Medicine**. *Project professionalism*. Philadelphia: ABIM Communications 1999:5.
6. **Swick HM**, Szenas P, Danoff D, *et al*. Teaching professionalism in undergraduate medical education. *JAMA* 1999;**282**:830–2.
7. **ABIM Foundation, ACP–ASIM Foundation, European Federation of Internal Medicine**. Medical professionalism in the new millennium: a physicians' charter. *Lancet* 2002;**359**:520–2.
8. **Archer R**, Elder W, Hustedde C, *et al*. The theory of planned behaviour in medical education: a model for integrating professionalism training. *Med Educ* 2008;**42**:771–7.
9. **Cruess SR**, Cruess RL. Understanding medical professionalism: a plea for an inclusive and integrated approach. *Med Educ* 2008;**42**:755–7.
10. **Wynia MK**, Latham SR, Kao AC, *et al*. Medical professionalism in society. *N Engl J Med* 2000;**431**:1612–16.
11. **Fauce T**. Developing and teaching the virtue-ethics foundations of healthcare whistleblowing. *Monash Bioeth Rev* 2004;**23**:41–55.
12. **Stern DT**, Frohna AZ, Gruppen LD. The prediction of professional behaviour. *Med Educ* 2005;**39**:75–82.
13. **Davis RL**, Wiggins MN, Mercado CC, *et al*. Defining the core competency of professionalism based on the patient's perception. *Clin Experiment Ophthalmol* 2007;**35**:51–4.
14. **Papadakis MA**, Teherani A, Banach MA, *et al*. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med* 2005;**353**:2673–82.
15. **Teherani A**, Hodgson CS, Banach M, *et al*. Domains of unprofessional behavior during medical school associated with future disciplinary action by a state medical board. *Acad Med* 2005;**80**(Suppl 10):S17–20.
16. **Parker M**, Luke H, Zhang J, *et al*. The "pyramid of professionalism": seven years of experience with an integrated program of teaching, developing, and assessing professionalism among medical students. *Acad Med* 2008;**83**:733–41.
17. **Medical Board of South Australia**. 25th Annual Report 2007-08: protecting the public, promoting professionalism. 2008. <http://www.medicalboardsa.asn.au/media/files/27471.pdf> (accessed 11 Jun 2008).
18. **Irvine DH**. Everyone is entitled to a good doctor. *Med J Aust* 2007;**186**:256–61.
19. **New South Wales Medical Board**. Reportable misconduct under the Medical Practice Act: guidelines for practitioners. 2008. <http://www.nswmb.org.au/index.pl?page=233> (accessed 22 Dec 2008).
20. **Pololi L**, Conrad P, Knight S, *et al*. A study of the relational aspects of the culture of academic medicine. *Acad Med* 2009;**84**:106–14.
21. **Kalet AL**, Sanger J, Chase J, *et al*. Promoting professionalism through an online professional development portfolio: successes, joys, and frustrations. *Acad Med* 2007;**82**:1065–72.
22. **Ginsburg S**, Regehr G, Mylopoulos M. From behaviours to attributions: further concerns regarding the evaluation of professionalism. *Med Educ* 2009;**43**:414–25.
23. **Miles MB**, Huberman AM. *Qualitative data analysis*. 2nd edn. Thousand Oaks, CA: Sage Publications Inc, 1994.
24. **Cruess R**, McLlroy JH, Cruess S, *et al*. The professionalism mini-evaluation exercise: a preliminary investigation. *Acad Med* 2006;**81**:S74–8.
25. **Arnold L**. Assessing professional behavior: yesterday, today, and tomorrow. *Acad Med* 2002;**77**:502–15.
26. **Mazor KM**, Zanetti ML, Alper EJ, *et al*. Assessing professionalism in the context of an objective structured clinical examination: an in-depth study of the rating process. *Med Educ* 2007;**41**:331–40.