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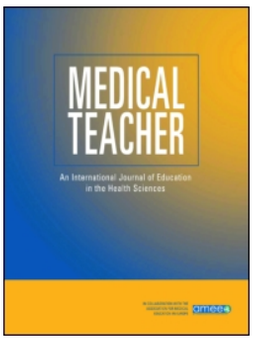

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Comparison of recommended sanctions for lapses in professionalism of undergraduate medical students in a Saudi Arabian and a Scottish medical school

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ABSTRACT

Background: Medical Professionalism is recognized as a cultural construct. We explore perceptions of the severity of lapses in professionalism of undergraduate medical students at two medical schools with different cultural contexts.

Methods: Respondents from two medical schools (Saudi Arabia & UK) recommended sanctions for the first time, unmitigated lapses in academic professionalism, using the *Dundee Polyprofessionalism Inventory 1: Academic Integrity*.

Results: While more than two-thirds of the recommended sanctions for the 30 items of poor professionalism were fully or nearly congruent among the 1125 respondents, there were substantial differences in recommended response for one-third of the items, with a strong tendency for the Saudi students to recommend more lenient sanctions than the Scottish students.

Conclusion: The strategy of using recommended sanctions as a proxy for the perception of the severity of different lapses in professionalism may be a useful tool in learning and teaching academic professionalism among medical students in different cultural contexts.

Introduction

Medical professionalism forms the basis of the contract between doctors and society; Cruess (2006) considers it to be a contractual relationship with a series of obligations and expectations based on mutual trust between the society and medical practitioners.

Today's doctors need to act according to professional values more than ever before. The principle of medical professionalism is based on dedicated services for the welfare of patients. It covers all aspects of higher attributes of being a physician and healer (Swick 2000).

The attributes of medical professionalism are well documented in numerous studies. The American Board of Internal Medicine (ABIM 1995) defined professionalism as a core characteristic of the profession of medicine and a fundamental component of clinical competency. However, these attributes are not universal; cultural differences do exist based on cultural variations (Cruess et al. 2010). Moreover, Chandratilake et al. (2012) and Cruess et al. (2010) have explained that professionalism is a culture-sensitive construct and therefore, is perceived and expressed with respect to local customs, beliefs, and cultures. Moreover, Jha et al. (2015) pointed out that medical professionalism is a complex social construct and the context, geographical location, and culture are important considerations in any discussion of professional behaviour.

It is well known that Arabian Peninsula is distinct in its culture, hence attributes of medical professionalism may vary in this part of the world. Unfortunately, the current healthcare system worldwide as well as in Saudi Arabia does not seem to yield all the outcomes a society expects, and behind this lies the gap in young doctors' knowledge and behaviour along the lines of professionalism (Sadat-Ali 2004). Thus, it is necessary to elucidate the current status of medical professionalism. The Committee of Deans of Medical Schools in the Kingdom of Saudi Arabia established a task force to develop a national competency framework for doctors (Zaini et al. 2011). It was recorded that, in the Kingdom of Saudi Arabia, there has been an increase in the frequency of medical errors claims (Shaheen 2015). This mirrors the observed trends elsewhere (Mueller 2009; Adkoli et al 2011). The UK General Medical Council has recently revised its student guidance on professionalism. Despite the proliferation of studies relating to professionalism, teaching and learning among undergraduate medical students, there are little data (Roff 2008) to guide the

Practice points

- Today's doctors need to act according to professional values more than ever before.
- Medical professionalism is perceived and expressed with respect to local customs, beliefs, and cultures.
- Differences in the perception of professionalism may be the function of different national and regional cultures.
- It is necessary to elucidate the current status of medical professionalism.
- The strategy of using recommended sanctions as a proxy may be a useful tool in learning and teaching academic professionalism.

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determination of standards and appropriate sanctions for professionalism lapses.

It is thus imperative that professionalism is incorporated into the medical curriculum in a way that helps its target audience know how best to deal with the situations which arise from someone violating the standards of professional conduct. In today's world now the emerging question is how to train medical students to act along the professional guidelines? To answer this question and let the best attributes be inculcated within the target audience, the first challenging step is to comprehend the level of students' cognizance and know their perception of what is good and what is not. Therefore, we aimed to explore the ambience of professionalism in undergraduate medical students at two medical schools with different cultural contexts.

Methods

Participants' perceptions of the importance of professionalism lapses were sought by asking participants at King Saud University (KSU) to choose from a hierarchical menu of sanctions for first time lapses with no mitigating circumstances. These were compared with published data from the UK (Roff et al. 2012)

1	Ignore
2	Reprimand (verbal warning)
3	Reprimand (written warning)
4	Reprimand, plus mandatory counseling
5	Reprimand, counselling, extra work assignment
6	Failure of specific class/remedial work to gain credit
7	Failure of specific year (repetition allowed)
8	Expulsion from college (readmission after one year possible)
9	Expulsion from college (no chance for readmission)
10	Report to regulatory body

Figure 1. Hierarchy of recommended sanctions.

Study design

The study design was cross-sectional and conducted in the College of Medicine of King Saud University, Riyadh, Saudi Arabia during the academic year 2014–15. The data were then compared with published results from a Scottish medical school.

Study instrument

An anonymous, self-administered, bilingual (Arabic and English) inventory (*Dundee Polyprofessionalism Inventory I: academic integrity*) was administered online. The participants were asked to recommend the sanctions (Figure 1), based on Teplitsky (2002) for 30 lapses in professionalism (Figure 2) with no mitigating circumstances by undergraduate medical students.

Data collection and analysis

Collected data were stored in secured computers (locked with sign in password) with frequent backing up in a location separate from the original. Data were coded and entered into the Microsoft Excel software and analysed1 using SPSS version 21.0 statistical software (Chicago, IL). Comparisons as median of students' (from KSA and UK) responses were included.

Participants

From KSU, K.S.A., 1431 medical students were contacted through student group leaders and requested to respond to the *Dundee Polyprofessionalism Inventory 1: Academic Integrity* – in English and Arabic. Of the 1431 students, 750 responded: a response rate of 52%. One hundred and sixty-two (22%) were first-year students; 195 (26%) second-year;

1. Getting or giving help for course work, against a teacher's rules (e.g. lending work to another student to look at)
2. Removing an assigned reference from a shelf in the library in order to prevent other students from gaining access to the information in it
3. Signing attendance sheets for absent friends, or asking classmates to sign attendance sheets for you in labs or lectures
4. Drinking alcohol over lunch and interviewing a patient in the afternoon
5. Exchanging information about an exam before it has been taken (e.g. OSCE)
6. Forging a healthcare worker's signature on a piece of work, patient chart, grade sheet or attendance form
7. Claiming collaborative work as one's individual effort
8. Altering or manipulating data (e.g. adjusting data to obtain a significant result)
9. Failure to follow proper infection control procedures
10. Threatening or verbally abusing a university employee or fellow student
11. Attempting to use personal relationships, bribes or threats to gain academic advantages by e.g. getting advance copies of exam papers or passing exam by such pressures on staff
12. Engaging in substance misuse (e.g. drugs)
13. Completing work for another student
14. Intentionally falsifying test results or treatment records in order to disguise mistakes
15. Physically assaulting a university employee or student
16. Purchasing work from a fellow student or internet etc. supplier
17. Lack of punctuality for classes
18. Providing illegal drugs to fellow students
19. Not doing the part assigned in group work
20. Examining patients without knowledge or consent of supervising clinician
21. Sabotaging another student's work
22. Inventing extraneous circumstances to delay sitting an exam
23. Sexually harassing a university employee or fellow student
24. Resubmitting work previously submitted for a separate assignment or earlier degree
25. Plagiarising work from a fellow student or publications/internet
26. Cheating in an exam by e.g. copying from neighbour, taking in crib material or using mobile phone or getting someone else to sit for you
27. Cutting and pasting or paraphrasing material without acknowledging the source
28. Damaging public property e.g. scribbling on desks or chairs
29. Falsifying references or grades on a curriculum vitae or altering grades in the official record
30. Involvement in paedophilic activities - possession/viewing of child pornography images or molesting children

Figure 2. Thirty statements included in the (Dundee Polyprofessionalism Inventory I: Academic Integrity) survey.

160 (21%) third-year; 114 (15%) fourth-year; and 122 (16%) fifth-year students.

Of the total agreed participants $n = 750$, there were 441(58.57%) males and 311 (41.30%) females.

From Scottish medical school (Roff et al. 2012), of the 700 medical students, 375 responded: a response rate of 54%. Forty-two (11%) were first-year students; 82 (22%) second-year; 75 (20%) third-year; 74 (20%) fourth-year; and 102 (27%) fifth-year students.

The male-to-female ratio was 1:2. A majority (259; 69%) of respondents were in the 20–24 years age group; 66 (18%) were younger than 20 years and 49 (13%) were older than 25 years.

Confidentiality

Throughout the study, participants' anonymity was assured and maintained by assigning each student with a separate code number for the later analysis.

Ethical approval

The survey included a written consent for the participants stating "your participation is entirely voluntary and you can decline to participate or withdraw from the survey at any time without penalty". Through the consent, participants were also informed that they were invited to respond to this survey and their responses will be taken as consent to participate on the understanding that the results will never be published or present in forms that will identify individual respondents. Permission to administer it to the student population at College of Medicine, King Saud University, was given by the university's institutional review board.

Results

The results helped identify the congruence and the differences among the medical students from Saudi Arabia and the UK.

Congruence

There was a congruence in median recommended sanctions by KSU Students and students from a Scottish medical school for the following behaviours (Table 1): *Signing attendance sheets for absent friends or asking classmates to sign attendance sheets; Lack of punctuality for classes; Completing work for another student;, Resubmitting work previously submitted for a separate assignment or earlier degree; Cutting and pasting or paraphrasing material without acknowledging the source; Altering or manipulating data (e.g. Adjusting data to obtain a significant result; Forging a healthcare worker's signature on a piece of work, patient chart, grade sheet; and Intentionally falsifying test results or treatment records in order to disguise mistakes).*

KSU students, one level stricter than Scottish students

KSU students selected one level stricter sanction as median than the Scottish students for five behaviours (Table 2): *Getting or giving help for course work, against a teacher's rules (3:2); Not doing the part assigned in group work (3:2); Examining patients without knowledge or consent of supervising clinician (3:2); Removing an assigned reference from a shelf in the library in order to prevent other students from gaining Access (4:3); Claiming collaborative work as one's individual effort (4:3).*

Scottish students, one level stricter than KSU students

The Scottish students were one level stricter than KSU students for (Table 3) *Plagiarising work from a fellow student or publications/internet (4:5); purchasing work from a fellow student or internet etc. Supplier (4:5); Sabotaging another student's work (5:6); Attempting to use personal relationships, bribes or threats to gain academic advantages (5:6); Engaging in substance misuse e.g. drugs (5:6); Falsifying references or grades on a curriculum vitae or altering grades in the official record (5:6).*

Items with more than one level of difference in recommended sanction

Table 4 reports the 11 items, in which there were substantial differences in the recommended sanctions between the two student cohorts, with a pronounced trend of KSU

Table 1. Congruence in median recommended sanctions between KSU students and students from a Scottish medical school.

Behaviour	KSU ($n = 750$)	Scottish (Roff et al. 2012) ($n = 375$)
Signing attendance sheets for absent friends, or asking classmates to sign attendance sheets for you in labs or lectures	2	2
Lack of punctuality for clases	2	2
Completing work for another student	3	3
Resubmitting work previously submitted for a separate assignment or earlier degree	3	3
Cutting and pasting or paraphrasing material without acknowledging the source	3	3
Altering or manipulating data (e.g. adjusting data to obtain a significant result)	4	4
Forging a healthcare worker's signature on a piece of work, patient chart, grade sheet or attendance form	5	5
Intentionally falsifying test results or treatment records in order to disguise mistakes	5	5

Table 2. KSU students 1 level stricter in median recommended sanctions as compared with students from a Scottish medical school.

Behaviour	KSU ($n = 750$)	Scottish (Roff et al. 2012) ($n = 375$)
Getting or giving help for course work, against a teacher's rules (e.g. lending work to another student to look at)	3	2
Not doing the part assigned in group work	3	2
Examining patients without knowledge or consent of supervising clinician	3	2
Removing an assigned reference from a shelf in the library in order to prevent other students from gaining access	4	3
Claiming collaborative work as one's individual effort	4	3

Table 3. Students from Scottish medical school, 1 level stricter in Median recommended sanctions as compared with Students at KSU.

Behaviour	KSU ($n = 750$)	Scottish (Roff et al. 2012) ($n = 375$)
Plagiarising work from a fellow student or publications/internet	4	5
Purchasing work from a fellow student or internet etc. Supplier	4	5
Sabotaging another student's work	5	6
Attempting to use personal relationships, bribes or threats to gain academic advantages by e.g. getting advance copies of exam papers or passing exam by such pressures on staff	5	6
Engaging in substance misuse (e.g. drugs)	5	6
Falsifying references or grades on a curriculum vitae or altering grades in the official record	5	6

Table 4. More than One level of differences in median recommended sanctions between students of KSU and Scottish medical school.

Behaviour	KSU ($n = 750$)	Scottish (Roff et al. 2012) ($n = 375$)
Exchanging information about an exam before it has been taken (e.g. OSCE)	1	5
Threatening or verbally abusing a university employee or fellow student	5	8
Physically assaulting a university employee or student	5	9
Providing illegal drugs to fellow students	7	9
Inventing extraneous circumstances to delay sitting an exam	3	6
Sexually harassing a university employee or fellow student	7	9
Cheating in an exam by e.g. copying from neighbour, taking in crib material or using mobile phone or getting someone else to sit for you	5	8
Involvement in paedophilic activities - possession/viewing of child pornography images or molesting children	7	10
Failure to follow proper infection control procedures	4	2
Damaging public property e.g. scribbling on desks or chairs	4	2
Drinking alcohol over lunch and interviewing a patient in the afternoon	6	4.5

students being less strict in their proposed response to 8 lapses. Notable exceptions to this trend are *Failure to follow proper infection control procedures; Damaging public property e.g. scribbling on desks or chairs;* and *Drinking alcohol over lunch and interviewing a patient in the afternoon.*

Discussion and conclusions

The results showed full congruence among the 1125 respondents for the recommended sanctions for 8 (27%) of the items of poor professionalism, and near congruence for 11 (37%) items. There is, however, a considerable difference in the recommended sanctions for another 11 (37%) of the lapses.

The present study has been limited to testing the feasibility of an online inventory to "map" student understanding of the relative importance of various lapses in academic integrity through the "proxy" of soliciting recommended sanctions in two different cultural contexts.

Previous work (Roff et al. 2015) has similarly reported differences between recommended sanctions by students from the two medical schools in one city, and between the staff of those two schools. The same study also reports differences between UK, Egyptian, Saudi Arabian, and Pakistani medical students and staff. These differences may be the function of different national and regional cultures as may be the ones we report in this study; we do not have space to explore this here. But, in their study of poor professionalism in relation to fitness to practise in 11 European Union member states, Struckmannn et al. (2015, p 323) comment that "a common understanding of definitions of what constitutes competence to practise, its impairment and its potential impact on patient safety becomes particularly important" in an era of international mobility for doctors. The strategy of using recommended sanctions as a proxy for perception of the severity of different lapses in professionalism may be a useful tool in learning and teaching academic professionalism among medical students.

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Disclosure statement

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