Medical Student Views of Acceptable Professional Behavior: A Survey

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ABSTRACT: Professionalism is a concept at the heart of good medical practice. Ensuring that medical students develop and display professional behavior is crucial, both to ensure that their early encounters with patients are safe and appropriate, and to help guard against difficulties in their future practice. As part of its role as the UK's medical regulator, the General Medical Council (GMC) sets the standards that doctors need to follow as well as overseeing UK medical education and training. This includes providing guidance on student professional values and fitness to practice, which it does in partnership with the UK Medical Schools Council (MSC). To inform policy development in this area, the GMC carried out a survey of student professional values between December 2014 and January 2015. This article expands on and discusses a report about the survey, produced and published on the General Medical Council (GMC) website in 2015.[1] The results of the survey are presented here. A total of 2,501 students responded to the survey, giving their views on the level of acceptability of 16 different scenarios. These results were analyzed by gender, year of study and entry route to medical school. While medical students responded overall in ways that indicate an understanding of professionalism, the results have highlighted some areas to focus improvements on, and differences between groups of students may be helpful to medical schools in planning how and when to teach certain aspects of professionalism.

Introduction

Medical professionalism

Professionalism is at the heart of how good doctors practice. The Royal College of Physicians defines professionalism as a set of values, behaviors and relationships that underpins the trust that patients have in doctors.[2] While the concept of professionalism can sometimes seem rather abstract, focusing on specific professional behaviors can help make it more tangible and easier to translate into practice. This can help with the "assessment…discussion and modelling of professionalism in both medical education and clinical care."[3]

As the UK's medical regulator, the GMC expects doctors to behave in certain ways, which are explained in its wide range of professional guidance and associated learning materials.[4] The introduction to the core guidance, *Good medical practice*, sets out how doctors must put their professionalism into action. They must make the care of their patients their first concern and they must be competent and keep their knowledge and skills up to date. They must have good relationships with patients and colleagues, be honest and trustworthy and act with integrity and within the law. They must also work in partnership with patients and respect their privacy and dignity.[5]

The importance of professionalism is clear from the GMC's fitness to practice statistics. The number of complaints to the GMC has increased significantly over recent years and complaints about communication and the doctor-patient relationship have increased more significantly than those in other categories.[6] Between 2010 and 2014, while 51% of cases following complaints raised by the public involved concerns about clinical competence, almost half of these involved additional concerns about communication or respect for patients, an important aspect of professionalism. A further 9% of cases were based solely on concerns about communication and respect for patients, and another 17% were about broader professional performance such as failing to work well with colleagues, failing to appropriately report on cases or share information, or bullying and undermining colleagues.[7]

WHILE THE CONCEPT OF PROFESSIONALISM CAN SOMETIMES SEEM RATHER ABSTRACT, FOCUSING ON SPECIFIC PROFESSIONAL BEHAVIORS CAN HELP MAKE IT MORE TANGIBLE AND EASIER TO TRANSLATE INTO PRACTICE.

Student professionalism

While the GMC does not regulate medical schools, it has a statutory duty to regulate all stages of medical education, including undergraduate education. This includes setting the standards[8] and outcomes that medical students must meet in order to graduate as a doctor[9] and providing quality assurance for medical schools. Ensuring that medical education includes sufficient and appropriate attention to professionalism is vital for two reasons: First, many medical students in the UK begin to have direct patient contact relatively early on in their studies and so must learn from the outset that this privileged position brings with it particular responsibilities. Medical schools in the UK report that students who find themselves in real difficulty later in their training have often experienced numerous minor setbacks early on.[10] Tackling these issues right from the start is important. Second, we know that in the United States there is evidence of a link between unprofessional behavior of students while at medical school and subsequent disciplinary action post-qualification.[11]

MEDICAL SCHOOLS IN THE UK REPORT THAT STUDENTS WHO FIND THEMSELVES IN REAL DIFFICULTY LATER IN THEIR TRAINING HAVE OFTEN EXPERIENCED NUMEROUS MINOR SETBACKS EARLY ON.

Medical schools in the UK must not graduate a student who they believe is not fit to practice medicine, and when applying for provisional registration with the GMC, students must make a declaration of fitness to practice. Medical schools in the UK have their own processes to deal with fitness to practice concerns that arise about their students, and there is some variation in the way that issues are handled.

The GMC and the Medical Schools Council (MSC), which represents the interests of UK medical schools, collaborate to produce guidance for medical schools and students on student professionalism and dealing with concerns about students' fitness to practice. In 2014, they began a review of that guidance[12] and new guidance was published in 2016.[13,14] This was in line with usual review cycles, but in particular its aims were to achieve more consistent outcomes for students across schools by giving more advice on the issues that medical schools find difficult to deal with and to provide clearer advice to students on positive professional behaviors.

While schools are free to design their own student fitness to practice processes and procedures, discussions with schools, students and other relevant parties had revealed some concerns about whether the same behavior may result in considerably different outcomes for students at different schools.

An earlier (unpublished) survey of medical schools in autumn 2014 had shown there to be considerable variation in the ways in which schools were implementing the GMC's guidance. For example, schools do not all have the same method of determining whether or not a particular incident has reached the threshold for being considered through their fitness to practice procedures, or is a lower level concern. 15 (of 35) schools said that they used GMC thresholds* and 3 told us about a particular process they use, such as reaching a certain number of completed concern forms or warnings. There were 21 schools (of 35) that would not issue a warning or a sanction to a student for low level concerns only, but 10 said they may give a warning, and 5 of those may also give a sanction. In two cases, the sanction may be as serious as suspension (4 schools did not provide information in response to this question).

Methods

In order to understand more about students' views of professionalism, and supported by the MSC, the GMC carried out an online, self-selecting, survey of medical students, asking for their views on the acceptability of 16 different scenarios.†

The scenarios were developed using information received by the GMC's Education Policy team during discussions with experts from UK medical schools, as well as information from the GMC's medical schools annual return process and the information provided by students when making declarations of fitness to practice at provisional registration. The questions (see appendix A) covered a range of themes, such as honesty, confidentiality, appearance, drug use, social media and raising concerns.

* As outlined in paragraphs 62-78 of the student fitness to practice guidance that was current at the time (see reference 12).

† There were 12 questions, but question 1 had five parts.

The scenarios were short and contained little context, so different interpretations were possible, but most of the scenarios involved behavior that the GMC and medical schools would consider to be unprofessional to some degree, from relatively minor and more debatable to more serious and inappropriate. Three scenarios involved behavior that the GMC and medical schools consider to be positive examples of professionalism (4, 7 and 12).*

Students were asked to give their views using a four-point Likert scale, which did not include a middle option, such as "don't know," and there were no free text boxes. This meant that respondents had to make a judgment about the acceptability of each scenario, and it was not possible to explore the reasons for their answers. The advantage of this approach was that the survey was short and easy to complete, which resulted in a high number of respondents.

The survey was anonymous and respondents were not required to register to complete the survey, so responses were not guaranteed to be unique. As the survey formed only one part of the evidence used to inform the broad policy development process, and as the likelihood of respondents entering multiple responses was felt to be quite low — whereas a requirement to register was quite likely to affect respondents' answers — it was felt that this approach was preferable.

THE SURVEY WAS DISTRIBUTED THROUGH THE GMC'S STUDENT NEWS EMAIL THAT IS SENT REGULARLY TO AROUND 17,000 MEDICAL STUDENTS.

Respondents were asked to give their gender, year of study and whether they had entered medical school as a graduate or as a school leaver (by "school leaver," we mean someone whose highest level of qualification is that which they have achieved in high school, usually A levels — or "Highers," in Scotland.) This provided an opportunity to look for possible patterns in the data, while minimizing any concerns respondents might have about possible identification. It was hypothesized that respondents may indicate different views about professionalism depending on how far through their course of study they were and whether they entered medical school as a graduate or school leaver, as a result of their past experiences in the course of study and elsewhere and their likely age and level of maturity. Questions about ethnicity and age were considered but rejected as they would make it more likely that students would be identifiable from their profile, especially if the number of responses was low. Gender was included as it allowed further breakdown but without any considerable increase in the risk of identification.

OVERALL, STUDENTS' RESPONSES SUGGESTED AN UNDERSTANDING OF PROFESSIONAL VALUES THAT WAS BROADLY IN LINE WITH THAT EXPECTED BY THE GMC AND MEDICAL SCHOOLS.

The survey was distributed through the GMC's student news email that is sent regularly to around 17,000 medical students, as well as through the MSC's network of medical school contacts and on social media.

After a simple examination and presentation of the observed responses, a chi-square test was carried out in order to give an indication as to whether there was any statistical significance to the differences observed. The results from this survey provided useful intelligence to consider when developing the revised guidance to schools and students and are intended to stimulate further discussion about teaching and learning about professionalism.

Findings

2,501 responses were received in the six weeks that the survey was open, beginning in December 2014. This represented just over 6% of all medical students in the UK at the time.

Overall, students' responses suggested an understanding of professional values that was broadly in line with that expected by the GMC and medical schools. In most cases, students categorized the scenarios that were designed to indicate less professional behavior as unacceptable or mostly unacceptable, and those designed to show more professional behavior as acceptable or mostly acceptable. Table 1 shows the number of responses to each question.

* Question 12 is counted as an example of a positive professional behavior, but it is more subject to interpretation than the others as the appropriateness of the scenario is more dependent on context.

Table 1
Responses to all questions

Question*	Number (and percentage) of respondents answering:††			
	Acceptable	Mostly acceptable	Mostly unacceptable	Unacceptable
1a) Is it acceptable for a medical student on a ward round to have a visible tattoo?	239 (10)	631 (25)	902 (36)	728 (29)
1b) Is it acceptable for a medical student on a ward round to wear a T-shirt with a slogan?	40 (2)	124 (5)	557 (22)	1777 (71)
1c) Is it acceptable for a medical student on a ward round to be unshaven?	605 (24)	1023 (41)	685 (27)	181 (7)
1d) Is it acceptable for a medical student on a ward round to wear black trainers?	281 (11)	563(23)	894 (36)	754 (30)
1e) Is it acceptable for a medical student on a ward round to wear a sleeveless top?	385 (15)	619 (25)	614 (25)	875 (35)
2) A second year medical student is occasionally late for lectures but one day has overslept — the student texts a friend and asks the friend to sign the student's name on the attendance sheet.	67 (3)	234 (9)	601 (24)	1599 (64)
3) A medical student forgets to bring a log book and is unable to get the supervisor to sign off practical skills that the student has carried out. After some consideration, the student decides to forge the supervisor's signature in the log book.	7 (0)	45 (2)	281 (11)	2168 (87)
4) A medical student thinks there may be staffing issues on the ward the student is attached to as part of a placement, which could raise some patient safety concerns. The student decides to draw this to the attention of the medical school.	1777 (71)	634 (25)	74 (3)	16 (1)
5) Two students are travelling home by bus and talking animatedly about an examination they have observed carried out on a patient that day. They don't refer to the patient by name but are talking loudly enough that other passengers can hear the details of their conversation.	69 (3)	478 (19)	1149 (46)	805 (32)
6) A medical student has had diarrhea and vomiting in the last 24 hours. The student has a full day of shadowing on the wards and decides it will probably be ok to go in.	10 (0)	76(3)	640 (26)	1775 (71)
7) A student has a particularly difficult experience when a patient the student has seen on the wards a number of times dies unexpectedly. The student decides it is necessary to talk the matter through and seeks pastoral support from the medical school.	2356 (94)	129 (5)	11 (0)	5 (0)
8) A student is distracted in a lecture and decides to check Facebook. The student decides to post a status update about how boring the lecture is and how bad the lecturer's dress sense is.	61 (2)	257 (10)	832 (33)	1351 (54)
9) During exam time a medical student buys drugs online that are usually only available on prescription, and uses these in order to stay awake and study.	51 (2)	154 (6)	539 (22)	1757 (70)
10) A medical student bumps into a previous patient while out on the weekend. The student saw the patient in A & E earlier that week and took a history. The pair get chatting and the patient invites the student back to the patient's flat for coffee. The student decides to go.	100 (4)	367 (15)	846 (34)	1188 (48)
11) A medical student travels by train every day but the student's ticket is never checked. It is coming up to the end of term and the student is running short of money, so, on this occasion, the student decides to travel without paying the fare.	198 (8)	397 (16)	843 (34)	1063 (43)
12) A medical student is asked by a ward doctor to site a cannula in a patient, but the student refuses. Having never done one before, the student doesn't feel confident doing this.	1907 (76)	507 (20)	69 (3)	18 (1)

*Editor's note: The wording of the questions has been slightly amended from the original colloquial British English used in the survey, but the meaning remains unchanged.

† Null and blank responses were excluded for all questions, as were "prefer not to say" responses for analysis by gender. For question 7 only, due to low expected values, Chi square was calculated using binary categories of all acceptable against all unacceptable.

† All percentages are rounded to the nearest whole number and so may not sum to 100. A very small number of respondents left some parts of question one blank. All questions required an answer but due to software limitations it was not possible to require a response to every part of question one. In all cases, the percentage of blank responses rounded to zero and have been excluded.

Respondent characteristics

The distribution of respondents by gender was as expected according to the medical student population distribution. For year of study, the distribution was similar to that of the population, although by proportion more students in the first year and fewer in the third and fifth years responded than expected, possibly due to changing priorities and availability of students throughout their course. Students who had entered medical school as graduates were over-represented in responses, making up 21% of respondents, compared to 8% of the population. Tables 2-4* show the percentages of respondents in each group compared to the percentage of medical students in that group across the population as a whole.

ACROSS MOST OF THE QUESTIONS, A GREATER PROPORTION OF WOMEN THAN MEN SAID THAT THE LESS PROFESSIONAL OR MORE QUESTIONABLE BEHAVIORS WERE UNACCEPTABLE OR MOSTLY UNACCEPTABLE.

Table 2
Distribution of respondents by gender

Gender	Percentage of respondents	Percentage of medical student population
Female	55	55
Male	43	45
Prefer not to say	2	N/A

Table 3
Distribution of respondents by year of study†

Year	Percentage of respondents	Percentage of medical student population
Foundation/pre-entry	N/A	<1
First	23	19
Second	18	19
Third	17	21
Fourth	20	21
Fifth	14	17
Sixth	7	2

*Tables taken from the GMC's original report on the survey, published in 2015. See reference 1.
† Figures in this table do not add up to 100 due to rounding (nearest whole number).

Table 4
Distribution of respondents by entry route

Graduate or school leaver†	Percentage of respondents	Percentage of medical student population
Graduate	21	8
School leaver	79	92

† In the UK, a graduate is someone who has graduated from a university level course with at least a bachelor's degree. By "school leaver," we mean someone whose highest level of qualification is that which they have achieved in high school, usually A levels — or "Highers" in Scotland. As shown in table 4, most medical school entrants in the UK are accepted on the basis of high school level qualifications and a bachelor's degree is not a requirement for acceptance into medical school.

Gender

Across most of the questions, a greater proportion of women than men said that the less professional or more questionable behaviors were unacceptable or mostly unacceptable. The exceptions to this were two of the scenarios about appearance, with men more likely than women to think that wearing sleeveless tops or black trainers was unacceptable or mostly unacceptable for students on a ward round.

In 10 of the 16 scenarios, the differences in responses by gender were significant at the 95% confidence interval of the chi-square test. The questions for which there was significant variation by gender were 1c, 1d, 1e, 2, 4, 5, 8, 9, 10 and 11.

Question 10, which was about maintaining boundaries with patients, yielded the most pronounced gender split in responses. By percentage, men were three times more likely than women to say it was acceptable (7% compared to 2%), and almost twice as likely to say it was mostly acceptable (20% compared to 11%) to accept the offer of coffee at the home of a patient, from whom they had once taken a history in the accident and emergency department.

IN 10 OF THE 16 SCENARIOS, THE DIFFERENCES IN RESPONSES BY GENDER WERE SIGNIFICANT AT THE 95% CONFIDENCE INTERVAL OF THE CHI-SQUARE TEST.

Question 8, which was about posting critical comments about a lecturer on Facebook during a lecture, also resulted in considerably more men than women choosing acceptable (4% and 1% respectively) or mostly acceptable (13% and 8%).

For question 4, which was about raising concerns, although there was no difference in the proportions of men and women choosing all acceptable or all unacceptable, men were more likely than women to say that the positive behaviors were acceptable (75% of men and 68% of women) as opposed to mostly acceptable (21% of men and 29% of women).

A GREATER PROPORTION OF GRADUATE ENTRANTS THAN SCHOOL LEAVERS VIEWED THE LESS PROFESSIONAL BEHAVIORS OR MORE QUESTIONABLE BEHAVIORS AS UNACCEPTABLE OR MOSTLY UNACCEPTABLE.

Figure 2: Responses to question 8, by gender
Views on acceptability of posting critical Facebook comments during a lecture

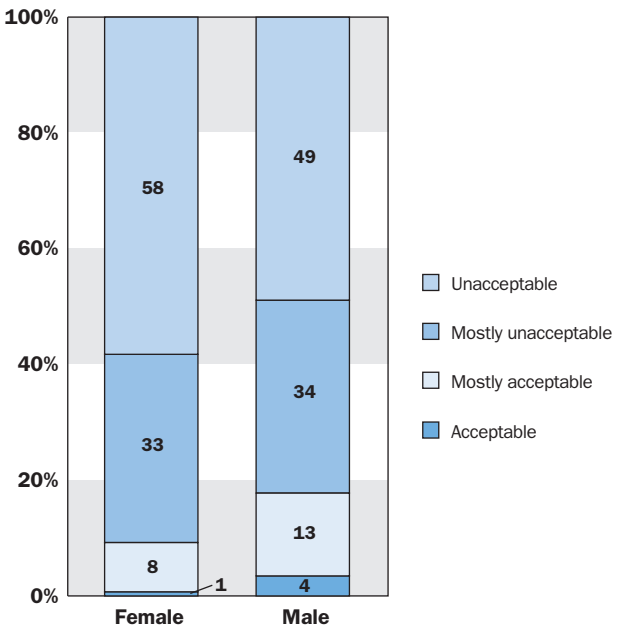


Figure 1: Responses to question 10, by gender*
Views on acceptability of a student going back to a patient's flat for a coffee

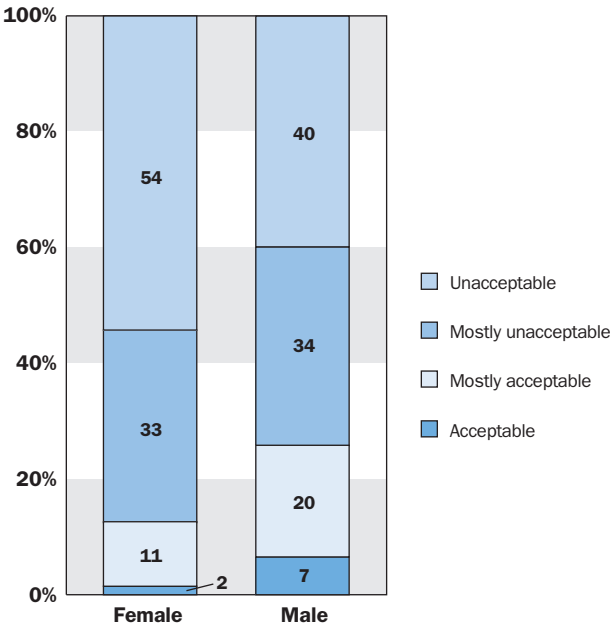
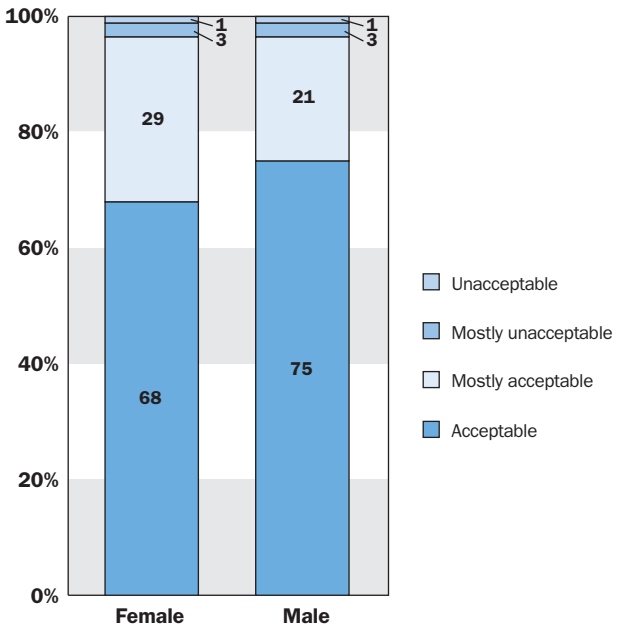


Figure 3: Responses to question 4, by gender
Views on acceptability of raising patient safety concerns



* Figures 1-3 exclude "prefer not to say" gender category. All graphs in this document are adapted versions of graphs used in the GMC's original report on the survey, published in 2015. See reference 1.

Entry route

A greater proportion of graduate entrants than school leavers viewed the less professional behaviors or more questionable behaviors as unacceptable or mostly unacceptable. This was observable across all but two scenarios, although in some questions the difference was very small. The exceptions were two of the scenarios in question one: whether it is acceptable for a medical student on a ward round to have a visible tattoo or to have a sleeveless top. In both cases, graduates were more accepting of this. In eight of the 13 questions involving an unprofessional or less professional behavior, the observable differences were statistically significant at the 95% confidence interval. The questions for which there was significant variation were: 1a, 1b, 1c, 2, 3, 5, 8 and 10.

RESPONSES TO 12 OF THE 16 SCENARIOS VARIED SIGNIFICANTLY BY YEAR OF STUDY (ALL EXCEPT 4, 6, 7 AND 10), BUT IT WAS NOT POSSIBLE TO ESTABLISH A VERY CLEAR OVERALL PATTERN.

Figure 4: Responses to question 2, by entry route
Views on acceptability of a student asking a friend to sign them in to a lecture if they have overslept

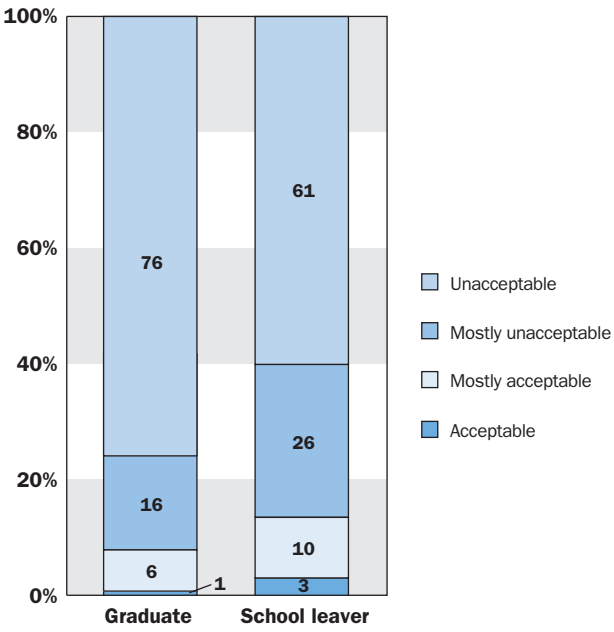


Figure 5: Responses to question 3, by entry route
Views on acceptability of a student signing their own logbook

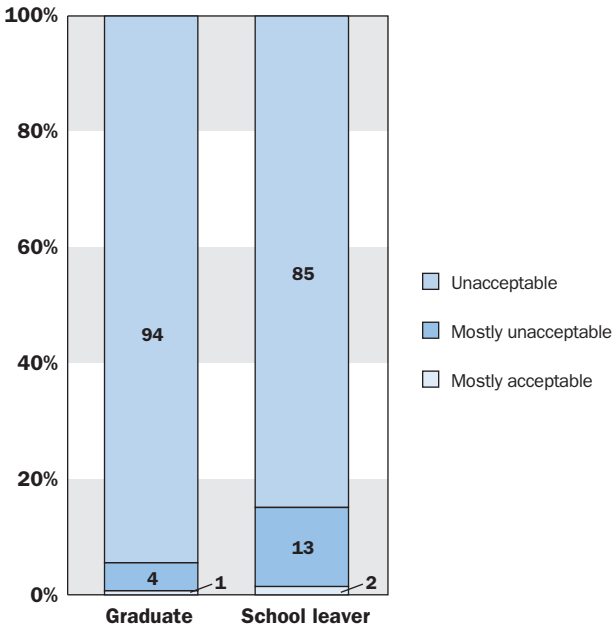


Figure 6: Responses to question 5, by entry route
Views on acceptability of discussing an examination while on the bus

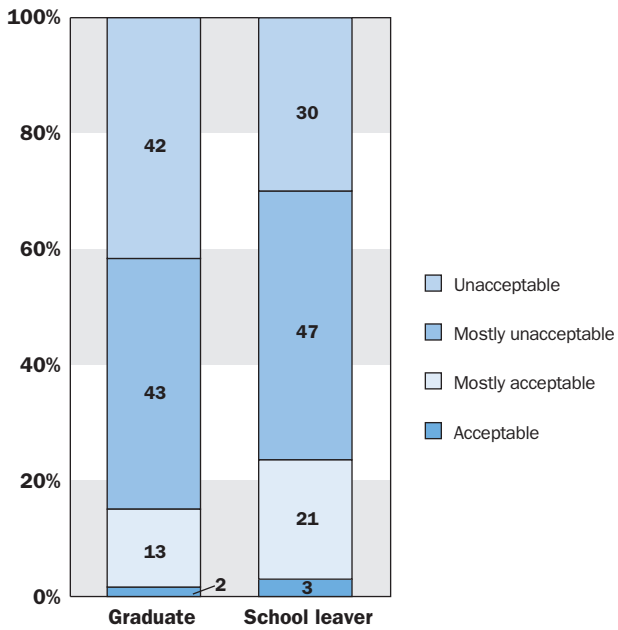


Figure 7: Responses to question 2, by year of study

Views on acceptability of a student asking a friend to sign them in to a lecture if they have overslept

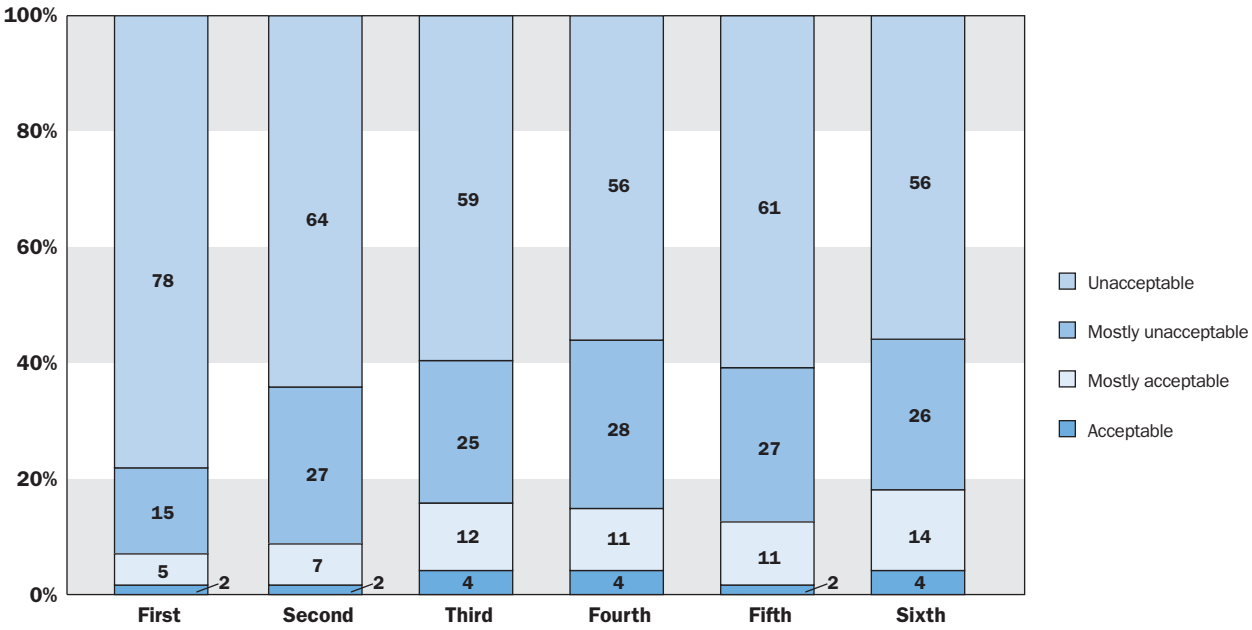


Figure 8: Responses to question 2, by year of study

Views on acceptability of discussing an examination while on the bus

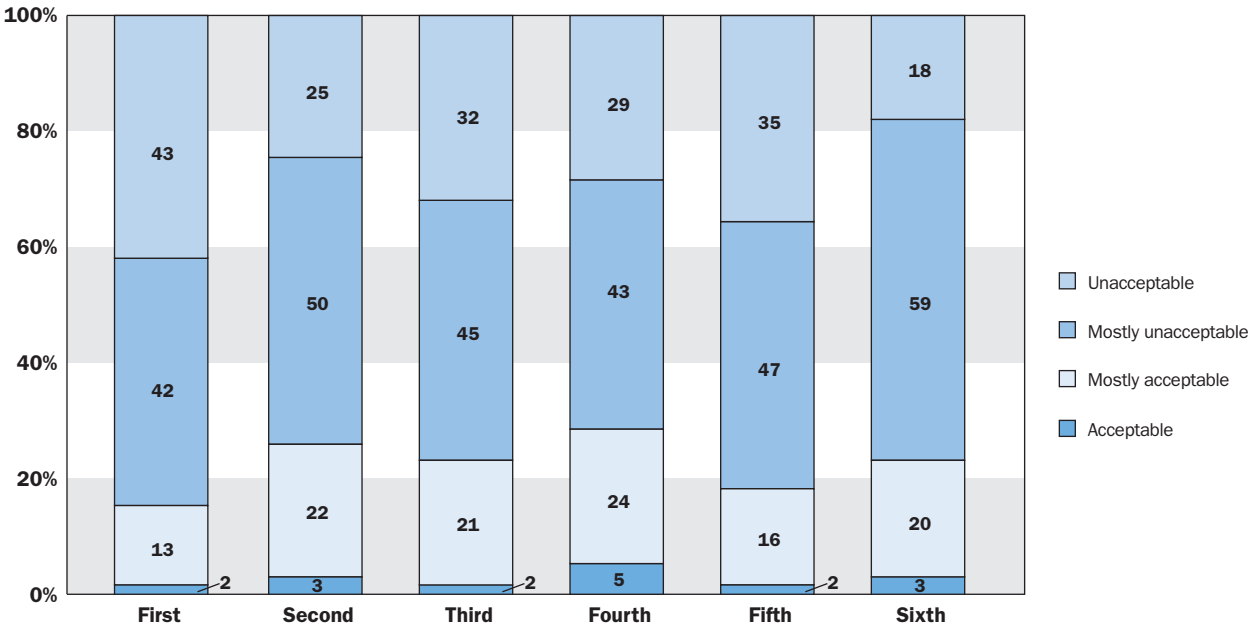


Figure 9: Responses to question 8, by year of study

Views on acceptability of posting critical Facebook comments during a lecture

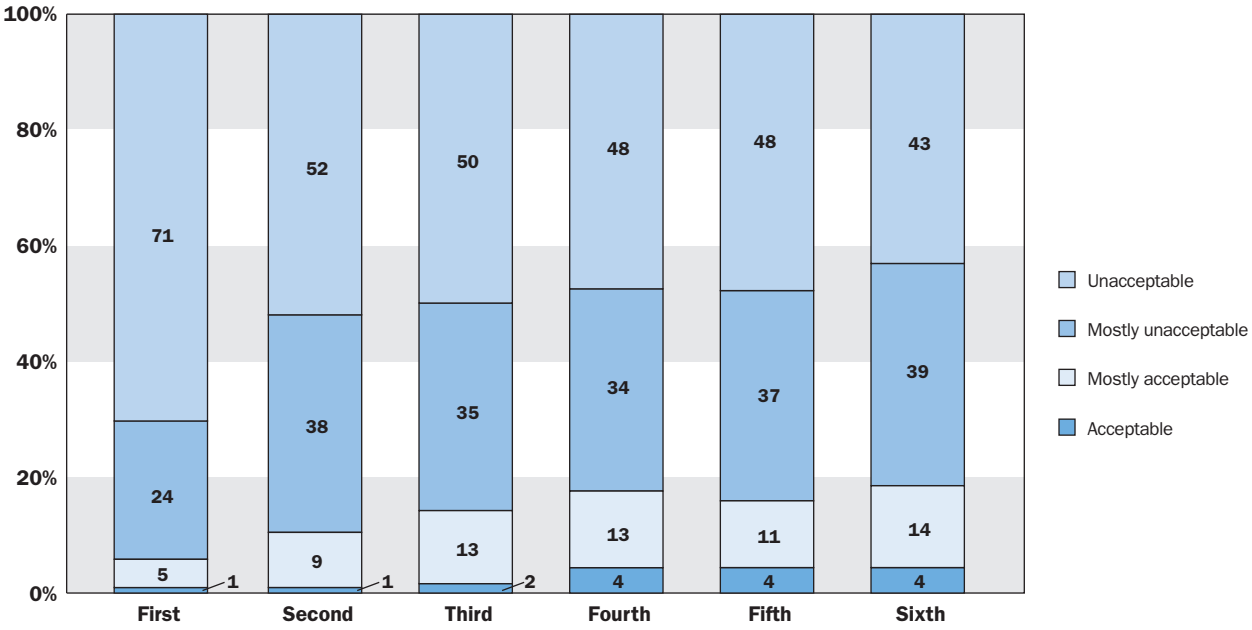


Figure 10: Responses to question 1b, by year of study

Views on acceptability of wearing a T-shirt with a slogan on it by year of student

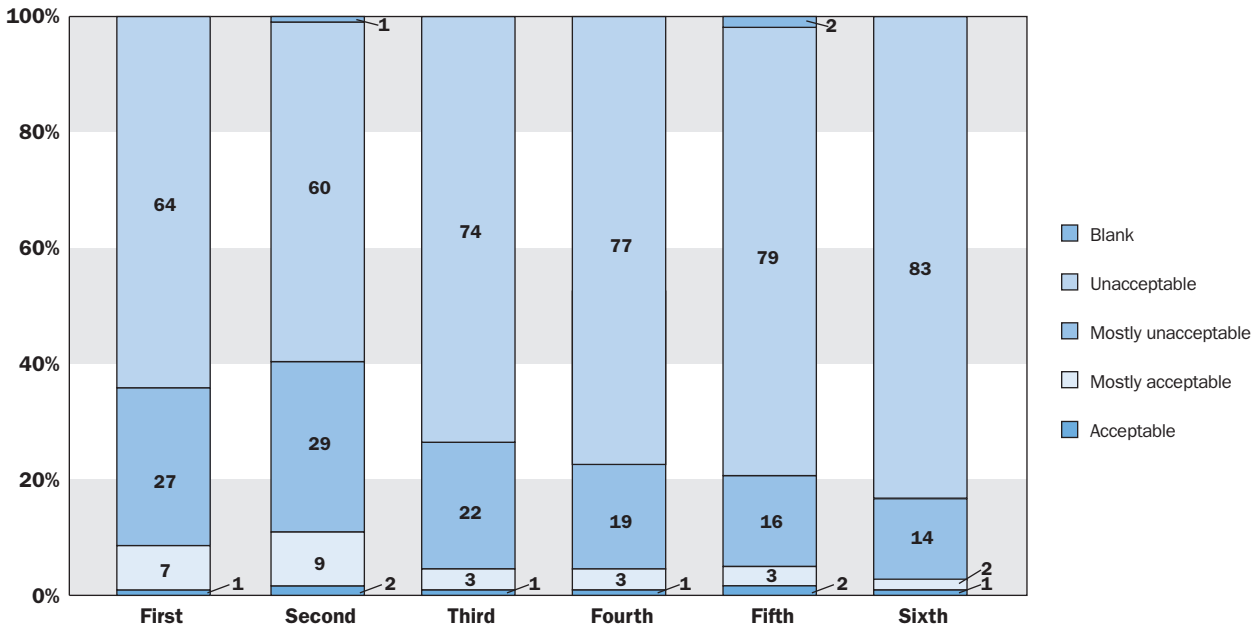
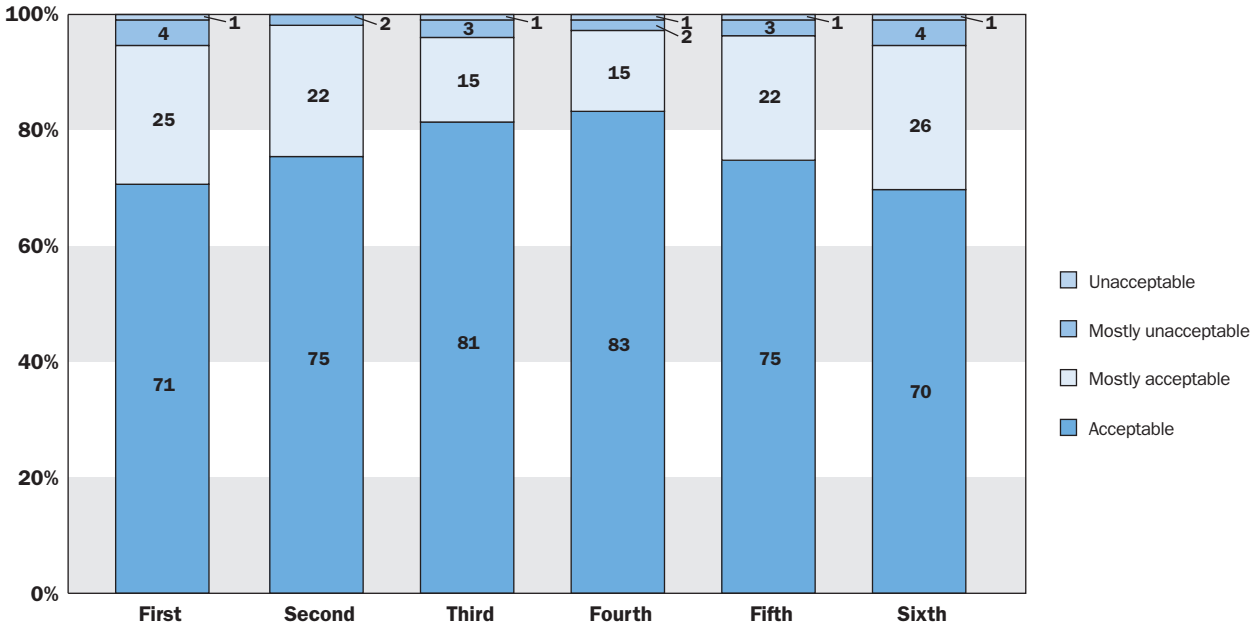


Figure 11: Responses to question 12, by year of study
Views on acceptability of a student refusing to site a cannula



There were no significant differences in responses from graduates and school leavers for any of the three questions involving positive behavioral scenarios (questions 4, 7 and 12).

The most pronounced differences between graduates and school leavers were for questions 2, 3 and 5. Questions 2 and 3 related to honesty and 5 related to confidentiality. For all of these questions, graduates were more likely than school leavers to say the behavior was unacceptable. For each of the other response options, where the percentage of respondents was greater than zero, school leavers outnumbered graduates by proportion.

Year of study

Responses to 12 of the 16 scenarios varied significantly by year of study (all except 4, 6, 7 and 10), but it was not possible to establish a very clear overall pattern. Responses to some questions suggested that there may be a stronger feeling among first-year students that the scenarios involving less professional or more questionable behaviors were unacceptable or mostly unacceptable, and there was a slight increase in the acceptance of these behaviors with students in later years, followed by a decreased acceptance among fifth-year students.

For questions 2, 5 and 8, which related to honesty, confidentiality and use of social media respectively, there were particularly pronounced differences in students' views, with first-year students considerably less accepting of the behavior displayed in the scenarios than students in other years.

Responses to question 1b, which asked about the acceptability of a student wearing a T-shirt with a slogan on it on a ward round also showed particular variation by year of study, with students who were further through their course being more likely to see this as unacceptable. This was unusual as most questions with an observable pattern showed first year students as less accepting of the less professional or more questionable behaviors.

> ...MOST STUDENTS DO SEEM TO RECOGNIZE THE VALUE OF RAISING CONCERNS, SEEKING SUPPORT AND ACTING WITHIN THEIR COMPETENCE, BUT SOME STUDENTS HAVE DOUBTS ABOUT THESE ISSUES.

For question 12, which involved a scenario in which a student refuses to site a cannula when not feeling competent to do so, the split between students who think it is unacceptable or mostly unacceptable and those who think it is acceptable or mostly acceptable was reasonably constant regardless of the respondent's year of study. However, the proportion of those who choose acceptable as opposed to mostly acceptable increased up to fourth year and then decreased.

Discussion

Overall, the results of the survey showed that students' views on the acceptability of the different scenarios were broadly in line with the views of the GMC and medical schools. Students tended to view the scenarios that included less professional or more questionable behavior as unacceptable or mostly unacceptable and those scenarios that included more positive behaviors were more likely to be seen as acceptable or mostly acceptable. The scenarios in question 1, which related to appearance, resulted in quite a spread of views, with students more frequently choosing one of the more equivocal options, saying these scenarios were *mostly* unacceptable or *mostly* acceptable.

SOME OF THE QUESTIONS INVOLVING LESS PROFESSIONAL TYPES OF BEHAVIOR WERE MORE ACCEPTABLE TO RESPONDENTS THAN OTHERS...THE FORTHCOMING REVISED GUIDANCE ON STUDENT PROFESSIONAL VALUES WILL SEEK TO ADDRESS THIS.

As the results from questions 4, 7 and 12 show, most students do seem to recognize the value of raising concerns, seeking support and acting within their competence, but some students have doubts about these issues, with considerable numbers choosing mostly acceptable rather than acceptable for questions 4 and 12. As is the case for all of the questions, it is possible that these respondents may have been speculating on the context. For example, those who did not answer "acceptable" for question 4 may have felt that a student may not be confident in his or her ability to judge whether their concerns were valid, or may be concerned about not being taken seriously. It is important to continue to encourage and support students to take appropriate action to promote patient safety and to make sure that any concerns they do raise are taken seriously.

Some of the questions involving less professional types of behavior were more acceptable to respondents than others. In particular, those that related to dishonesty that could be seen as low level — such as a friend signing a student in to a lecture — or irrelevant to the student's role as a medical student — such as failing to pay a train fare — were more acceptable to respondents than the GMC and medical schools would hope. The forthcoming revised guidance on student professional values will seek to address this by making clearer the importance of maintaining standards of behavior even outside of the medical school context.

WE KNOW THAT EFFECTIVE TEACHING AND LEARNING ABOUT PROFESSIONALISM IS IMPORTANT TO MAKE SURE THAT TODAY'S STUDENTS BECOME GOOD DOCTORS IN THE FUTURE.

Differences by gender, year of study and entry route raise some interesting questions and could be the result of various different factors, including the stage at which students begin clinical work, or begin certain types of clinical work; the point at which certain aspects of professionalism are taught, and how they are taught; and social and cultural norms and expectations, which may correlate with personal characteristics such as gender and age (for which year of study and entry route can be seen as proxies). The results of this survey are particularly interesting, given GMC data showing that male medical graduates applying to the GMC for registration are more likely to declare an issue that requires an investigation than female applicants[15] and male doctors are more likely to face allegations than female doctors.[16]

We know that effective teaching and learning about professionalism is important to make sure that today's students become good doctors in the future. The GMC is already helping medical schools and postgraduate medical educators to support and encourage professional behavior throughout

medical education and training. Its work on generic professional capabilities will embed professionalism in the postgraduate medical curricula and there is an intention to broaden this work to cover undergraduate and foundation-stage training. The new guidance on student professional values[14] will help students to develop their professional behavior, and further exploration of the issues raised in this research may be useful in helping medical schools to consider when and how best to teach particular aspects of professionalism. ■

About the Authors

Cathy Finnegan, MSc, is a policy officer in the Standards and Ethics Team at the GMC.

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Appendix A

Questions for the survey of medical students

Sift question

Please confirm that you are a current UK medical student [only those who selected yes progressed to the survey itself]

- Yes
- No

Scenarios

Responses were all on a four point scale:

- Acceptable
- Mostly acceptable
- Mostly unacceptable
- Unacceptable

All questions were mandatory, although it was not necessary to complete all parts of question 1. This was due to a software limitation. (Editor's note: The wording of the questions below has been slightly amended from the original colloquial British English used in the survey, but the meaning remains unchanged.)

1. Is it acceptable for a medical student on a ward round to:
   a. have a visible tattoo?
   b. wear a T-shirt with a slogan?
   c. be unshaven?
   d. wear black trainers?
   e. wear a sleeveless top?
2. A second year medical student is occasionally late for lectures but one day has overslept — the student texts a friend and asks the friend to sign the student's name on the attendance sheet.
3. A medical student forgets to bring a log book and is unable to get the supervisor to sign off practical skills that the student has carried out. After some consideration, the student decides to forge the supervisor's signature in the log book.
4. A medical student thinks there may be staffing issues on the ward the student is attached to as part of a placement, which could raise some patient safety concerns. The student decides to draw this to the attention of the medical school.
5. Two students are travelling home by bus and talking animatedly about an examination they have observed carried out on a patient that day. They don't refer to the patient by name but are talking loudly enough that other passengers can hear the details of their conversation.

6. A medical student has had diarrhea and vomiting in the last 24 hours. The student has a full day of shadowing on the wards and decides it will probably be ok to go in.
7. A student has a particularly difficult experience when a patient the student has seen on the wards a number of times dies unexpectedly. The student decides it is necessary to talk the matter through and seeks pastoral support from the medical school.
8. A student is distracted in a lecture and decides to check Facebook. The student decides to post a status update about how boring the lecture is and how bad the lecturer's dress sense is.
9. During exam time a medical student buys drugs online that are usually only available on prescription, and uses these in order to stay awake and study.
10. A medical student bumps into a previous patient while out on the weekend. The student saw the patient in A & E earlier that week and took a history. The pair get chatting and the patient invites the student back to the patient's flat for coffee. The student decides to go.
11. A medical student travels by train every day but the student's ticket is never checked. It is coming up to the end of term and the student is running short of money, so, on this occasion, the student decides to travel without paying the fare.
12. A medical student is asked by a ward doctor to site a cannula in a patient, but the student refuses. Having never done one before, the student doesn't feel confident doing this.

Monitoring questions

What year are you in?

- First
- Second
- Third
- Fourth
- Fifth
- Sixth

Did you start medical school as a school leaver or as a graduate?

- Graduate
- School leaver

Are you male or female?

- Male
- Female
- Prefer not to say

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