

**Professionalism in the pre-registration pharmacist placement:  
an exploratory stakeholder study**

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## Abstract

Interest in professionalism within UK healthcare has increased following reports highlighting poor patient care. This, combined with the development of new patient-facing roles for pharmacists, has led to questions about how pharmacists develop professionalism.

The pre-registration placement is a key component of the education and training of pharmacists. This is when pre-registration trainees spend 52 weeks in an approved training site under the supervision of an experienced tutor.

This study explored how professionalism is understood, developed and assessed during the pre-registration placement from the perspectives of the professional regulator, which is the General Pharmaceutical Council, service users, pre-registration trainees and pre-registration tutors.

An interpretative paradigm was adopted, involving a semi-structured interview, focus groups and qualitative e-questionnaire. An active thematic interpretative analysis was used to identify and evaluate patterns and meaning across all data sets.

Stakeholders understood professionalism in ways that were dynamic and subjective; a shared definition was elusive. Trainees and tutors provided insights into a series of transformative moments which potentiated professionalism development. The first moment being the issuing of the title *pre-registration trainee*. All groups reported that emotional connections with patients throughout the placement aided professionalism maturation from a *self-centred student* to becoming an *outwardly looking and responsible professional*. Tutors indicated the rate of professionalism development may vary across sectors of pharmacy practice, with community pharmacy facilitating faster professionalism maturation due to increased trainee autonomy. Although no tutors reported that patients formally assessed trainees' professionalism, service users expected to be involved.

This study proposes the existence of transformative moments and maturation periods during in pre-registration training and suggests both are essential to *becoming* a professional. The study suggests careful planning of training

placements to optimise professionalism development across different sectors of practice. Formal and consistent involvement of patients in assessments of trainee's achievement of professionalism is recommended.

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## Chapter 1 Introduction

This study set out to explore how professionalism is understood during the pre-registration placement and, how the training and assessment of professionalism is perceived and experienced during pre-registration training from a range of perspectives.

This introductory chapter, provides the background and context for the study. This includes an overview on the regulatory, leadership and educational organisations which contribute to the development and regulation of pharmacy practice. The history to pharmacy becoming a profession, the role pharmacists undertake in practice today and future aspirations are also discussed, before outlining the career pathway to become a registered pharmacist and where the pre-registration placement fits within this pathway. This chapter finishes by outlining my position and experience as a pharmacist and in pharmacy education, and my rationale for undertaking this study.

### 1.1 Pharmacy workforce within the NHS; current and future direction

The NHS was established in 1948, with a view to providing free healthcare to all at the point of use (NHS, 2018). Today, it is under increasing pressure to achieve these aspirations due to population growth in the UK, an aging population (Murry, 2016) and healthcare staff shortages (Sizmur and Raleigh, 2018). The NHS has responded by producing strategy documents describing the intentions for the NHS. These include the Five Year Forward View (NHS England, 2014) next steps on the Five year forward view (NHS England, 2017b) and NHS Long Term Plan (NHS England, 2019b).

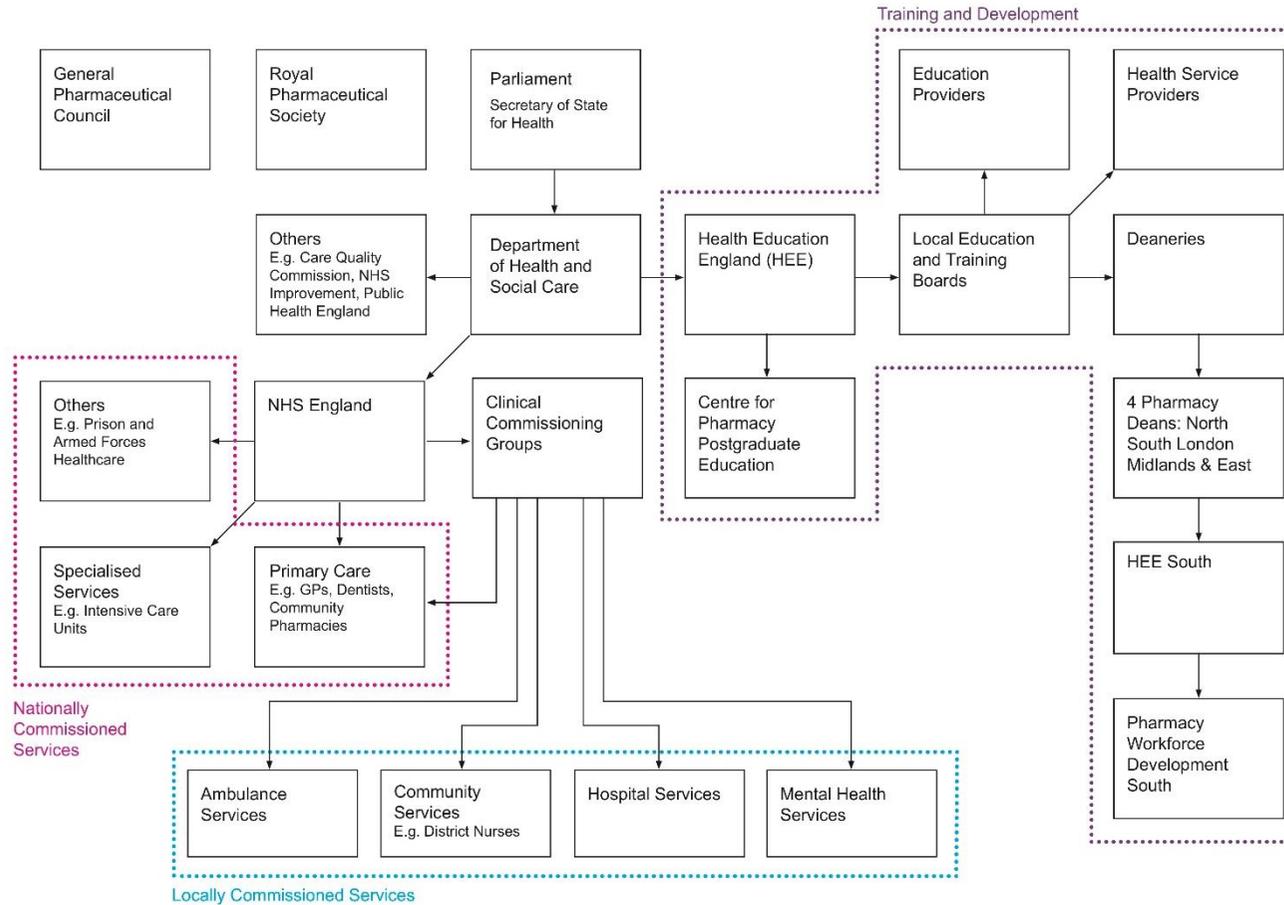
The recent NHS Long Term Plan sets the direction for new models of service, with greater focus on reducing health inequalities and improved health support for young people (NHS England, 2019b). It also focusses on developing the healthcare workforce and improving digital solutions across the NHS. Most significantly for the pharmacy profession, it states:

“Pharmacists have an essential role to play in delivering the Long Term Plan.” (NHS England, 2019b, P.82).

The Long Term Plan describes current and future contributions pharmacists can provide, such as clinical pharmacists undertaking patient-centred care in hospitals and within general practices to help patients get the most benefit from their medicines. The plan is clear; there is an expanding need and opportunity for more clinical pharmacists within general practice, community services, urgent care, care homes and in mental health. In the proposed models of care pharmacists will be active members of wider multidisciplinary teams. The NHS Interim People Plan states that there must be training for pharmacists to undertake these roles, including a new foundational programme for pharmacists (NHS England-Improvement and Health Education England, 2019).

To help to understand how this workforce development will take place, I will describe the NHS organisations that commission pharmacy services, the pharmacy organisations that regulate and support pharmacists and what this means for the education and training of the workforce (Figure 1-1 p.3). The following figure describes how the Department of Health, commissioners, providers, sectors of pharmacy practice, Health Education England, the pharmacy regulator and the professional leadership organisation are connected.

Figure 1-1 NHS and Pharmacy organisations



The Department of Health cascades funding through NHS England to support the commissioning and delivery of pharmacy services in England. Community pharmacy in figure 1-1 (p.3) is located within the primary care services, which are directly commissioned from NHS England. Geographically community pharmacies are often found in high street, shopping centres or near to GP locations. Their main business is dispensing prescriptions issued from GPs and assisting patients with minor ailments and long term chronic disease management. In recent years community pharmacies have expanded the healthcare services they offer. Many pharmacies now provide medicines use reviews, flu vaccinations, an NHS Urgent Medicine Supply Advanced Service and support patients with self-care via various healthy living pharmacy campaigns (Pharmaceutical Services Negotiating Committee, 2019c). A named responsible pharmacist must be onsite to oversee the provision of these services. They will work alongside pharmacy technicians, dispensers and medicine counter staff. The sector comprises of independently owned pharmacy organisations through to large national chains. Community pharmacies must have General Pharmaceutical Council (GPhC) approval of a training scheme before they can offer a pre-registration pharmacist training place (General Pharmaceutical Council, 2019i). The community pharmacy organisation will often recruit the trainee themselves, although many now participate in the Health Education England (HEE) recruitment scheme (NHS England, 2019a). Two thirds of pre-registration trainees in the UK undertake their placement in community pharmacy (Health Education England, 2019a). However, in 2018 HEE reported that the fill-rate of community pharmacy pre-registration places was 62% compared to 100% in the hospital sector (NHS England, 2019a).

HEE is a non-departmental public body of the Department of Health and has oversight for workforce planning, recruitment, funds and educational support of a range of healthcare staff that provides care for NHS patients across England (Health Education England, 2018). Within pharmacy, HEE funds training and development opportunities both at a national and local level. The Centre for Pharmacy Post Graduate Education (CPPE) is a national organisation providing learning resources and events for registered pharmacy professionals and pre-registration trainees providing NHS services (Centre for Pharmacy Postgraduate Education, 2018). At a local level, four pharmacy deaneries

(London, Midlands and East, North and South) provide and/or commission training programmes. HEE South commission Pharmacy Workforce Development South (PWDS) to provide training courses and the provision of support for pre-registration pharmacist tutors and their trainees undertaking a scheme involving a South West NHS hospital. Note: until 2019 PWDS was previously known as South West Medicines Information and Training (SWMIT).

Hospital pharmacy, also referred to the acute sector, relates to practice within (mostly) an NHS hospital. A hospital pharmacy will be run by a range of pharmacy team members from assistant technical officers through to consultant pharmacists. Together the staff will undertake roles from dispensing, technical services and medicines information to more near-patient or clinical activities such as medicines reconciliation, medicines optimisation and counselling. The hospital pharmacy team will have daily interactions with other healthcare professionals. Hospitals wishing to provide a pre-registration pharmacist training scheme must undergo the same training site approval process with the GPhC that community pharmacy organisations undertake (General Pharmaceutical Council, 2019i). Approximately one third of the pre-registration places in the UK work within the hospital sector (Health Education England, 2019a). A trainee will see their tutor less than in community pharmacy, as the trainee will often work alongside other members of the pharmacy team for during the placement.

The GPhC is a statutory organisation, independent from government. It is the pharmacy profession's national regulator and maintains a register of pharmacists and pharmacy technicians in Great Britain. As mentioned, the GPhC, approves pre-registration training sites as well as setting the training requirements for the undergraduate degree and pre-registration pharmacist 52 week placement (General Pharmaceutical Council, 2019d). The same pre-registration training requirements apply to all premises wishing to train a pre-registration trainee (General Pharmaceutical Council, 2019i). The GPhC provides guidance for those undertaking a pre-registration tutor role (General Pharmaceutical Council, 2019f) and additionally sets a registration exam. This must be passed within three attempts for the trainee to join the pharmacist register.

Pharmacists have the choice to join the Royal Pharmaceutical Society (RPS); the leadership and professional support body for the pharmacists and pre-

registration trainees within the UK. The RPS is independent to the NHS and GPhC, and seeks to support its members in all sectors of pharmacy practice and all stages of their careers to develop their practice. For example, the Medicines Ethics and Practice guide helps trainees understand the legislation around medicines, an online practice registration test, supports trainees in preparing for the registration exam and pharmacists with a high level of experience are recognised through faculty membership (Royal Pharmaceutical Society, 2019a).

## **1.2 Introduction to the pharmacy profession and the pre-registration placement**

### **1.2.1 Pharmacists; the professional expert in medicines**

Medicines are the second largest spend within the NHS budget (NHS England, 2018). With an aging UK population and increasingly more patients living with long term conditions, the NHS is exploring different approaches for utilising healthcare staff and resources more effectively to meet these needs (NHS England, 2017b). The Five Year Forward View (NHS England, 2014), next steps on the Five year forward view (NHS England, 2017b) and NHS Long Term Plan (NHS England, 2019b) support the unique training and skill set pharmacists have to help to optimise the use of medicines. This can be seen in action by pharmacists undertaking new and more clinically focused roles in range of healthcare settings. These include;

- acting as independent prescribers in all sectors of clinical practice (Jebara, 2018)
- accessing the NHS England pharmacy integration fund to train for roles within general practice, integrated urgent care settings and care homes (NHS England, 2019c)
- using the NHS England pharmacy integration fund to undertake funded post graduate qualifications to enhance their clinical skills (Health Education England, 2019c)
- providing a broad range of high quality public health services, such as support for stopping smoking and weight loss, brief alcohol interventions, the treatment of minor ailments, supply of, and advice about contraception, and provision of healthy living pharmacies

(Pharmaceutical Services Negotiating Committee, 2019a;  
Pharmaceutical Services Negotiating Committee, 2019b)

- providing medication reviews on discharge from hospital and discharge planning to enable the safe transfer of medicines between sectors (Royal Pharmaceutical Society, 2012)
- improving the productivity and efficiency targets of their organisations as well as implementing transformational changes (University Hospitals Bristol, 2018)

Additionally, the NHS Digital Medicine Strategy has transformed how pharmacists work, with pharmacists able to prescribe or dispense electronic prescriptions, access patients' summary care records and receive electronic referrals for patients requiring out of hours services (Murry, 2016).

Pharmacists are increasingly moving away from dispensing prescriptions written by a doctor to utilising their medicines knowledge within the multidisciplinary team and skills to independently prescribe and provide person-centred care (John, 2018).

The 2005 Pharmacy contract between NHS England and community pharmacies in England and Wales, was the first to include payment for essential, advanced and enhanced services provided from community pharmacies, as well as funding each item of NHS medication dispensed (Pharmaceutical Services Negotiating Committee, 2019d). The services provided ranged from supporting people with self-care, to providing medicine use reviews (MURs) and flu vaccinations (Rapport et al., 2010).

Within hospital practice, pharmacists are being directed to spend at least 80% of their time undertaking clinical roles, rather than dispensing or other infrastructure activities (Winter and Adcock, 2016).

Therefore, there is greater focus on pharmacists in all sectors of pharmacy practice to undertake more autonomous and patient focused activities.

Agomo (2012) argues that the move from dispensing to patient-centred activities demands a higher level of professionalism. One of the reasons proposed for a change in professionalism requirements for pharmacists is that rather than following the directions on a prescription from a doctor there is greater autonomy over the new clinical services they will offer. To contextualise

these developments in professionalism further, I will consider what a profession is and what this means for pharmacy.

### **1.2.2 What is a profession?**

A profession has been described as a group of people with special knowledge, a code of ethics providing some regulation, a professional culture, and a position of power or privilege that sets members apart from society around them (Traulsen and Bissel, 2004). The people with this position professed their better knowledge to those around them (Martimianakis et al., 2009). I will explore professional regulation and professional characteristics in more detail to explain why the concept of professionalism is at the heart of current practice.

I start by considering how the role, title and training of the pharmacist developed. The title of pharmacist originated from apothecaries who dispensed and compounded medical products. By the 19th century, the Apothecary Society had evolved into a Pharmaceutical Society of Great Britain. This organisation was formally recognised in 1843 by a Royal Charter. This enabled the Society to require specialist training to dispense and sell medicines, set membership exams and award profession related titles (General Pharmaceutical Council, 2018a). The foundations of formal training to become a pharmaceutical chemist or pharmacist, as defined then, can be traced back to 1919, when a national syllabus required future registrants to complete a period of study at an approved institution before registration. The first reference to the origins of the pre-registration scheme was in 1926 with the mandatory requirement for all future registrants to undertake an apprentice style pupillage to gain practical workplace experience. The first reference to the pre-registration year was in 1972, although the registration exam, to test pharmacy practice, did not appear until 1993.

From the 1843 Royal Charter onwards, a pharmacist could be considered a professional, as they had specialist knowledge to perform the role and a framework of regulation that differentiated and protected the title. However, the professional nature of the role has been challenged. This was mainly for two reasons; firstly the commercial aspect of community pharmacy was viewed as being in conflict with professionalism (Aziz et al., 2009; Rapport et al., 2010) and secondly, pharmacists who are not independent prescribers, did not work

autonomously because they did not have control over their practice. In other words they worked on the direction of the prescription from a doctor (Agomo, 2012). Traulsen and Bissel (2004) highlighted that only in the 1990s when pharmacists moved on from technical tasks to roles demanding greater patient contact and more complex decisions did pharmacy become a profession. Martimianakis et al., (2009) recognised that because pharmacists were increasingly and actively undertaking tasks that were not dependent on a doctor's directions they could be seen as professional.

In 2007, the UK Government set out a White Paper highlighting the requirement for legislative changes to how the pharmacy profession was regulated and presented. The paper outlines splitting of the roles of Royal Pharmaceutical Society of Great Britain's (RPSGB) to form two organisations; the GPhC being responsible for regulation and the RPS for professional leadership. The White Paper cites the development of pharmacists' roles and the increased risk this places on patients as one reason for this change;

*“Pharmacists are no longer constrained by outmoded limits on their ability to prescribe independently... As a profession, pharmacists are entering a new era, in which they will have much greater scope to apply their high levels of expertise in direct patient care. With these changes comes the need to ensure that their regulatory arrangements are in keeping with their increasing levels of professional responsibility and the accompanying benefits and risks to patients that that entails.” (Secretary of State for Health, 2007, P.29)*

This change from the RPSGB to the GPhC and RPS has enabled the profession to have an independent organisation to regulate and uphold standards, and a distinct professional leadership body who can support, promote and develop the profession (The Pharmaceutical Journal, 2007).

Recently the GPhC published a series of new standards for pharmacy professionals (General Pharmaceutical Council, 2017c). The title of this document makes it clear that pharmacists are recognised as professionals. The document lists nine standards that pharmacists must adhere to when providing any service in any sector of pharmacy practice, and outside of work hours.

The GPhC also define the learning outcomes and performance standards for the pre-registration pharmacist training placement (General Pharmaceutical Council, 2019d). Pre-registration training is a central part of my research,

therefore the following section aims to provide important contextual background for this placement.

### **1.3 The pre-registration trainee pharmacist placement**

I will firstly consider the design of the placement and how this relates to the Master of Pharmacy degree, the location(s) of the training placement, the requirements to become a pre-registration tutor and the tutors' role in the placement, and finally the assessments undertaken during the placement.

The design of the pre-registration trainee pharmacist placement in England is predominantly a 52 week workplace-based training and assessment experience that takes place only when the person has completed a four year Master of Pharmacy degree. However this model is being challenged. The University of Bradford has offered a split pre-registration scheme to all its undergraduate students for many years. This involves trainees undertaking a five year degree with their pre-registration placement integrated into the degree in two six month blocks; one at the start of the fourth year and one at the end of the fifth year. Graduation and registration with the GPhC happen at the same time. More recently, other institutions have also begun to offer integrated programmes for overseas and UK based students (University of Nottingham, 2019). The five year integrated degree and pre-registration schemes provide the opportunity for the student to link University based teaching with clinical practice more closely, which may influence how they understand and develop their professionalism.

The pre-registration training placement can be carried out within a GPhC registered training site in any healthcare setting. A site wishing to have a trainee must submit a training plan to the GPhC that demonstrates how a trainee will achieve all the performance standards and training learning outcomes over the placement (General Pharmaceutical Council, 2019d). The GPhC will review the application before deciding if the training programme will be approved as a training site.

Every pre-registration trainee needs at least one work place pre-registration tutor. The tutor and trainee inform the GPhC of the training relationship by both signing a learning contract describing the commitments the tutor and trainee make to each other. Any registered pharmacist can become a tutor if they have also worked for at least three years in the sector of pharmacy practice in which

they are tutoring, are not under investigation by the GPhC for any fitness to practice restriction, are not in a significant relationship with the trainee and work at least 28 hours over 4 days (General Pharmaceutical Council, 2019f). Two tutors can be recognised as jointly tutoring one trainee where a tutor may work part time or the placement is taking place over different sectors of pharmacy practice (General Pharmaceutical Council, 2017a). There is no requirement from the GPhC for the tutor to have completed any further training although HEE have provided optional training events for tutors (Centre for Pharmacy Postgraduate Education, 2019).

The tutor is responsible for facilitating the trainee's learning, acting as a mentor to the trainee, displaying leadership skills, providing formative feedback to the trainee and assessing the trainee to decide if they are of a satisfactory level to register as a pharmacist (General Pharmaceutical Council, 2019f).

There are two forms of assessment during the placement; the tutor evaluation of the trainee's portfolio and the GPhC registration assessments that are both required by the GPhC. I will discuss each in more detail.

The GPhC require a tutor and their trainee to meet every 13 weeks to review a portfolio of evidence the trainee has collected to demonstrate satisfactory progress towards achieving the GPhC performance standards (General Pharmaceutical Council, 2019e). It is the tutors responsibility to assess if the trainee has met a satisfactory level at each 13 week milestone (General Pharmaceutical Council, 2019e). At week 39, the pre-registration tutor decides if the trainee is ready to sit the GPhC registration assessments. At week 52 the tutor must decide if the trainee has consistently and repeatedly demonstrated achievement of all the 76 performance standards set out by the GPhC. Tutors are required to inform the GPhC of their decisions.

The GPhC also requires the trainees to sit a registration exam. All trainees, regardless of sector of pharmacy practice, will sit the same GPhC registration assessment. The exam consists of two papers that assess a range of topics including; expectations of a pharmacy professional, validating therapeutic approaches, safe and effective systems for pharmaceutical services, working with patients and calculation ability (General Pharmaceutical Council, 2019e). A trainee is allowed up to three attempts to pass both papers in one sitting (General Pharmaceutical Council, 2019h).

Only if the tutor signs the trainee off as having demonstrating achievement of the performance standards and the trainee passes the registration exam will they be able to register as a pharmacist.

### **1.3.1 Rotational pre-registration programme**

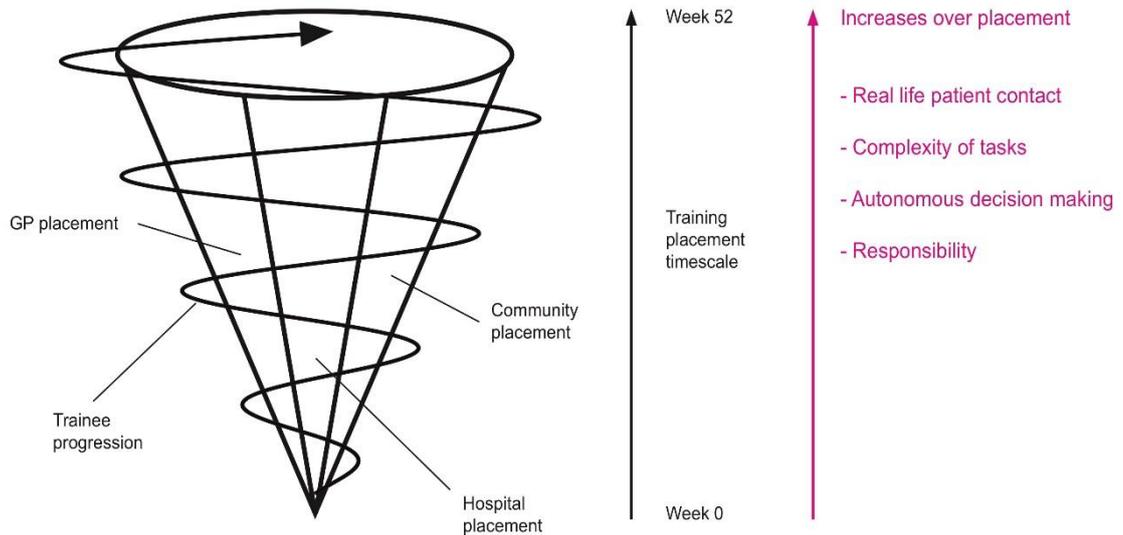
Historically pre-registration placements were typically undertaken within one sector of pharmacy practice; principally in a hospital or community pharmacy. Some placements offered an optional two weeks of the placement in the other major training setting.

In 2015, SWMIT together with the relevant clinical workplaces produced an innovative, rotational pre-registration placement. This training placement involved learning experiences in a GP practice, Clinical Commissioning Group (CCG), mental health trust and/or community pharmacy with an acute hospital setting. This development was designed to better prepare the future pharmacist workforce for a career undertaking a variety of patient facing roles in different sectors of pharmacy practice. Each rotation builds on the experience and knowledge from the previous rotation. For example the trainee might experience working on an elderly admissions ward during their hospital rotation, followed by observation of Medicines Use Reviews and care home services in their community rotation, followed by a GP care home visit and attending a pharmacist prescriber clinic during their GP surgery rotation. The organising concept is that the trainee's responsibility, clinical skills and independence of practice should increase as the programme progresses.

Since 2015, the number of rotational programmes has rapidly increased in the South West of England, with 10 placements in 2017-2018 and 18 in 2018-2019 out of 45 training places. Most rotational placements have included a GP partner. Since this time, the Pharmacy Integration Fund has been set up to increase the number of pre-registration schemes with 3 or 6 months of the training year in general practice. The scheme had 120 places on offer for the 2019 trainee intake (Health Education England, 2019c). The rationale for the changes in training design was ease the pressure of general practice by developing the practice-based pharmacist role (Health Education England, 2019a) and to meet the aspirations of the Five year Forward View (NHS England, 2017b). It has been shown that the move to these more patient-

centred activities demands a higher level of professionalism (Agomo, 2012) yet there are currently no studies exploring the understanding, development and assessment of professionalism within rotational pre-registration programmes.

**Figure 1-2: Example of rotational pre-registration programme design**



## 1.4 Summary

In this introductory chapter I have contextualised professionalism within the NHS pharmacy workforce, highlighted the increasing number of patient-centred, and autonomous roles pharmacists are undertaking, and linked these clinical activities to demanding a greater level of professionalism than dispensing. I have discussed how changes to the regulation, education and the professional leadership of pharmacists has challenged and facilitated the development of these enhanced clinical roles. Therefore justifying the importance of professionalism to the profession.

I have shown how pharmacists are central to the future plans of the NHS and how the design of rotational pre-registration programmes, aims to train the workforce to meet these aspirations. However, research into how professionalism is understood, learnt and assessed during these placement is lacking. As increasingly more pre-registration training programmes are rotational in design, it is therefore both important and worthy that professionalism within the pre-registration placement is explored in more detail.

I will now explain my research stance, why I have a personal interest in professionalism and how I can see this research will have an impact on pharmacy education.

I conclude the introduction with describing how subsequent chapters of the thesis are organised.

## **1.5 My research stance**

I registered as a pharmacist in 2004 having completed my 52 week pre-registration training within an NHS hospital pharmacy. Since this time, I have worked within the hospital sector, been a pre-registration tutor and been involved in the development and delivery of post-registration pharmacist and pharmacy technician programmes at CPPE. This has provided me with experience of both national and local facilitation of training and development for the pharmacy workforce (Figure 1-1 p.3). In 2009 I took at position at South West Medicines Information and Training (now PWDS) as the South West NHS hospital pre-registration training lead. My role includes the planning and facilitation of residential training courses for trainees undertaking their pre-registration within an NHS hospital placement in the South West. Until my maternity leave, I was also working two days a week as a generalist hospital pharmacist and as a locum in community pharmacy which gives me insight into the day-to-day working environment of the two main sectors of clinical practice.

Professionalism is a topic tutors often speak to me about, particularly when concerned about signing a trainee off as satisfactory at one of the 13 week reviews required by the GPhC.

In 2013 I started my doctorate to explore understandings of professionalism with a view to developing new knowledge to inform the debate on professionalism learning and assessment.

I will write my thesis in my first person. This is because the data has been collected via a co-constructive process between study participants and myself (discussed in chapter 3: methodology and methods). Therefore I have influenced and am inherently part of the study through the judgements made throughout the research journey, therefore I was not aiming to be objective. I have assumed a reflexive approach during my study to critically consider when,

how and why I made the decisions I did about my research and the potential impact this would have had on my study, findings and implications for practice. Together, my position within this field of pre-registration education and my reflexive stance enables rigor and trustworthiness to be placed in the research approach and its contribution to the field, policy and practice.

## **1.6 Thesis organisation**

My thesis consists of a further five chapters which encompass a review of the literature (chapter 2), justification of my methodological approach (chapter 3), presentation and analysis of my findings (chapter 4), interpretation of my findings (chapter 5) and finally discussion of the implications and conclusion (chapter 6). I will expand on each of these chapters;

Chapter 2: Review of literature: The objectives of my literature review were to identify what concepts of professionalism exist within healthcare, what the current understanding is of professionalism and how it is taught and assessed, particularly within the pre-registration trainee pharmacist placement. I focus on the pharmacist career pathway and discuss some pertinent studies exploring pharmacy undergraduate and post-graduate views of professionalism development. I use the Dreyfus model of skills acquisition (Dreyfus, 2004) to contextualise the development of professionalism within the UK pre-registration training placement and explore the definitions of professionalism, linking these to the roles pharmacists are currently undertaking. Finally I use the Miller's pyramid for assessing clinical competence (1990) to explore how professionalism is assessed. I highlight pertinent gaps in the literature, and the extent of stakeholder engagement in informing our thinking about professionalism. This chapter closes by stating the research questions and the unique contribution this study explorative can bring.

Chapter 3: Methodological approach: Here I present and justify the methodology and methodological approach adopted to explore the study area. This includes the ontological and epistemological assumptions which informed my critique of a range of qualitative methods that could be used to explore the perspectives of the participant groups and explains, with reference to my research questions, why I chose the study design I did. Ethical considerations and data collection methods are also discussed. Finally, I present the thematic

framework approach used to analyse the study data. The process of working with the data (from familiarisation to mapping thematic codes) is detailed to show how the study's key concepts and findings emerged.

Chapter 4: Findings and analysis: In this chapter I present the findings from all the data collection steps. Key concepts identified through the thematic framework analysis process are used to structure this chapter including; perceptions of professionalism, professionalism development and judgements on professionalism.

Chapter 5: Interpretation: In this chapter I present the study's key concepts and overarching themes and discuss them in relation to current policy and research in the field. The key themes are: understanding professionalism, transformative moments and maturation periods in the development of professionalism, rate of professionalism development, patient involvement in professionalism development and assessment. Together these map how a trainee becomes a pharmacist.

Chapter 6: Discussion and conclusion: In this chapter, I revisit the research questions in the light of the study's findings, which highlight the variety of ways to understand of professionalism, and the challenge this brings to an agreed definition within the profession. The existence of transformative moments and periods of maturation are proposed as an explanation of how professionalism is learnt in the pre-registration placement. The factors that affect the rate of professionalism development are highlighted. The over reliance on the Miller's framework or pyramid (1990) for the current assessment of professionalism is challenged, and the work of Cruess et al., (2016) is extended by suggesting patient feedback and trainee reflection could be used to assess 'is'. I discuss my research approach, its limitations and I also reflect on the strength of my study contribution. This makes a timely contribution to current practice and policy, particularly with GPhC currently reviewing the initial education and training standards for pharmacists (General Pharmaceutical Council, 2019a).

Finally, I discuss my research approach, its limitations and reflect on the strength of my study contribution before proposing avenues for future research.

## Chapter 2 Reviewing the literature

### 2.1 Introduction

This study seeks to explore how professionalism is understood during the pre-registration placement and, how the training and assessment of professionalism is perceived and experienced during pre-registration training from a range of stakeholder viewpoints.

I carried out my literature or narrative review (Grant et al., 2009) to identify the current research and discussions regarding professionalism within pre-registration pharmacist training and pharmacy practice. I used the 'SPIDER' approach (Sample, Phenomenon or Interest, Design, Evaluation and Research) to structure my literature review (Cooke et al., 2012). Through this process I wanted to make clear the current published studies in the field, identify any knowledge gaps and show the significance of my research is seeking to address. Finally, I also wanted to introduce and debate relevant theories, concepts and methodology that support my research.

To achieve this, I start this chapter by describing my literature searching strategy, the databases and additional resources and how I have used them to find material relevant to my study. The inclusion and exclusion criteria used to evaluate the information that were found is discussed.

The evaluation and discussion of my literature review has been organised into three sections;

Firstly, how professionalism has been understood within healthcare in general and then within pharmacy is discussed. I have highlighted the variety of definitions presented in the literature and the challenges this has provided to how professionalism is understood.

The approaches used to teach professionalism are then discussed, with particular focus on studies exploring pharmacy undergraduate and pre-registration professionalism development. The final section focuses on how professionalism is assessed within the pre-registration placement. The role of mentors, portfolios, multiple choice examinations, reflection and patient involvement in the assessment of trainees is discussed. The challenge of the

Miller's pyramid framework (1990), as the structure used for the performance standards within the pre-registration scheme, is also debated. Particular reference is given in this chapter to the assessment approaches used by pre-registration tutors when they seek to objectively measure professionalism in their trainees.

The chapter concludes with stating the research aim and questions that have presented by identification of gaps in the current literature.

## **2.2 Literature review**

### **2.2.1 Aim**

The aim of the literature review was to identify what concepts of professionalism are held and how professionalism may be taught and assessed particularly within the pre-registration trainee pharmacist placement. The purpose being to search, select, and synthesise existing knowledge to identify key concepts within the field of professionalism in healthcare education and specifically within the pre-registration pharmacist placement. I critique and highlight the limits of knowledge presented in the current literature, and identify where gaps in current knowledge exist to situate and direct where my research can contribute.

Finally, I describe how the existing literature provided a conceptual framework to help me make sense of the data collected in my study (Ridley, 2012; Peña, 2010).

### **2.3 Literature search process**

Ridley (2012) identifies a range of different techniques for carrying out a literature search from snowballing to key word searches on databases. The choice and justification of the approach taken will depend upon the aim of the research, the topic area and the role of the researcher.

From my professional role as a pharmacist and educator in pharmacy, I was party to conversations with others involved in pharmacy and I was aware of information produced by pharmacy organisations regarding the understandings, teaching and assessment of professionalism. However, I did not know what published research existed. Therefore I started my literature review by producing concept maps, of the key areas my study should explore (One

example in appendix A). The concept maps helped to define each of my research areas and focus my literature searching strategy on certain key words or elements within the results.

### **2.3.1 Database search strategy**

I used the 'SPIDER' approach (Sample, Phenomenon or Interest, Design, Evaluation and Research type) as a searching tool because this approach is useful in qualitative studies involving different methods (Cooke et al., 2012) (Appendix B).

The SPIDER terms were used to search a range of electronic databases in a systematic manner. Initially I used the National Institute for Health and Care Excellence Healthcare Database Advance Search (HDAS), which contains EMBASE, MEDLINE, CINAHL and other repositories. I ran my search in July 2015. I set my inclusion criteria to contain only articles published after 1990, because this was when pharmacists roles began to change from dispensing to patient-centred activities, and in the English language. I did this because I wanted the literature to explore current pharmacy and healthcare practice and be in a language I could read. I undertook the same process with PubMed, Web of Science and PsycINFO.

I saved my searching strategies, amended these accordingly as my research progressed, and set up weekly email alerts to notify me of any recent developments.

The electronic databases above do not include all pharmacy practice journals. Therefore, to ensure key pharmacy publications, from the pharmaceutical professions' own professional bodies were included, I completed a separate search of their websites. As a member of Royal Pharmaceutical Society, I had full access to reports, comments and editorials on *The Pharmaceutical Journal* website available to members only. I also reviewed a range of associated websites, including the GPhC, RPS, HEE and The Department of Health, for relevant information. In addition, I searched on the EThOS website for any applicable research completed by doctoral students.

Citation searching software, such as that available from University of York, identified where a paper of interest had been referenced in other literature

(University of York, 2019). This removed the reliance of only using keywords or descriptors to locate relevant items.

As my research area became more focused, I also followed up references from key texts I had read using the 'snowball technique' (Ridley, 2012). This helped extend the scope of my literature review within my field of interest.

Finally, whilst practicing as a pharmacist, I was occasionally sent information or came across a report that related to my study topic which I added to my literature review process.

### **2.3.2 Literature search checking**

My search strategy was checked by a healthcare librarian (AS) at University Hospitals Bristol Foundation Trust to quality assure my process. Later in my research journey, themes of interest to the study questions had begun to emerge that were not present in my original concept map, for example the role of the patient in the assessment of professionalism. Therefore I revised my searching strategy to include these emerging themes. A librarian (DM) at the University of Leeds also reviewed my updated search strategy to provide rigor to my process.

### **2.3.3 Literature search results**

A table summarising the articles found from each of the literature searching steps can be found in Appendix C.

## **2.4 Thematising the literature**

To move from the literature found to the themes and topics discussed below, I initially read each title and abstract returned during the searches. Those articles important to my area of interest were printed off on paper and also saved electronically. Any articles that were duplicated between databases were removed. I designed a summary sheet to record my analysis of the paper and implications to my research area. I attached one summary sheet to each paper or report I read. Literature that had direct relevance to my research area was collated onto a mind map around a central idea or question, such as how professionalism was understood. Focused notes were made on the mind map relating to the contribution each article made to the idea or question. A reference code was used to link the notes made back to the original article. As

this process progressed, it became apparent which areas of the topic had differing viewpoints and where gaps in the knowledge existed. I concluded that the following three areas of professionalism were the most relevant to research problem I wanted to explore. Furthermore my research had the potential to address omissions and extend current published evidence in these three areas.

- Understandings of professionalism
- Teaching professionalism
- Assessment of professionalism during the pre-registration placement

I will now discuss each of these topics in turn; highlighting current debates and knowledge, relevant theories and concepts plus the argument for and significance of undertaking this research.

## **2.5 How professionalism is understood**

### **2.5.1 Interest in professionalism**

Reports highlighting poor patient care within the NHS, such as the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), the Berwick report (Department of Health and Social Care, 2016) and the Gosport Independent Panel (Gosport Independent Panel, 2018) have scrutinised and asserted the need for NHS staff to demonstrate professionalism. This has included calls for improved routes for raising concerns regarding care provided, tougher external inspections, better use of pharmacists' clinical skills and lifelong education and development for healthcare professionals across all healthcare settings (Zijlstra-Shaw et al., 2012). Demonstration of professionalism has been linked to the trust that patients, carers and the public place in healthcare staff (Hammer, 2006; Willis et al., 2012). The publicised displays of poor practice and identification of poor professionalism and have led to an erosion of public respect within healthcare (Engel et al., 2009).

Within pharmacy, it is not only concerns from patients about incidents of poor professionalism but also the new roles pharmacists are undertaking which have led to increased focus on professionalism. Pharmacists are expanding the clinical roles they are assuming, for example working in emergency departments and in care homes (Robinson, J., 2018). Waterfield (2010) and Wilson et al., (2010) argue that the change in the scope and role of the

pharmacist, from dispensing to more practice based settings, demands that a different type of professionalism is displayed. This is because poor professionalism has been linked to poorer outcomes for patient wellbeing, for example reduced patient satisfaction and reduced patient adherence to medication (Hammer. D et al., 2003). The need to prepare pharmacists for these new roles adds urgency to the exploration of how professionalism, and teaching for professionalism, is understood across all sectors of pharmacy practice.

### **2.5.2 Defining professionalism**

Within healthcare, there is much research into and literature exploring professionalism. This has mostly been centred on studies from America and within the field of medicine. There are increasingly more studies exploring professionalism within pharmacy and pre-registration training in the UK but rarely is the term 'professionalism' defined and there is no consensus about its meaning (Rutter and Khalid, 2010; Willis et al., 2012; Elvey et al., 2015). Even the GPhC, which frequently used the term professionalism in publications had not explicitly defined their understanding of the concept and its impact on pre-registration training, until the concluding months of this study (General Pharmaceutical Council, 2019a).

In November 2018 the GPhC published revised draft standards for the initial education and training of pharmacist in readiness for consultation (General Pharmaceutical Council, 2019a). The proposed standards shine a light on the GPhC's understanding of professionalism and the impact this may have on the pre-registration placement. In the proposed new standards, professionalism is explicitly referred to within domain two. This domain consists of fourteen learning outcome statements that together seek to describe a person displaying professionalism. These include a person who applies professional judgement in the work place setting. These draft standards are only proposed and subject to a consultation and review in 2019. Therefore it is unclear if the proposed standards will be changed or accepted in any different form, and when any new standards will be embedded in the pre-registration scheme. As the standards are still under consultation and therefore were not in use when the research was conducted, my data gathering and analysis concerns the current (pre-2019) pre-registration standards and tutoring requirements.

As demonstrated by the proposed changes to the training standards, the GPhC has a pivotal role in the development and assessment of future pharmacists. However, the GPhC has not featured as a stakeholder in any study exploring professionalism within the UK pre-registration placement. I think this is a significant oversight.

Returning to how professionalism is understood, it is possible to summarise some of the perspectives identified in the literature. Table 2-1 (p.25) summarises the ways professionalism has been defined by three papers. The purpose of highlighting these papers is to compare three important contributions to the field and to also begin to identify a research gap. I will now explain why I have included these three papers, over other research into the subject area.

I chose to highlight the White Paper on pharmacy student professionalism produced by the American Pharmaceutical Association of pharmacy students and the American Association of colleges of pharmacy Council (Benner and Beardsley, 2000) because this was the first jointly produced student and educational institution document defining professionalism. Also because in 2000 few studies had been published in the UK within pharmacy and therefore this paper made a founding contribution to the debate. Although American, undoubtedly it informed later studies exploring professionalism within the UK. This is evidenced by Schalfheutle et al., (2012) citing the paper in their research exploring how UK pharmacy students learn professionalism in their undergraduate degree. This White Paper appears to be the first to formally seek to understand professionalism and its influence on the education and training of the pharmacists.

The study by Elvey et al (2015) explored patient-centred professionalism in the behaviours of UK early career pharmacists. Elvey et al., used focus group interviews and critical incident technique to facilitate discussions. I chose to highlight the contribution this paper brings to defining professionalism because it illustrates the transition from professionalism being focused on qualities of the healthcare individual to one centred on outcomes for the patient. I argue this marks a shift towards patient service and patient perspectives being prioritised. However, it is important to note that Elvey et al., only included recent pharmacist registrants, tutors and pharmacy staff from either hospital or community practice in their study. Pre-registration trainees and patients were

not included, therefore the viewpoints presented may not be the perspectives of trainees or users of healthcare services.

The right hand column of table 2-1 below lists the learning outcomes stated in the professionalism domain of the GPhC consultation on the initial education and training standards for pharmacists (General Pharmaceutical Council, 2019c). I have included this document because this is the first time the GPhC has explicitly stated in a public document their understandings of what constitutes professionalism in relation to pre-registration training, the document indicates the importance placed on professionalism for the pre-registration placement going forward and is a very recent publication.

The rows within the table illustrate and link terms with similar meanings across the three different columns and papers. Where a box is empty, this means that that paper did not highlight a similar idea to the other paper(s). Reflecting on the table, there are several areas over the last 19 years that have not changed and show consistent similarity, for example responsibility and trustworthiness. However, there are also some differences, for example the GPhC does not include mention of the patient. However, their consultation document has patient-centred care within a different learning outcome domain to professionalism. This may highlight how difficult professionalism is to define. It is important to note that there is a consultation taking place on the GPhC's initial education and training standards for pharmacists (General Pharmaceutical Council, 2019a), therefore the wording, classification and scope of the professionalism domain may change.

Together these papers show the transition from early definitions of professionalism to current understandings and where changes have taken place. However, none of the three papers have made it explicit if and how the perspectives of patients and trainees on rotational programmes have been involved. Therefore my study will seek to address this knowledge gap in the current debate into defining professionalism.

**Table 2-1: Different approaches and terms used to understand professionalism.**

Benner and Beardsley (2000)	Elvey et al (2015)	Professionalism domain of GPhC consultation on the initial education and training standards for pharmacists (2019c).
Accountability	Knowing the rules of practice	Responsibility, accountable, understands the legal and ethical implications in the environments in which they work
Commitment to self-improvement of skills and knowledge		Recognise and work within the limits of knowledge and skills, seek support, refer to others when needed. Reflect upon, identify and address their own learning needs
Conscience and trustworthiness	Trust	Act openly and honestly when things go wrong, raise concerns
Relationship with patient	Putting patients' needs first	
Creativity and innovation		Develop effective strategies to lead and improve quality in practice
Ethically sound decision-making	Professional judgement to complex situations	Apply professional judgement in all circumstances
Knowledge and skills of a professional	Being knowledgeable	Demonstrate the values, attitudes and behaviours expected from a pharmacist

Benner and Beardsley (2000)	Elvey et al (2015)	Professionalism domain of GPhC consultation on the initial education and training standards for pharmacists (2019c)
Leadership		
Pride in profession		
Service orientated	Accurate dispensing	Accurate and safe work of themselves and others
	Respectful communication	
		Engage with public health policies
		Critically evaluate and use national guidance and clinical evidence to support medicines use
		Health and safety health in the workplace
		Recognise when their performance or the performance of others is putting people at risk and take appropriate actions
		Proactively engage in the management of risks and impacts
		Respond to complaints, incidents or errors; prevent them happening again
		Understand and address the importance of infection control

Martimianakis et al., (2009) argued that understanding professionalism is much more complex than a list can capture because professionalism involves power and causal relationships. This may be why some researchers have resorted to using diagrams to convey their ideas. For example, Fish and Coles (1998) used an iceberg of professional practice, and Hammer et al.,(2003) an umbrella, to illustrate their conceptualisation of professionalism. With these diagrams, professionalism is the outcome or end result that depends on a range of different elements, such as empathy and specialist knowledge, being present. Together these papers illustrated that understanding professionalism is complex and that different approaches are being adopted in an effort to understand this complexity.

Hodges et al., (2011) argue that understanding professionalism is more complicated than establishing if an individual demonstrates professionalism. Rather, there are three domains; individual, interpersonal and societal, which together enable professionalism to be understood. This is an interesting proposition and allows for relationships with others, for example with patients, to influence a person's potential ability to display professionalism. Hodges et al., also take account of the expectations placed on healthcare, via the societal domain, in determining how professionalism is understood. Birden et al., (2014) raise the point that the dynamic nature and variety of healthcare situations could be one reason for this lack of a conclusive definition of professionalism. The influence of society and sociological frameworks that exist around a profession are also seen as important in other healthcare research (Zijlstra-Shaw et al., 2012; Goldie, 2013).

Zijlstra-Shaw et al., (2012) in their paper seeking to define professionalism within dental education, highlighted the influence the sociological construct and obligations society places on healthcare. They add that professionalism is not fixed, but rather changes depending on the public expectations and state:

*“medical professionals can no longer expect passive acceptance by the public of their authority” (Zijlstra-Shaw et al., 2012, P.e128).*

Here Zijlstra-Shaw, et al., suggest that patients may have their own views on what professionalism means to them, that the patients' understanding on

professionalism may be different to medical professionals' and patients actively bring their viewpoints on professionalism to interactions with healthcare staff. However the authors recognise further research is needed to explore this potential difference further.

Green et al., (2009) explored the views of patients, doctors and nurses on the topic of professionalism demonstrated by healthcare staff. Green et al., facilitated a series of focus groups with the aim of producing a list of behavioural signs that participants felt were observable in healthcare staff and perceived as important with respect to professionalism. Importantly, each focus group only contained one participant type, for example patients were only present in the patient focus group. This allowed comparison of the behavioural signs of professionalism identified by the different participant groups. Their conclusion shows that, although there were commonalities between the three participants group as to what behaviours demonstrated professionalism, there were also some crucial differences. For example, patients reported maintaining privacy and exploring the patients' needs as an illustration of healthcare staff showing professionalism, whereas this was not mentioned by the nurses or the doctors. I argue that the Green et al., study reinforces the view that everyone has a different perspective on what professionalism means to them, with patients in particular having their own insights.

I discuss the emergence and understandings of patient-centred professionalism in the next section.

### **2.5.3 Patient-centred professionalism**

The White Paper '*Equity and excellence: liberating the NHS*' (Department of Health, 2010) talked of patients being at the centre of healthcare and with patients involved in their healthcare choices.

*"No decision about me without me" (Department of Health, 2010, P.13)*

Since then the patient's profile has increased across all areas of healthcare. This marks a shift from the traditional paternalistic relationships between doctor and patient to one where the patient is involved as an equal and collaborative partner in decisions about their wellbeing (Elvey et al., 2015).

This emerging concept of patient-centred care is defined by the GPhC as;

*“Having conversations with patients that are tailored to their needs and their preferences, not using a ‘one-size-fits all’ approach”*  
(General Pharmaceutical Council, 2015, P.6)

However, it is not always clear what patient-centred care and professionalism actually means in practice. This was explored by Elvey et al., (2015) who researched pharmacists who were 1-2 years post registration and working in different sectors of pharmacy practice. Participants were asked for their perspectives on patient-centred professionalism. The authors identified three elements of patient-centred professionalism. These were; professional competency, ethical values and good communication skills. These themes were broken down further, as illustrated in table 2-1 (p.25). However, the study did not formally involve patients in the data collection other than inviting a lay representative, who had used pharmacies, to review the interview transcripts and discuss the themes identified with the research team. Although the involvement of a patient’s voice is welcome, I argue there is a need for further studies to include more than one patient voice at the point of data review to more accurately represent the patient’s perspective. Elvey et al., (2015) also recognised that further studies into pharmacy professionalism need to include the patient’s viewpoint.

Rapport et al., (2010) took a broader view in recruiting participants to their study, exploring patient-centred professionalism within community pharmacy in Wales. Members of the public, pharmacists, pharmacy staff and policy makers were all included in consultative workshops. The study used thematic analysis to identify eleven themes from the workshops. Safety, relationships with patients and professional pressures are three of the themes that resonate with adopting a patient-centred approach. The authors concluded that pharmacists found managing a patient-centred approach alongside work pressures demanding and sometimes conflicting. However, this study did not include the views of pre-registration trainees. Trainees may have the same perspective, or their own unique circumstances may provide a different understanding of patient-centred professionalism.

These studies illustrate that patient-centred professionalism is becoming an expectation within several areas of pharmacy practice. However, this is not

without challenges such as facilitating patient engagement whilst also meeting increasing service demands. This could explain why there is limited research into this area and why the research that is published predominantly only seeks the views of pharmacists.

Therefore there is need to include a wider mix of stakeholders to gain a more holistic viewpoint of how professionalism is understood and where these views show similarity or divergence. This is relevant for considering how professionalism is perceived to be developed and assessed during the training placement. Stakeholders should ideally include trainees, tutors, service users and the GPhC. I will discuss why it is important to include each of these groups. Pre-registration trainees have a unique insight as they are in a training placement, they are being assessed on the pathway to registration. Pre-registration tutors have a role in supporting, assessing and signing a trainee off for registration as a pharmacist, therefore their involvement will provide insight into their teaching and decision making processes, and the assessment strategies they use. Although Rapport et al., (2010) included service users as one stakeholder group, this study was confined to community practice. Therefore my study will include service users because the outcome of the care pharmacists give have direct implications on service users. Finally, no study has sought the view of the GPhC, as the professional regulator, on professionalism. It is important to seek the views of the GPhC because they set the standards for pharmacist professionals. Inclusion of the GPhC in this study provides an original contribution to compare with other stakeholders' views to explore where similarities or differences in understanding of professionalism may exist, and what this means for the development and assessment of professionalism within the pre-registration placement.

#### **2.5.4 Summary**

From current published literature I have identified that, in response to poor episodes of patient care, there is a substantial interest from patients, the public, NHS staff and regulatory bodies in how professionalism is understood within healthcare. I have shown there is no accepted definition of what professionalism means. However, there is some commonality within the literature that professionalism has influence on and is influenced by behaviour, character, attitudes and values. I have highlighted how adopting a patient-centred

approach seems to suggest a way in which professionalism could be conceptualised.

There are a limited number of studies exploring how professionalism is understood from a range of stakeholder perspectives, particularly within the field of pharmacy. As the pharmacist training standards are currently being revised (General Pharmaceutical Council, 2019a) and pharmacists are increasingly undertaking autonomous and clinical roles, there is an urgent need to not only research current understandings of professionalism, but also to consider the training and assessment of professionalism on the pharmacist career pathway from a range of stakeholder perspectives. My research will seek to address this need.

In the next section I discuss the literature on how professionalism is taught along the pathway to registration as a pharmacist, with particular focus on the pre-registration placement and the factors that may affect how professionalism is learnt by trainees.

## **2.6 Teaching professionalism**

### **2.6.1 Professionalism in the curriculum**

Despite the absence of consensus about the meaning of professionalism, and scepticism about defining professionalism by the use of checklists of traits and behaviours (Martimianakis et al., 2009) the government and educational organisations still seek to teach and assess professionalism.

The 2015 NHS constitution states that workforce development should entail not only acquisition of knowledge and skills but also the values that allow healthcare staff to use these skills in the workplace and through which professionalism can develop (Department of Health, 2015). Hammer et al., (2003) when thinking about how professionalism is displayed in practice, argue the importance of understanding the values that underpin behaviour. This has been reiterated in the recent HEE education and training quality framework for all healthcare professionals (Health Education England, 2018). This puts an obligation to include, and be seen to include, the development and demonstration of professional values in undergraduate teaching, work placement experience and in registered health professionals' competence

across the health care professions (Traulsen and Bissel, 2004; Engel et al., 2009; Cruess, S., R. and Cruess, 2012; Birden et al., 2013).

The profession of medicine, in particular, has led the way in exploring and reporting on how professional values and professionalism could be integrated with learning for practice in healthcare. Durham University applied a conscientiousness index tool to assess their first and second year medical students' professionalism (McLachlan et al., 2009). The tool sought to objectively measure a student's behaviour using a range of parameters, such as attendance at training and responding to emails from teaching staff. The tool did identify that second year students were more conscious of professionalism than first year students. However, some concerns were raised that the tool did not feature patient involvement or varied clinical environments. This is a significant oversight because patients have different understandings of professionalism than the health care professionals (Green et al., 2009). There is a danger of developing a tool to assess professionalism amongst health care practitioners which excludes what patients expect or recognise as professionalism. The need to include the patient perspective in how professionalism is taught and assessed has added importance now patients are actively included in their health decisions (NHS England, 2017a).

More recently, a range of tools have been used within medical undergraduate training to help foster and nurture professionalism. For example, Neve et al., (2017) evaluated the pedagogic approach of using small group teaching and audio-diaries to learn professionalism. Eight to ten students attended clinician facilitated 'jigsaw' sessions, where students share, discuss and reflect on placement experiences and how they relate to future roles. The students also kept reflective audio-diaries after each jigsaw session. The authors report the approach allows students a safe environment to learn from their workplace experiences and its contribution to their future professional roles.

Although parallels can be made between educating for medicine and pharmacy there are also key differences. Notably, the pharmacy pre-registration placement is normally a 52 week placement after graduation, whereas workplace experience is integrated throughout the five year medical degree. Birden et al., (2014), have shown how differences in curriculum design and involvement in the workplace impact on how professionalism is learnt. This

strengthens the case for my pharmacy-focused study to illuminate how professionalism is taught and learnt within the pharmacist career pathway.

### **2.6.2 Professionalism teaching within the pharmacy degree and pre-registration training**

To understand professionalism teaching during pre-registration training, it is appropriate to start by considering how professionalism is taught during the pharmacy undergraduate degree. At Wolverhampton University, final year pharmacy undergraduate students explored what professionalism meant to them in focus groups (Rutter and Khalid, 2010). They found students reported visits to practice locations and seeing positive role models in action helped them greatly in the formation of their views of professionalism. The study identified four major themes – appearance, personal characteristics, responsibility and knowledge which are similar to those identified in table 2-1 (p.25). However features such a relationship with patient, trust of others and service delivery were not identified as significant by the research participants. The study authors recognised that this study was small and that additionally the pre-registration placement may have had an impact on the individuals' understanding of professionalism. They suggested the pre-registration placement required further investigation.

Schalfheutle et al., (2012) took a broader perspective and sought to understand how professionalism was taught to pharmacy undergraduates from three UK Universities. The authors adopted a qualitative methodological approach by reviewing course materials, interviewing teaching staff, observing classes, holding six focus group events for final year students and constructing a thematic curriculum map. The study concluded that role models were important, particularly teacher practitioners, and cited practice based experiences as influential in the development of professionalism. Schalfheutle et al., reported that real life examples and role models were seen as helpful teaching approaches, particularly for aspects of the curriculum that may be hidden such as attitudinal and behavioural attributes. The authors argue that professionalism is not taught, but an understanding of it evolves for the learner over time and through varied experiences. Consequently, a continuum of professionalism learning is integrated throughout undergraduate training. Schalfheutle et al., also recognised that the University classroom is an artificial arena for learning

about professionalism and they did not explore if and how ideas about professionalism introduced in this setting translated into the workplace. Importantly, the study did not explore the pre-registration placement, which emphasises the potential contribution this study, which focuses on the pre-registration placement, brings to the debate on professionalism development of the future pharmacist workforce.

The pre-registration year was studied more closely by Jee et al., (2016) in his research into professional socialisation during the training placement. 20 trainees undertaking hospital or community training placements in the North West of England were interviewed. Jee et al., defined professional socialisation as the:

*“Process by which individuals selectively acquire the values and attitudes, the interests, skills and knowledge in the groups of which they are, or seek to become a member” (Jee et al., 2016, P.283)*

He found that professional socialisation, particularly exposing the hidden or informal aspect of the training programme, was a key aspect in how professionalism is learnt during the pre-registration year. Jee et al., concluded that real life experiences and the pre-registration tutor were important influences in the professional socialisation process. Unfortunately this study only focused on the perspective of trainees. I think this was an oversight, as it would have been beneficial to appreciate the tutor and patient perspective in the professional socialisation process. Also, Jee et al., commented that having a pre-registration placement within only one setting, for example hospital practice, may have implications for a trainee’s skill set post-registration. A hospital based trainee would have involvement from a range of individuals in their training and would learn about more specialist and complex medications. This was compared with community trainees who worked more closely with their pharmacist tutor and were more skilled in over the counter medicines and less complex medications. No opinion was given on which, if any sector provided the best training, merely that they were different. However they questioned whether pre-registration training within only one sector was the best preparation for registration. The trainees rotating around several different pharmacy sectors in their pre-registration programme were not included or referred to. Consequently this study may not be relevant to the increasing numbers of trainees

undertaking rotational pre-registration programmes in the South West and more recently, nationally.

These studies provide an insight into how professionalism has been taught in the undergraduate degree and during the pre-registration placement. They also highlight the importance of the pre-registration placement for the development of professionalism skills for practice (Schafheutle et al., 2012; Willis et al., 2012; Jee et al., 2016). However, few studies have involved current trainees, their tutors, patients and other stakeholder groups in the context of research into pre-registration placements. I argue this limits our understandings of how, when and by whom professionalism is taught during the pre-registration placement. Furthermore, no studies have included trainees on newly emerging, but rapidly expanding, pre-registration training programmes that involve the trainee rotating around several sectors of pharmacy practice. Therefore it is uncertain what impact rotational schemes may have on how professionalism is taught. My study will seek to address these questions.

### **2.6.3 Integration of the undergraduate degree and pre-registration training placement**

In 2011, HEE began to explore how the pre-registration year could be improved via a Modernising Pharmacy Careers (MPC) board. The work streams reviewed how to ensure a sustainable supply of qualified pharmacists with the right knowledge, skills, values and behaviours to deliver the care needed in all sectors of pharmacy practice for NHS patients on day one of registration. The MPC board identified that:

*“The current arrangements have a major gap in how the concept of ‘professionalism’ is developed and nurtured within the MPharm”  
(Modernising Pharmacy Careers, 2011, P.24)*

The MPC board proposed integration of the pre-registration year within the undergraduate four year degree and the development of an integrated degree and registration approach. The rationale for this change was to improve contextualisation, as well as enhance the development of professionalism practice values and attributes of professionalism (Smith and Darracott, 2011). There is still currently no formal decision on the integration of the degree and pre-registration placement. The recently proposed pharmacist training

standards (General Pharmaceutical Council, 2019c) do not specify a separate set of performance standards for the pre-registration placement, as was previously the case. Instead, the proposed standards detail four learning outcomes domains spanning a five year programme of study (the undergraduate degree and pre-registration training). The GPhC proposes that this will facilitate a continuum of learning across the whole of the five years, with the placement programmes interspersed during the degree, leading to simultaneous graduation and registration as a pharmacist.

*“There needs to be a much stronger link between the currently separate elements of academic study in the MPharm degree and the workplace experience contained in the pre-registration year. We therefore propose a closer integration of study and practical learning and to set the learning outcomes to be achieved over five years to adequately prepare student pharmacists for their future roles.”*  
(General Pharmaceutical Council, 2019a, P.38)

As highlighted, these are still proposed standards and currently most pre-registration placements are a one year placement after a student has graduated with a master of pharmacy degree. However, the GPhC requires that there are meaningful placements throughout the undergraduate programme in addition to the pre-registration placement (General Pharmaceutical Council, 2011). Yet, from personal knowledge, I am aware that there is variety in the duration of these placements, when in the undergraduate programme they occur and in what practice settings they are undertaken. Therefore, currently, the pre-registration training placement remains the only consistent work-place training experience every newly registered pharmacist will have undertaken. This means that for the foreseeable future we need to critically review how professionalism is taught during pre-registration training to ensure a future pharmacist workforce can meet the challenges of practice as a pharmacist. As the whole of the 52 week pre-registration placement is based in a workplace setting, I will next discuss the workplace setting and its impact on how professionalism is taught during the pre-registration placement.

#### **2.6.4 Workplace learning and developmental changes**

The workplace has already been identified as playing a key part in the development of professionalism within pharmacy (Schafheutle et al., 2012; Willis et al., 2012). The varied contexts and situations enable practice and professionalism to be learned by use of a portfolio (Friedman et al., 2001) in a workplace (Elliott et al., 2009) and by catching the informal curriculum in that setting (Al-Eraky, 2015).

More recent studies would seem to suggest that trainees undergo professionalism development linked to professional socialisation within the pharmacy team (Jee et al., 2016). Professionalism development was linked to trainees changing from dispensing based tasks during the start of their year to more patient facing roles towards registration. However, Jee et al., does not consider in detail what elements may have prompted these changes. The shift could have been prompted by the task itself, increased patient contact or even the allocation of increased responsibility. It is also unclear whether the trainee had insight into this developmental shift. Jee et al., also suggested that this change happened gradually over the whole of the training year. However Jee et al., only involved trainees, not other key contributors to the pre-registration pathway, such as tutors, patients and the GPhC. I argue a deeper analysis of the potential developmental changes that occur within the workplace during pre-registration is needed to appreciate how workplace learning takes place, and what may help or hinder the rate of developmental change in professionalism.

One model that has been used to consider how skills are developed is the Dreyfus model of skill acquisition (Dreyfus, 2004) and presents an opportunity to consider how professionalism is taught and learnt. In the next section I will explore the stages to the Dreyfus model and how it has been used when considering professionalism teaching.

#### **2.6.5 Dreyfus model of skill acquisition**

Dreyfus (2004) presented a five stage model to illustrate how an adult can acquire skills in a progressive way. Dreyfus gave each stage a name and described the features that could classify a person as occupying that stage. The five stages are summarized in table 2-2 below;

**Table 2-2: Five stages of the Dreyfus model of skill acquisition (2004)**

Stage	Classification	Characteristics	Role of tutor
1	Novice	The stage of development when a person knows when to do things according to facts but is unable to put this knowledge into a real life context.	Teach rules, break down task
2	Advanced beginner	The stage of development when a person, after seeing many examples, begins to then imitate the characteristics themselves in some real-life situations. The person would use the principles learned to help them understand and work in practice. However, the person will still use an analytical approach.	Teach meaning into real life context
3	Competence	The stage of development when a person has more exposure in the clinical workplace and is involved with increasingly diverse situations. Dreyfus highlights that the person will realise there is not a rule for dealing with each encounter and therefore they need to evaluate and decide on a course of action. This brings with it responsibility and an emotional connection based on the person's feelings about the choices they made	Guidance with learning from mistakes and impact on others
4	Proficiency	The stage of development when a person is unable to detach from the emotional connections and return to a rule based stance to deal with a task. The person understands what they need to achieve, but will still need to decide what action to take to get to this point. Their response will not be intuitive.	Support learner reflection to understanding self and outcomes of task
5	Expertise	The stage of development when through more experience the person expert knows with immediate intuition what to do in a situation and does not give time to considering other options to take	Encourage learner reflection on personal intuition

The Dreyfus model has been used within other healthcare professions as a theoretical framework to compare how professionalism is learnt and what may further influence the development of professionalism. Field (2014) used the Dreyfus model in a stepwise manner to consider how sonographers, within the field of obstetrics and gynaecology, learn clinical ultrasound skills over their training programme. Field successfully mapped the progression of a sonographer to each of the five stages and also proposed how workplace supervisors may help in the progression between stages. However, Field criticised Dreyfus for the overreliance of intuition to define stage 5. He argued that it is still possible that an expert will analyse some situations, rather than having a completely intuitive approach. Others have reached a similar conclusion (Peña, 2010). Neville et al., (2018) used the model to help understand how the introduction of a formal dental scrubs ceremony had influenced professionalism learning in dental undergraduates. They concluded that the second year undergraduates were likely to be on the novice stage at the time of the ceremony, because of the students' focus on the rules surrounding the uniform they were given and their focus on their personal studies. Importantly, using the model illustrated that the ceremony did not cause any transformation or change in the student's stage of skill acquisition.

Field (2014) and Neville et al., (2018) provide us with an insight into how the Dreyfus model could be used to map a learner's stage of professionalism development and the impact particular events may or may not have on the progression of this development. I am unaware of any research studies that have directly linked learning about professionalism amongst pharmacy trainees during their pre-registration placement to the stages in the Dreyfus model. I think it is essential to consider what stage(s) a trainee may move through during their pre-registration training and what factors influence or hinder their progression towards professionalism between stages of the Dreyfus model. Therefore I will use the Dreyfus model in my study. The outcome may provide a better insight into training programme design and support for trainees on the pathway to become a pharmacist.

### **2.6.6 Role of pre-registration tutors**

The contribution of the pre-registration tutor is a well-researched area of trainee development. Many studies highlight that the tutor has a vital role in the training and assessment of a pre-registration trainee (Willis et al., 2012; Jee et al., 2016). Tutors have also been identified as role models and mentors for the future pharmacy workforce and are important in determining the quality of the training programme offered (General Pharmaceutical Council, 2019f). In an ideal scenario, as a role model, the tutor would provide an illustration of excellent practice and, despite potentially not being explicitly aware of the educational theory, would nevertheless scaffold and continually adjust the support provided to the trainee via socialisation to assist the trainee to adopt the skills needed for day one of registered practice (Hammer, 2006; Elliott et al., 2009). The Dreyfus model (2004) provides some suggestions of how an instructor could help with this progression in practice by facilitating the learner's experience (Table 2-2 p.38).

Pharmacists are not required to do any further training or assessment to undertake the role of pre-registration tutor. The GPhC has produced guidelines for tutors but these are not mandatory standards (General Pharmaceutical Council, 2019f). Therefore, without a current clear definition of what the GPhC understands as professionalism, tutors may be underprepared to take on the formal role of training their trainee, including supporting the development of their professionalism. A study by Jee et al., (2016) exploring professional socialisation in the development of professionalism in the North West of England, concluded pre-registration training programmes varied hugely and between sectors of practice. The authors suggested tutors required more training to provide a consistent approach to how professionalism could be developed.

One way to take this further could be the use of pre-registration programmes that involve the trainee rotating around different sectors of pharmacy practice, as illustrated in figure 1-2 (p.13). The schemes require tutors from different sectors of pharmacy practice to work together to design one training scheme and jointly tutor a trainee. The pharmacists are recognised as joint tutors by the GPhC and both take responsibility for the trainee's development (General Pharmaceutical Council, 2017a). These rotational training programmes are a

recent and rapidly expanding progression of how pre-registration training could be designed. Currently there are no published studies on how tutors working together on a scheme may be facilitating the development of professionalism. I argue that, as more employers are looking towards rotational pre-registration schemes as an option, it is a critical time to research the tutor's role. This has informed my research.

### **2.6.7 The influence of the sector of pharmacy practice on professionalism development**

There is acceptance within the literature that pharmacy practice is diverse and therefore trainees in different training sites will have varied learning experiences (Jee et al., 2016) although trainees are required to achieve the same range of performance standards. Jee et al., did not suggest how hospital or community practice influenced the development of professionalism, and whether one sector had a more positive impact than another. Instead, Jee et al., reminded the reader that, although not mandatory, a pre-registration training programme could take place over several pharmacy sectors.

However, simply involving more sectors of practice into a training scheme may not alone produce more opportunity for learning about professionalism. Al-Eraky (2015) suggested that variation in training practice is important in understanding professionalism, but he suggested learners should also use vignettes and guided reflection to potentiate the teaching and learning potential of professionalism from all the different learning experiences. The vignettes and guided reflection would enable the learner to think more critically about a situation and consider the merits of other options if the event were different.

This process of 'reflecting on action' has been stated to help with the development of professionalism by requiring the person to self-assess by considering their internal influences and the external context that affected the event (Bernabeo et al., 2013). By reflecting, the person may become more self-aware of their viewpoints on professionalism by identifying potential professional and non-professional characteristics. Reflection on action is a key skill the trainees' portfolio of evidence seeks to foster. However it is unclear if trainees have an insight into their professionalism development and how other

learning approaches, such as guided support by tutors or vignettes, may have influenced professionalism learning in the pre-registration placement.

### **2.6.8 Summary**

In this section I have discussed the importance of the pre-registration placement as the critical time professionalism is taught during the pathway to register as a pharmacist. Patient contact, tutor support and trainee role changes have been suggested as possible factors encouraging professionalism development in trainees. The Dreyfus model (2004) has been proposed as a framework to think through how professionalism may develop. Although the model has received some criticism, I think it provides a useful framework to consider the potential shifts which may take place during the pre-registration placement in and across different sectors of pharmacy practice. Therefore I will use the model to assist with my interpretation of this studying findings. Finally I illustrated how reflection has been reported to assist professionalism development, but I have questioned if and how such approaches are adopted within the pre-registration placement.

In the next section, I will evaluate the literature into the assessment of professionalism and use the Miller's pyramid (Miller, 1990) to illustrate how professionalism is thought to be assessed. However, I also highlight the challenge surrounding how tutors actually assess, what they assess and who they may involve in the process.

## **2.7 Assessment of professionalism**

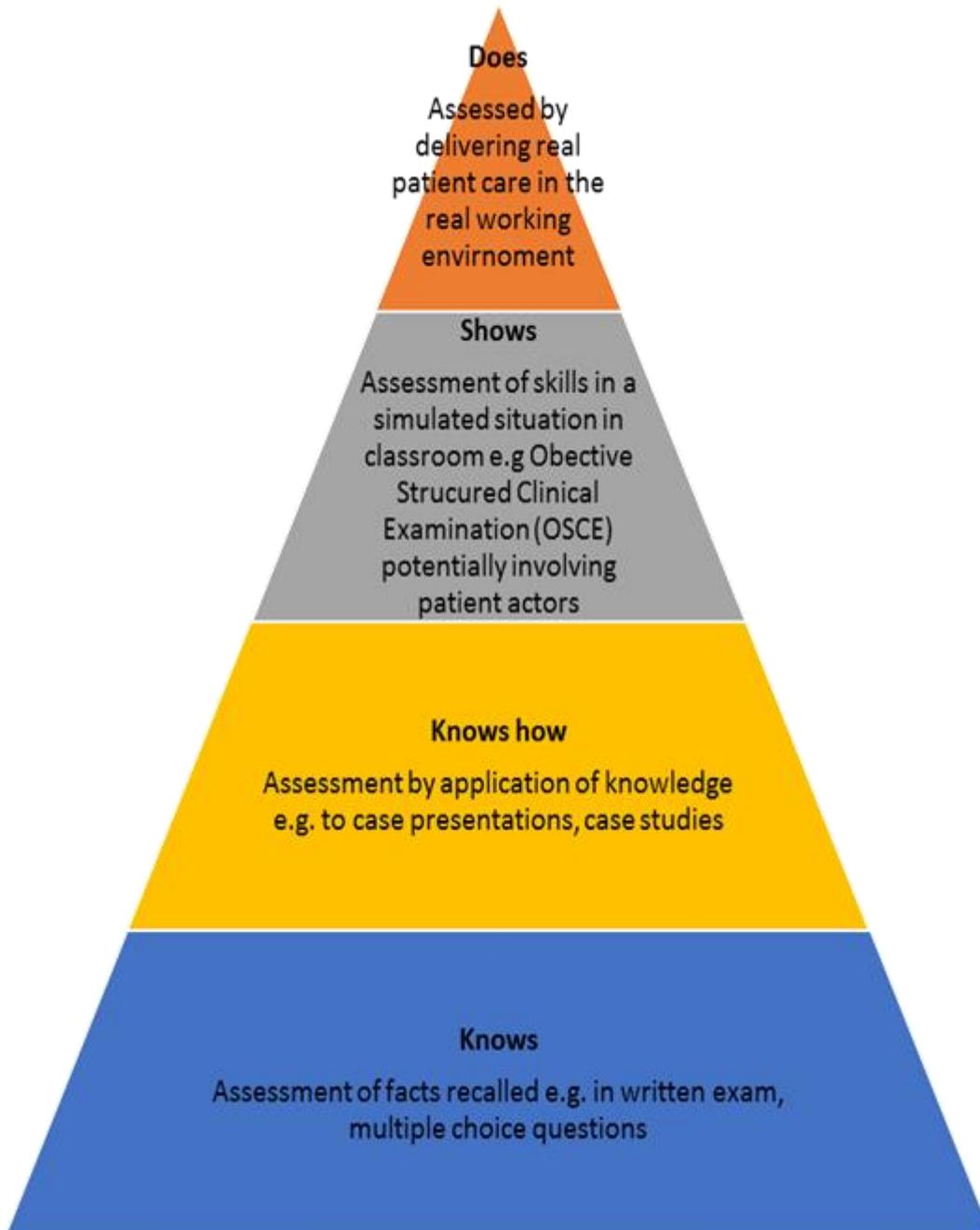
### **2.7.1 From *know* to *is***

The medical literature suggests professionalism should be assessed early, frequently (Kelley et al., 2011) and include both formative and summative elements (Elliott et al., 2009). Each of these elements feature in the pre-registration training programme, in two ways. It is a GPhC requirement that the trainee's portfolio of evidence will be formatively assessed by their tutor at week 13, 26 and 39 weeks, with a summative assessment at week 52. At the end of the placement, the trainee must demonstrate achievement and competence in all the 76 performance standards set by the GPhC for the tutor to sign the trainee off as satisfactory. None of the performance standards explicitly mention the word professionalism, although standard A.1.1 does refer to the trainee

acting as a member of the profession (General Pharmaceutical Council, 2019g). The trainee must also pass both papers in the GPhC registration exam in one sitting. This summative assessment evaluates if the trainee has met a minimum standard (General Pharmaceutical Council, 2019h). Both tutor sign off at week 52 and passing the GPhC registration exam are required for the trainee to register as a pharmacist.

Miller's pyramid (1990) is a framework used to describe clinical competence and how it can be assessed in the classroom and workplace settings. The pyramid uses four levels to illustrate how a person progresses from knowing in the classroom to doing in the workplace, and maps the assessment methods that can be performed each stage. The GPhC uses Miller's pyramid to illustrate how the portfolio and registration exam complement each other as assessment approaches on the pathway to registration (General Pharmaceutical Council, 2019b) (see Figure 2-1 p.44).

**Figure 2-1: Miller's pyramid, adopted by the GPhC for the pharmacy context (General Pharmaceutical Council, 2011)**



The GPhC registration exam assesses the knowledge of the trainees. However, since 2016, a new format GPhC registration exam has been in place which focuses more extensively on professional judgements, decision making and has greater patient emphasis. The exam also allows trainees access to a range of resources typically found in the workplace, such as clinical guidelines and medicine information leaflets. The trainee is required to review these information sources, extract relevant information and apply this to the question asked. The exam style have been welcomed as being more representative of daily practice (Page, 2015) and it could be argued that the trainees will need to demonstrate greater professionalism to pass the exam, for example they will need to *know how* rather than just *know*. The GPhC exam pass rates always fluctuate, but since 2014 have frequently been within the 70 – 80% range. Interestingly the year the new style registration exam was introduced, the pass rate was 95%, this has since dropped to 78% in June 2017 and 79% in June 2018 (Torjesen, 2016). It could be that the 2016 cohort were particularly different in ability to other cohorts.

However, research indicates that professionalism is better assessed in the workplace or practice environment (Goldie, 2013). The reasoning being that this, produces a representative insight into how the person actually behaves and acts within the workplace. Therefore, it seems reasonable to conclude that professionalism would be mostly demonstrated by the fourth and highest level of Miller's pyramid, *does*. Consequently I argue that professionalism is assessed in the trainees' portfolio of evidence. The trainee has to build a portfolio of evidence that demonstrates their achievement of *doing* the GPhC performance standards in practice. The trainee will have informal formative feedback with work-based tutor(s) on a regular basis and formal 13-week interval assessments with their named tutor(s) regarding their achievement of the standards. A final summative assessment will take place at week 52 for the tutor to decide if the trainee has achieved and can *do* all the 76 standards to a satisfactory level to register as a pharmacist.

However, Cruess et al., (2016) question whether the assessment of *doing* is an appropriate measure of professionalism. They argue the recent focus within the medical profession for doctors to continually demonstrate their professional values means that *doing* is not enough. Also the authors highlight the

importance of professional identity in relation to professionalism. They propose a learner's development of their professional identity is the basis of professionalism and only by *being* a professional would professionalism be achieved, in a way that *doing* could not. The authors propose that only by *being* would the person demonstrate their inner values as behaviours that others could observe. This led Cruess et al. to propose a further 5th layer on the top of the Miller's pyramid (Miller, 1990): *is*. Cruess et al., described a person at *is* level as someone who:

*“Consistently demonstrates the attitudes, values, and behaviours expected of one who has come to “think, act, and feel like a physician.” (Cruess. R. L et al., 2016, P.181)*

Although Cruess et al., base their understandings around the development of the *is* layer on a doctor's development, the principles could also be applied to the pharmacist career pathway, not least because of the importance of public trust and the increasingly clinical roles pharmacists are undertaking.

Cruess at al., agree with Miller that each level requires a different assessment approach and that the *is* level will therefore require an approach that

*“would encompass the individual's attitudes, values and beliefs” (Cruess. R. L et al., 2016, P.182)*

Returning to pharmacy, the GPhC only use the four stages of the Miller's pyramid to broadly structure both the current training standards for pharmacists (General Pharmaceutical Council, 2011) and also the proposed revised standards (General Pharmaceutical Council, 2019e). Within the published studies exploring pre-registration trainee professionalism development, I am not aware of any study that engages with the possibility of incorporating the existence of an *is* level and what this may mean for the assessment of professionalism within the pre-registration training year. I argue that to achieve a deeper understanding of this topic and the level of which professionalism should be assessed demands the views of tutors, trainees, the GPhC and patients to be included. This would provide insight from a range of perspectives, all of whom have unique contributions to make regarding professionalism. I argue together these insights would allow a deeper understanding of how professionalism is perceived to be, or should be assessed at the point of care,

possible self-reflection by the trainee, assessment by a workplace tutor and a summative assessment by the professional regulator. This realisation has informed this research. In the next section I will consider in more detail the tutor led assessment.

### **2.7.2 Tutor led assessment**

Tutors are required to evaluate the trainee's portfolio of evidence to decide if the trainee has demonstrated the required performance standards, including professional behaviour, in order for them to register (General Pharmaceutical Council, 2011).

Similar to the challenge of defining professionalism, none of the 76 GPhC pre-registration performance standards explicitly uses the term 'professionalism'. Two of the standards refer to awareness of professional limitations and behaving in a manner consistent with the profession (General Pharmaceutical Council, 2019g) which could be linked to definitions discussed in section 2.5. Therefore it would be down to the tutor and trainee to decide what professionalism encompasses. Additionally, the GPhC does not specify how each performance standard should be measured, so tutors are therefore not guided or trained in making these decisions, which raises the question about what decision-making process they adopt.

Research by O'Sullivan et al., (2012) and Goldie (2013) indicates many tools could be used to assess professionalism. Some of the assessment approaches these authors refer to include; mini-clinical evaluation exercises, ethical dilemmas, multiple choice questions, patient assessment questionnaires, multisource feedback, time management inquiry forms, objective structured clinical examinations (OSCEs), reflection and peer feedback.

From experience I am aware tutors in the South West may use some of these assessment approaches, such as results from the South West regional pre-registration formative OSCE. However, I am unsure how widely some of the other tools and approaches, such as patient feedback, are adopted.

Ideally any assessment tools adopted should be objective, reliable, valid and feasible (Engel et al., 2009). However, healthcare is a complex area and simple tick box type assessments are not enough (Martimianakis et al., 2009). O'Sullivan et al., (2012) and Goldie (2013) also add that no one single

assessment would be suitable to assess professionalism, but rather a variety of different assessments over the whole placement would be most appropriate to overcome limitations associated with each method. This point is illustrated by (Christou, M et al., 2011) who explored the assessment of professionalism via a questionnaire which included parameters such as accountability, legal and ethical knowledge and communication. The questionnaire was given to tutors and trainees from two regions of the UK. The trainees scored themselves via a self-assessment, with tutors separately assessing their trainee. The questionnaires were given out at the start and end of the training year and the responses from both trainees and tutors compared. The study identified that trainees often rated themselves as less able than their tutors reported them to be. This correlates with other study findings (Karukivi et al., 2015).

Research also proposes that an assessor may bring their own bias into the assessment of professionalism. Gallagher (2010) explored the role of the assessor, as an observer of practice, in the assessment of professionalism in undergraduate medical, nursing and physiotherapy students. He argued that professionalism is difficult to assess, is subjective and proposed that the presence of the assessor-observer introduced bias into the assessment. Although Gallagher's study did not include any pharmacy students, I think his study opens the debate for the approach and nature of how professionalism may be assessed.

The above studies do not provide a definite method of how to assess professionalism, nor who should assess and when the assessment should take place. One way to take this discussion further is to review the study by Cruess et al., (2016) and their suggestion of an *is* level added to the top of Miller's pyramid (1990) to describe the attainment of professionalism. Cruess et al., did not provide any direction on what assessment methods could be used to assess the *is* level but seem to suggest that assessments should take place over time, in different experiences, and include social interaction from the community of practice surrounding the learner.

There is no direction in the current pre-registration education and training standards from the GPhC as to what professionalism means, how to teach it or how to assess it. It is therefore the responsibility of the named tutor to decide if the trainee is competent enough to sit the registration exam, ultimately register

and practice as a pharmacist. Furthermore, as more trainees are undertaking rotational pre-registration schemes, involving two tutors, this has opened the discussion as to how the tutors work together in their assessment of the trainee, and how they negotiate differences in their appraisal of the pre-registration trainee. To date, there is no published literature exploring what approach(es) tutors use within the UK take to assess professionalism within their trainees. As the pre-registration year is such a vital part of the career pathway, this is a gap in current knowledge that this study will address.

### **2.7.3 Patient involvement**

Patient involvement has been argued as fundamental to the concept of patient-centred professionalism (Section 2.5.3). Additionally Campbell et al., (2011) have shown how patient involvement in the assessment of doctors' professionalism can inform their development. However the situation is different in pre-registration pharmacist training. Jee et al., (2016) identified that trainees undertaking their placements in both hospital and community settings had little feedback directly from patients on the quality of the trainees' interactions with them. The implication was that a third party, not the patient, would offer the feedback to them. As highlighted previously, Green et al., (2009) explored patients', doctors' and nurses' views of how professionalism was perceived to be demonstrated. The study identified that patients had a different understanding of how they experienced professionalism, compared to those reported by the doctors and nurses. Therefore, if a large proportion of professionalism concerns patient-centeredness, patient involvement must feature in the development and assessment of these qualities amongst pre-registration trainees. Prior to my research, no study had involved patients, together with other stakeholders in the pre-registration training programme, in an exploration of how professionalism is assessed during the placement.

### **2.7.4 Summary**

In this section I have described the current focus by the GPhC on the Miller's model to frame the assessment of professionalism within the pre-registration placement and the challenges with this approach. I have identified the potential of the concept of an *is* level, proposed by Cruess et al., (2016) to adapt and expand the assessment of professionalism from simply *doing* the role of a

pharmacists to *being* a professional and displaying professionalism. I have identified that there has not been any research into the presence of an *is* level within the pathway to developing into a pharmacist and what this may mean for the assessment of trainees and those involved in the assessment(s) in any sector of pharmacy practice. The literature also identified that the patients' viewpoint in the assessment of professionalism in the pre-registration placement is under researched.

## **2.8 Conclusion: The research problem**

The aim of the literature review was to identify what concepts of professionalism are held and how professionalism may be taught and assessed within the field of pharmacy education, particularly within the pre-registration trainee pharmacist placement.

I found there is focus on understanding professionalism within pharmacy education and practice for two reasons: firstly as a result of patient concerns regarding poor professionalism within healthcare and secondly because of pharmacists undertaking increasingly autonomous and patient facing roles in the UK. However, there is no agreed definition within the profession as to what professionalism means. Therefore multiple studies and publications have sought to define the concept, the most recent being within the GPhC consultation of the initial education and training of pharmacists (General Pharmaceutical Council, 2019a). This draft proposal emphasises the importance of professionalism by naming one of the learning outcome domains professionalism. However, by definition, the proposed standards are a suggestion from the GPhC and open for wider comment.

The review of the literature into how professionalism is taught has found the pre-registration placement is the principle time during the career pathway to register as a pharmacist, when professionalism is learnt. The pre-registration placement has been explored by many studies, but few have included more than one stakeholder perspective and no studies to date have involved trainees on rotational placements over different pharmacy sector locations. I have argued this prevents full understanding of how professionalism is learnt during the placement, what factors may stimulate, hinder or affect the rate of this learning. I have proposed that the application of the Dreyfus model of skills

acquisition (2004) to the pre-registration placement, may be a new way to assist with this evaluation. Such understanding is vital at this time because the GPhC are consulting on proposed changes to the pre-registration placement and more trainees are undertaking placements across pharmacy practice sectors.

The assessment of professionalism within pharmacy was reported in the literature to focus on the role of the tutor and their evaluation of trainees' achievement of the GPhC performance standards. Miller's pyramid (1990) was highlighted as being the framework relied upon by the GPhC to describe the assessment outcomes of the pre-registration scheme. However limitations to Miller's pyramid to the assessment of professionalism have been raised by Cruess et al., (2016). However, Cruess et al., do not provide direction on the detailed methods that could be used to assess professionalism. The literature proposes that patient involvement and learner reflection could be two possible approaches to assessment of professionalism, however this has yet to be explored and evidenced within the pre-registration placement.

I have discussed, critiqued and highlighted the limits of knowledge presented in the current literature. I have identified where gaps in current knowledge exist to situate, justify and inform where my research will contribute and to direct my research questions.

## **2.9 Research aim**

To explore the development and assessment of professionalism in pharmacist trainees during pre-registration training across different healthcare settings from a range of insights and perspectives.

## **2.10 Research questions**

In the context of the pre-registration pharmacist placement;

1. What concepts of professionalism do service users, the professional regulator (GPhC), trainees and tutors hold?
2. What approaches to learning and teaching professionalism are experienced and or taken during the pre-registration pharmacist placement?
3. How are judgements made on a pre-registration trainee's achievement of professionalism in their placement?

### **Chapter 3 Methodology and Methods**

The research problem I set out to explore was how professionalism within the pre-registration pharmacist training year is understood from a range of stakeholder perspectives.

In my literature review chapter, I discussed how a range of approaches have already been taken to explore professionalism within the pharmacist career pathway, identifying that many focus only on the trainee and tutor viewpoints within the pre-registration placement. No studies explored the understandings of professionalism and relationships to professionalism teaching and assessment from other stakeholders, for example service users and the GPhC. I also identified few studies comparing the understanding of professionalism, as well as its teaching and assessment across different sectors of pharmacy practice within the UK. My study therefore seeks to address this research gap.

In this chapter I explain the approach I employed to gain new insights into this topic area. I discuss my ontological and epistemological assumptions and how this paradigm informs my research strategy. Amendments to my study design, following discussions with my transfer viva panel are explained. I state my ethical approval information and discuss the ethical considerations. I justify the data collection method, recruitment strategy, sampling approach and setting I adopted for each step. The chapter closes by outlining my data analysis process.

### 3.1 Study aim

The aim of my study is to understand the complex and changing reality of what is understood as professionalism within the pre-registration training year from a range of perspectives.

The research questions that underpin my study aim are, in the context of the pre-registration pharmacist training placement;

1. What concepts of professionalism do service users, healthcare professionals, the professional regulator (GPhC), trainees and tutors hold?
2. What approaches to learning and teaching professionalism are experienced or taken during the pre-registration pharmacist placement?
3. How are judgements made on a pre-registration trainee's achievement of professionalism in their placement?

My research questions are exploratory and concerned with understanding and experience. This situates me within a constructivist research paradigm, which I explore further below.

### 3.2 Knowledge construction to research process

Tavakol and Sandars (2014b) state

*“A paradigm is a comprehensive belief system or worldwide view that provides a general perspective or framework to guide an understanding of the phenomenon under investigation” (Tavakol and Sandars, 2014a, P.747)*

Tavakol and Sandars claim every researcher has their own view of the world or paradigm. The paradigm adopted determines how researchers investigate problems and guide how they explore the questions raised.

It is accepted that there is no ‘correct’ way of carrying out research. Rather there is a critical process of seeking to understand the research problem by recognising the ontological (nature of reality) and epistemological (relationship between researcher and knowledge) assumptions. These assumptions in turn, guide the decisions about methodology (Tavakol and Sandars, 2014a; Ritchie et al., 2014).

Over the past 40 years, there has been an increase in the number and complexity of research paradigms developed and adopted. However, health researchers in particular, frequently fail to reference their stance in published work (Bunniss and Kelly, 2010). This can lead to confusion when appreciating the findings of the research (Mackenzie and Knipe, 2006).

### **3.2.1 My ontological assumption**

My research aims are concerned with exploring people's understandings and perspectives and adding to the conversation about the development and assessment professionalism in the pre-registration placement.

Potentially, multiple and conflicting truths could emerge from the data interpretation (Bunniss and Kelly, 2010). This is because I think everyone involved in my study has a different insight (Tavakol and Sandars, 2014b). Importantly, my assumptions are that all of the truths and knowledge presented are correct, of equal merit and there is no ultimate truth (Cleland, 2017). I argue that any differences in the nature of reality and knowledge exposed in this study would be an important outcome enabling discussion and deeper questioning of pre-registration education.

### **3.2.2 My epistemological assumption**

My viewpoint is that the understandings of professionalism my study seeks to explore only present through dialogue with others. By sharing experiences, reasoning, discussing areas of agreement and challenging each other, a group of people will socially construct what is known about professionalism. Consequently, the knowledge that emerges is unique to that time, context and group, as further experiences and external influences may change a participant's understanding. Therefore, the knowledge created is inherently subjective and dependent on the persons present at that time (Tavakol and Sandars, 2014b).

As the researcher, I am actively involved in each step of the data collection and analysis. Hence, the study cannot be bias free as my positionality is subjective; I am part of, and impact on, the study (Tavakol and Sandars, 2014b). Put another way, a different researcher would bring their own values, background and experiences to the study and potentially present different truths as an

outcome (Pole and Lampard, 2002). Consequently, there is no objective reality; the study is open to infinite interpretations and no general laws can be produced (Tavakol and Sandars, 2014b).

As a practicing pharmacist with experience in pre-registration training, my positionality is such that I understand the study context and contribution the findings may have to the field. Many of the published studies exploring pre-registration professionalism development within the UK have been led by research units, such as the Centre for Pharmacy Workforce Studies in Manchester, or by individuals involved in pre-registration training, such as Christou et al., (Christou, M. and Wright, 2011). Many of the researchers involved in these studies were pharmacists and have a role in pharmacy training. Therefore, although my role in the study topic may seem closely linked to the area I work within, this is not unusual in health professions education research. I am also a pharmacist as well as educator and researcher, which has helped me consider the wider impact of the study outcomes for pharmacy practice.

My research position as pre-registration training lead for, predominantly, the NHS hospital sector may influence the validity and credibility of the study. Therefore I have adopted an open attitude (Long and Godfrey, 2004). By assuming an explicitly reflective stance and recording my experiences and analytical processes, others can clearly appreciate my interpretations, knowledge claims and the foundations these are based on in order to critique my approach, should they wish to do so (Braun and Clarke, 2006; Thanh and Thanh, 2015). This approach helped to separate what may be my own ideas about my research topic from those emerging from the study data. My reflexive dialogue present at all stages of my data collection, analysis and claims contributes the study quality (Long and Godfrey, 2004).

### **3.2.3 Methodology**

Reflecting on my assumptions and the range of research paradigms presented in the literature, it is clear that I have chosen to adopt a constructive or qualitative approach to illuminate my research topic (Bunniss and Kelly, 2010; Tavakol and Sandars, 2014a; Cleland, 2017).

My research centres on the shared discussions between participants and myself. Only by discussing experiences did a deep understanding and insight into the reality of this phenomenon, within this context, present itself (Thanh and Thanh, 2015). The feature of 'understanding' is a methodology associated with the interpretivist stance. Therefore I adopted an inductive reasoning approach to the analysis and sought to understand or interpret the phenomenon (Cleland, 2017). I started with the rich description of real life experiences from my participants and sought to understand their different perspectives. I used an inductive reasoning process to look for patterns in the observations and across the findings. In analysing discussions, I sought to gain new explanations and understandings of professionalism, rather than prove a theory (Richards, 2014). This intended outcome for my study illustrates my interpretivist stance. Interpretivist approaches are an established perspective from which to carry out research into a range of topics within healthcare (Long and Godfrey, 2004), including professionalism (Robinson, A.J. et al., 2012).

### **3.3 Research design**

My initial study application set out to explore the views of the GPhC, pre-registration trainees, pre-registration tutors, service users and a range of healthcare professionals. However, during my transfer viva, the assessors questioned me on the rationale for this and suggested that including five stakeholder groups maybe too complex.

The purpose of involving a range of stakeholder groups in this study was to provide different perspectives and illuminate areas of commonality and difference. Heale and Forbes (2013) describe this as a triangulation approach. Although Heale and Forbes (2013) welcome triangulation within healthcare research as it provides detail and rigor, they also challenge its adoption. The authors highlight that triangulation brings together different data sources and gives them equal weighting, however they may not have equal importance to the research plus each data set still has potential to be flawed, which may be harder to identify if different data sets suggests a similar conclusion and the more stakeholders involved the more complex the study analysis becomes.

Following, my transfer viva and critical reflection on the challenges of triangulation, I concluded that focusing the study questions on fewer stakeholder groups might enable deeper thinking and potentially have greater research impact.

The healthcare professional group, although an original perspective, was not a core aspect to illuminate at this time. Therefore I included trainees, tutors, service users and the GPhC to provide a unique insight into how professionalism is understood, taught and assessed. My rationale for including these participant groups was that trainees and tutors have direct experience of the placement; the GPhC will have a stance on how it expects professionalism to be taught and assessed and importantly patients will have a view about how they are, or could be involved in this process.

### **3.4 Order of stakeholder involvement**

With four different stakeholder groups (service users, trainees, tutors and the GPhC) I needed a strategy for deciding the order to which to approach each group. Deshefy-Longhi et al.,(2009) state that too often, researchers with multiple groups do not provide the rationale for the order of their data collection, yet this affects the validity of the research data. The order of the data collection should be an informed decision having weighed up the pros and cons. I will now make clarify the reasoning behind my data collection step choices.

My study purpose was to explore professionalism from a range of perspectives. The GPhC has never actively participated in any study to date on the understandings, teaching and assessment of professionalism. Also the GPhC set the professional regulations and standards for all pre-registration trainees and registered pharmacists. Therefore I decided the GPhC should come first because this this might provide some unique insights into the topic.

To ensure each data collection step informed subsequent data collection steps. I fully transcribed the event promptly and reviewed the data for initial points of interest relating to the study questions. If I thought a topic, such as decision making, merited further exploration by a different stakeholder group I included this in the subsequent data collection step(s). This enabled all steps in the data

collection process to build upon each other thus providing a richer discussion on the areas of interest (Deshefy-Longhi et al., 2009).

I decided the trainees, rather than the tutors or service user group, would be the most suitable participant group to follow the GPhC because I wanted to link the regulation closely to how the trainees actually experience the training placement. The trainees would be most informed and able to contribute to the study towards the end of the pre-registration year which runs August-July. As the pre-registration exam is sat in late June and typically trainees take annual leave before and after the exam, participation would be maximised during May.

With respect to the service users, I decided that I wanted insight into the viewpoints of the GPhC and trainees, before service users were asked for their perspectives of professionalism. This was because I wanted to understand the possible regulation restrictions and trainee concerns before getting the service users viewpoints. Also, as involvement of service users in this study was a unique feature, I wanted to use the GPhC and trainee views to inform data collection with service users. This allowed me to ask whether the service users agreed or disagreed with some of the views they put forward. From a practical point of view, I decided that it would be helpful for the service users to be as soon as possible after the GPhC and trainee methods. My reasoning being that if there were any news or media exposure on pharmacy at that time, this may influence their understanding and would potentially affect all data collection (van Bekkum and Hilton, 2013).

Tutors have a key role in the development and assessment of their trainees, with tutors potentially making this decision on their own. Therefore I decided that the tutors should be involved as the last data collection step. This allowed for other viewpoints, from all the previous data collection steps, to be included in the questions asked to tutors. Therefore potentially providing challenge and exposing areas of similarity or difference.

The next sections discuss a range of data collection methods used in qualitative research, before explaining and justify the study design, methods and procedures for each of my data collection steps.

### **3.5 Data collection methods used in qualitative research**

My study sought explore how professionalism is understood from a range of stakeholder perspectives and I have argued that only by discussing and interpretation of participants experiences will a deeper insight into the reality of this phenomenon present. I decided to include each participant group only once in my study but argue that multiple perspectives achieves richness in my data.

My approach is qualitative and therefore the data collection methods chosen my support this methodology (Tavakol and Sandars, 2014a; Tavakol and Sandars, 2014b). I will now discuss the strengths and limitations of methods used in qualitative research.

Interviews have been used in qualitative studies exploring professionalism (Jee et al., 2016). Interviews allow participants to discuss a subject in-depth and in their own words with an interviewer (Drever, 2003). However individual interviews only provide insight into one participant's perspective (DiCicco-Bloom and Crabtree, 2006; Tavakol and Sandars, 2014b). A group interview, typically with two to three participants, allows for discussion between participants to identify areas of commonality or difference (Drever, 2003). Producing a semi-structured schedule in advance to guide an interview (DiCicco-Bloom and Crabtree, 2006), whilst also allowing for participants to share additional insights (Drever, 2003). It is good practice for probes and prompts can also be added to an interview schedule to explore of the depth and breadth of the topic area (Drever, 2003). Interviews are frequently used in healthcare studies (Chadwick et al., 2008)

Focus groups have been used in qualitative studies exploring professionalism (Schafheutle et al., 2012; Lewis et al., 2012; Elvey et al., 2015) and within healthcare to explore understandings of complex topics and service developments (NHS England, 2016). A focus group differs from a group interview in that in may require less direction from the researcher (Drever, 2003) and works well with six to ten participants (Chadwick et al., 2008). Focus groups still require participants to share personal views and experiences to enable an insight into the different perspectives held (DiCicco-Bloom and Crabtree, 2006). To achieve this, facilitation of a focus group is essential to potentially prevent one outspoken member preventing others from contributing to the discussion

(Leung and Savithiri, 2009; McLafferty, 2004). McLafferty (2004) suggests using a semi-structured schedule is one way to approach the facilitation of a focus group. The inclusion of activity or stimulus at the start of a focus group schedule can engage and encourage the group into a conversation (Silverman, 2013), particularly if participants are not known to each other (Drever, 2003). Activities have also been used in focus groups exploring professionalism (Lewis et al., 2012). Observers are an accepted part of the focus group design in medical educational research (Stalmeijer et al., 2014). The role of the observer is to watch the discussion and take handwritten notes of any non-verbal communications, any occurrences where participants may be trying to speak but was unable to, any comments or areas of interest that were overlooked in the conversation flow and to give the facilitator constructive feedback on their skills (Stalmeijer et al., 2014).

All face to face interviews and focus groups allow identification of any social cues, such as body language (Opdenakker, 2006). Social cues may help provide a deeper insight into the participants' viewpoints, for example their agreement with each other by nodding, in a way that telephone interviews or synchronous verbal online conversations cannot show (Drever, 2003). This may be particularly important for qualitative interpretative studies (Collard and Van Teijlingen, 2016). Opdenakker (2006) identifies that the lack of social clues may affect the flow and meaning within conversation. However, noting social cues may be more challenging when methods involve greater numbers of participants (Drever, 2003). To reduce this impact, audio recording conversations and the use of an observer have been suggested (Chadwick et al., 2008; Stalmeijer et al., 2014).

Internet based conferencing facilities for focus groups and online written (synchronous or asynchronous) conversation forums have been used in health research (Collard and Van Teijlingen, 2016). Although these approaches would have allowed participants to remain at their locations firewalls, particularly on NHS computers, may have prevented some participants from accessing websites (Opdenakker, 2006).

Questionnaires have been typically classified as a data collection tool used in the positivist and post-positivist paradigms (Mackenzie and Knipe, 2006,

Bunniss and Kelly, 2010). However, it is possible to use questionnaires in an explorative and qualitative manner to illuminate unexpected ideas and gather rich descriptions from participants (Braun and Clarke, 2013). Questionnaires have also been used within studies exploring professionalism (Christou et al., 2011). In qualitative studies, questions should be designed to enable participants to express their viewpoints and experiences (Boynton and Greenhalgh, 2004). This should include open text boxes allows participants, in their own words, to disagree with statements given and explain their reasoning behind their choices (Braun and Clarke, 2013). Questionnaires can be administered in a paper or electronic format. E-questionnaires avoid the need for postal addresses and are quick to administer. However, computer access and/or skills are required which may deter some participants from taking part in an e-questionnaire. Yet, there is some evidence of higher return rates with e-questionnaires compared to paper versions (DiCicco-Bloom and Crabtree, 2006).

In this section I have discussed the merits of a range of methods used in qualitative data collection. I next discuss the ethical considerations in my study before and before explaining the method I used for each of my data collection steps.

### **3.6 Ethical considerations affecting all data collection steps**

I will now discuss the ethical factors I considered for all the stakeholder groups. If specific ethical concerns relating to an individual group were of concern these have been discussed within each method step (section 3.8 – 3.11).

#### **3.6.1 Participant wellbeing**

The wellbeing of all participants involved in my study was my first concern. I reasoned that professionalism was unlikely to be contentious or embarrassing topic. However, I did recognise a small possibility some content that may be upsetting for individual participants to share and other participants to hear, for example personal experiences of poor professionalism. To manage this for face to face methods with more than two participants, I involved an observer to assist me with ensuring the wellbeing of participants. This is an accepted role

for observers (Chadwick et al., 2008). To help in this role the observer was introduced to participants, but did not take part in discussions.

I considered what may be a reasonable and practical amount of time a person could participate in any data collection. I concluded face to face interactions should last no more than one and a half hours (Drever, 2003) and that completion of online questionnaires, should take no longer than 30 to 45 minutes, to reduce participants missing questions (DiCicco-Bloom and Crabtree, 2006). For physical wellbeing, light refreshments were available at face to face data collection steps and all locations were easily accessible.

### **3.6.2 Power relationships**

I carefully considered potential power relationships that may be perceived to exist between study participants and myself. I concluded that for the GPhC participant group the balance of power was in their favour. I am a registrant of the GPhC and subject to their regulation process. However, it may be viewed that I have a power relationship over the other participant groups because I am involved in the regional pre-registration training scheme, although importantly I did not have a role in signing the trainees off for registration with the GPhC, and I am a pharmacist.

To reduce any perceived power differential the trainee, tutors or service users might feel, I only involved trainees towards the end of the pre-registration training year, when the relationship with the training team was coming to an end. Also a third party sent out the invitation to the trainees, tutors and service users. Therefore removing any obligation people might have felt to volunteer to an email sent from me.

All participants were given study information before they were involved. Therefore participant consent was fully informed and there was no coercion.

### **3.6.3 Confidentiality and anonymity**

The study was designed to encourage participants to share their views on professionalism. To achieve this, a coding system, rather than the person's name, was used in all verbal transcriptions to allow for the conversations to be fully understood but preventing the identities of the participants from being

disclosed. Only I knew the coding system and I names saved separately to the coding system I used. Also any quotes used were anonymised. For the questionnaire I did not ask the respondents name or work location. I also blanked out any Universities, pharmacy companies or people mentioned in the course of the data collection, to preserve the anonymity of third parties.

#### **3.6.4 Participant checking**

Opinions differ as to whether interview transcriptions and themes should be checked by participants. Richards (2014) advocates that participants check for accuracy whereas Goldblatt et al., (2010) raised concerns about the ethical implications for doing so, such as possible loss of anonymity and how to present data to participants in a way they can interpret. On balance I decided against a participant check of the transcriptions and final themes presented.

#### **3.6.5 Raising concerns**

Participants were made aware that any content presented that was of concern would be escalated and, where possible, without identifying the participant. However, if this was not an option, the participant was made I aware I would discuss this with them and mutually decide a way forward.

#### **3.6.6 Data protection**

All data was stored securely on a password controlled and encrypted computer. Consent forms were stored separately in a locked filing cabinet. All data will be destroyed two years following the submission of my thesis.

### **3.7 Ethical approval and health and safety**

My study context is within the NHS and involves voluntary contributions from NHS service users, the professional regulator for pharmacy and NHS staff. As an NHS employee, I contacted the University Hospitals Bristol Research and Innovation team and my study was categorised as service evaluation. I submitted my ethics application and fieldwork risk management forms to University of Leeds ethical review panel.

Ethics was granted reference: AREA 14-129. (Appendix M)

Health and safety risk category: Low

## **3.8 GPhC**

My focus was involvement of members of staff from the GPhC who were involved with the design and implementation of the pre-registration training programme requirements.

### **3.8.1 Data collection method**

As this was my first data collection step, I concluded a group interview would be most suitable because I could explore the perspectives of members of staff from the GPhC in detail (Drever, 2003). I envisaged small numbers of participants would be involved, therefore suiting a group interview method.

### **3.8.2 Sample**

I used purposeful sampling to involve members of staff from the GPhC pre-registration education team only. This was because these individuals would have experience from the regulator's perspective of what professionalism means to them and how they think professionalism is taught and assessed during the pre-registration year (participant demographics found in 4.1.1).

### **3.8.3 Procedures**

A semi-structured interview schedule was developed from information gained from literature review to provide some structure (deductive) whilst also allowing room for new ideas from participants (inductive). The schedule for the semi-structured interview was reviewed by doctorate supervisors prior to the interview with the GPhC participants.

I used two digital voice recorders to record the oral conversation for later verbatim transcription and made handwritten notes of non-verbal communication.

After the interview, I reflected on the interview process and the initial themes identified to inform the next data collection step.

### **3.8.4 Recruitment**

From my role as a regional pre-registration training lead, I had an email address for a member of the GPhC pre-registration team. This person agreed to email the study information leaflet and consent form to colleagues (Appendix D, E, F).

### **3.8.5 Setting**

The group interview took place in April 2016 in a meeting room at the GPhC headquarters.

## **3.9 Pre-registration trainees**

The purpose was to encourage the trainees to share their lived experience of pre-registration training to explore what they understood by professionalism and how they felt had been taught and assessed.

### **3.9.1 Data collection method**

I concluded that a semi-structured focus group would be the most suitable method to collect the data needed from the trainees for my study as it is potentially less intimidating for than one to one interviews. It would allow the trainees to listen, debate and share their lived experiences as described by Webb and Kevern (2001) and offer an insight into the level of consensus of understanding within the group.

### **3.9.2 Sample**

All the trainees from the 2015-2016 year group who participated in the SWMIT pre-registration training programme were my sample group. I chose this group because I am aware of the design of their training programmes and some of the learning and assessment approaches the trainees undergo during their training. There were 40 trainees in group. (Participant demographics found in 4.1.2)

### **3.9.3 Procedures**

I developed a semi-structured focus group schedule. This included an activity and then questions designed around the emergent themes from the GPhC interview and literature readings with respect to the study questions.

I decided to use an observer at the focus group. The observer was a pharmacist and involved in the training team, therefore they would have insight into the topics being spoken about. The observer was known to the trainees but did not sign off trainees for registration and therefore they did not have any power relationship over the trainees.

### **3.9.4 Recruitment**

A third party (SWMIT administrator) sent out the focus group invitation to the 40 trainees participating in the training programme via email (Appendix G) and collated names of those who volunteered to take part. The invitation was sent out in April 2016. Seven trainees replied within one week to express their interest in taking part. Seven participants is a reasonable number of individuals to make effective discussion and facilitation of a focus group (McLafferty, 2004). Therefore sampling of the volunteers was not needed.

### **3.9.5 Setting**

The focus group took place in a large meeting room at a conference centre in May 2016 at the end of a training day.

## **3.10 Service users**

The purpose was to enable service users to share their viewpoints on professionalism and how they viewed pharmacists should be trained and assessed for professionalism.

### **3.10.1 Data collection method**

For similar reasons to the trainees method, I concluded a focus group would be the most appropriate method to allow for discussion between participants, identification of similarity and difference across the group in viewpoints, and potentially less daunting for participants than one to one interviews.

### **3.10.2 Specific ethical considerations**

It was possible that service users under 16 years old and people for whom English is not their first language might volunteer to take part. However, my ethics approval was only for adults. Therefore only those volunteers that met the ethical inclusion criteria would take part. Communications were clearly written in English only. This could have excluded some users of the NHS who may not be able to read English, however, I did not have the resources to employ a translator and for a focus group to be successful participants needed to be able to communicate with others.

To ensure participant wellbeing, a feedback form was provided at the end of the focus group (Appendix H). This enabled participants to feedback on their experience of the data collection. I decided to distribute a feedback form to the service users as this is an approach advocated by NHS Improvement (NHS Improvement, 2019).

### **3.10.3 Sample**

I wanted six to ten participants to volunteer to take part in the focus group. I decided that if more than ten service users wished to take part, I would use purposeful, rather than random sampling to select participants (Silverman, 2013) to potentially allow for deeper exploration of a topic (DiCicco-Bloom and Crabtree, 2006). I asked volunteers to let me know their gender, age and briefly their experience with healthcare. My reasoning was to enable a difference in experience and therefore a platform for potentially a more diverse background from which people could discuss the topic area. Fourteen people contacted me to take part. Two did not respond to my requests for information, and two were unable to attend on the event date chosen. This left ten people. I invited all ten to take part. The participant demographics can be found in 4.1.3.

### **3.10.4 Procedures**

Before the event, I sent out a leaflet produced from the RPS entitled 'Considering pharmacy – What you need to know' to those who had volunteered (Appendix I). The leaflet was directed at school children interested in a career in pharmacy and describes the qualifications and roles a pharmacist may undertake. My purpose was to share with the service users the different roles pharmacists may have in different health sectors.

I developed a semi-structured focus group schedule by reflecting on my approach from the trainee and GPhC data collection steps. Questions, pointers and probes were included as well as scope for the conversation to flow into aspects of professionalism I had not considered (Drever, 2003). I used the leaflet sent out before the event as the basis for an activity at the start of the focus group (Appendix J). My supervisors reviewed the focus group schedule before the event.

### **3.10.5 Recruitment**

The public and patient engagement team within my organisation sent the invitation letter, participant information form and consent form (Appendix F) to a database of email addresses they held of persons who had received NHS care and were happy to be contacted to help with any studies seeking public opinion on a topic. People who wished to volunteer contacted me directly, therefore avoiding any perceived potential power relationship between the volunteers and public engagement team.

It is accepted that recruitment via email would exclude people without computer access but as the patient and public engagement team were unable to accommodate the processing of a postal invitation, the most practical way forward was to invite participants electronically. Also, over 80% of the adult population in the UK access the internet weekly therefore I concluded an email invitation may be an acceptable approach (Office for National Statistics, 2016).

No payment was offered for volunteering. However travel was reimbursed.

### **3.10.6 Setting**

The focus group event took place in a large meeting room within an NHS training department.

## **3.11 Tutors**

Tutors were included in my study to discover what they understood by professionalism and how they currently train and assess professionalism during pre-registration training.

### **3.11.1 Data collection method**

I decided that a qualitative e-questionnaire would be the most practical method to engage South West tutors as the geography of the region plus increasing service demands could lead to low attendance at a face to face event.

### **3.11.2 Sample**

There were 40 tutors within the South West, including one tutor based within community pharmacy and two within general practice. The e-questionnaire was

sent to all 40 tutors. I did not sample this participant group. The participant demographics can be found in 4.1.4.

### **3.11.3 Procedures**

Online Survey (previously Bristol Online Survey) was used to design and distribute the questionnaire. I designed the questionnaire using themes and comments raised in previous data collection steps that I wanted to explore further with the tutors. The questionnaire consisted of fourteen questions (Appendix L). Boynton and Greenhalgh (2004) suggest that a questionnaire should be twelve questions or less to encourage a reasonable completion and response rate. However, I argue that focusing on a number of questions is too simple; rather the research aim and what data is hoped to be generated by the method should lead the design.

The questionnaire included single answer selection to a question, and Likert scale grids, as well as open text boxes for tutors to expand on their choice. The purpose of including variety in the format helped meet my qualitative study aims by producing a focused response to some closed questions, but also enabling tutors to contribute richer comments to the open text boxes.

Before sending to tutors, the questionnaire was reviewed by my supervisors and piloted on two occasions to check for clarity, easy of completion and question validity (Boynton and Greenhalgh, 2004). As a questionnaire pilot should be undertaken by a person representative of the sample group (Boynton and Greenhalgh, 2004) both pilots involved pharmacists who were involved with pre-registration training.

### **3.11.4 Recruitment**

In June 2017, a third party (SWMIT team administrator) sent all tutors in the South West an email to their work address containing the electronic participant information, consent form (Appendix K) and questionnaire link.

### **3.11.5 Setting**

The tutors had four weeks to complete the questionnaire, with a reminder email at the two week point.

### 3.12 Summary of methods

**Table 3-1: Summary of the method approach adopted**

	Participant group			
	1) GPhC	2) Trainees	3) Service users	4) Tutors
<b>Method</b>	Semi-structured group interview, digitally voice recorded and transcribed	Focus group, digitally voice recorded and transcribed, observer present.	Focus group, digitally voice recorded and transcribed, observer present.	Qualitative e-questionnaire, mixture of single answer responses and open text boxes
<b>Recruitment</b>	Member of GPhC staff cascaded email invite to pre-registration team	3 <sup>rd</sup> party cascaded email invite to all trainees on training scheme	3 <sup>rd</sup> party cascaded email invite to service user database	3 <sup>rd</sup> party cascaded email invite to all tutors with trainees on SW scheme. Four week timeframe for a response
<b>Sampling</b>	Not needed	Not needed	Not needed	Not needed
<b>Setting</b>	GPhC offices	Training room	NHS training room	Wherever tutor accessed

### **3.13 From findings to analysis**

I adopted an interpretative analysis approach to identify, evaluate and consider patterns and meaning across the whole data set, which included the interview, both focus groups and the e-questionnaire. I chose to use a thematic framework approach, as suggested by Braun and Clarke (2006) and Srivastava and Thomson (2009) to help structure my analysis and explore the meaning in my data (Tavakol and Sandars, 2014b).

Long and Godfrey (2004) argue qualitative research approaches must have a transparent analysis process to enable others to appreciate the enquiry process and therefore the contribution the study brings. I reason that by using a framework, my process can be critiqued and the implications of my study viewed with quality and rigor.

The framework structure consists of five stages; familiarisation, thematic framework creation, indexing of thematic codes, charting and finally mapping and interpretation. A similar approach has been used in other studies exploring professionalism (Elvey et al., 2015).

#### **3.13.1 Familiarisation**

Familiarisation is described as the act of the researcher immersing themselves in the data (Srivastava and Thomson, 2009). I achieved familiarisation by personally transcribing verbatim the voice recordings from the interview and focus group events. As I listened and transcribed, I also made additional notes of interest or surprise. After transcribing each event, I listened to the recording and simultaneously read the transcript. This enabled me to confirm the accuracy of the typed record and immerse myself further in the data (Srivastava and Thomson, 2009).

The Online Survey tool used for the tutor questionnaire has some basic, mainly quantitative analysis functions, such as adding up the number of responses and percentage of responses to a simple choice from a list question. However, my survey had several questions that required tutors to write a statement in a comments box. Therefore I decided a more complex familiarisation approach was needed. To achieve this, I began by reviewing the e-questionnaire responses in two ways. Firstly per individual, because some tutors had written

'as above', thus by looking at each person's replies I was able to see the whole of their individual response. Secondly, I reviewed each question in turn and looked at the statements made by all the tutors. This gave me an overview of the comments for each question, and if there was any similarity or difference between the individual responses. I repeated this process several times to ensure familiarisation with the findings and could therefore actively interpret the data.

### **3.13.2 Thematic framework**

During the familiarisation process, I became aware of a range of topics and themes from within each method step, and also across the different steps. I wanted to capture these viewpoints and also make explicit how I made judgements about the meaning from the data. Therefore I began to note these themes and ideas presented from the text. During this process I tried to keep an open mind as to the meaning of the data. I did this by reporting as many possible themes as the data as presented, and also by starting with the data rather than trying to locate a theme already identified in new data (Srivastava and Thomson, 2009).

### **3.13.3 Indexing of thematic codes**

I wanted to visualise all of my data themes to provide an overview and potentially cluster themes together to make categories. I also wanted to explore the relationships between and within the themes, and across the different method steps.

I initially used the computer programme NVivo (version 11), to assist in managing my data. As my study adopts an interpretative perspective, I was keen to ensure a logical and transparent approach to my analysis so others could fully understand and appreciate the claims of knowledge I was making. I thought the NVivo software would help me with this. After loading my transcriptions, I ran several queries, including the 'word frequency' tool to identify words and stemmed words within each transcription. With the GPhC interview transcription, the top three words were – 'staff' with 131 occurrences, 'think' with 66 occurrences and 'know' with 65. I reflected on this, and concluded it was very interesting that 'staff' was so high. However, on returning to the original transcription, I realised that I had identified the GPhC members of staff

as 'staff A' and 'staff B' in the transcription. NVivo simply had added up the entries and could not differentiate between the administration coding and conversation transcription. This realisation led to me to being more cautious about the contribution NVivo could bring to the analysis. Drever (2003) also adds caution in using computer based analysis programmes as some researchers

*“Lose the feel of the data” (Drever, 2003, P.66)*

I can relate to this comment, particularly because my part-time researcher status meant I was not actively working on my research all the time. This experience with NVivo, together with my reflections on how I wanted my involvement and interactivity in the thematic analysis to progress and inform my study discussion, led me to choose that a paper approach. I reasoned a paper and simple computing approach to the analysis would provide the rigor and confidence in the results needed because I had small data sets and could perform key word searches electronically.

### **3.13.3.1 Thematic analysis matrix**

I developed a thematic analysis matrix (table 3-2 below) to logically and systematically review the data to allow for indexing of the themes, and subsequently building to categories (Richards, 2014) whilst keeping the research questions in mind (Drever, 2003). I argue this process has built rigour into my study and reduced researcher bias by allowing transparency to the judgements I have made (Long and Godfrey, 2004). I used the same process for the interview, focus group conversations and tutor questionnaire. This was based on approaches described by DiCicco-Bloom and Crabtree (2006), and Srivastava and Thomson (2009).

**Table 3-2: Thematic analysis matrix example**

Text from transcription	Description	Preliminary theme	Category

I used one grid per data collection step. I inserted the data from the transcription into the left hand column. Each time a different person spoke, a new row was

started. I highlighted sections of the text in each row(s) that was of interest to my study aim. I worked along the row and through the columns to the right, entering my reflections into each column. The aim was to produce a category name that described and referenced the original text (Richards, 2014) rather than imposing any established categories into the data I collected.

Some categories included several rows of text indicating conversation between several participants contributed to the category classification. This shows how participants within the focus group or interview collectively worked together to create this knowledge.

The headings of the three columns provided a framework to explicitly challenge and structure my reflections, judgements and analysis as I moved through indexing. The process was very intensive and also iterative. I wanted to make sure the analysis was grounded in the original data, but, at the same time use my skills to understand the meaning of what was being said, make decisions around the importance of this content, filter out what was not relevant to the study and classify those areas that with little impact (Richards, 2014).

Srivastava and Thomson (2009) describe this as

*“not (an) automatic or mechanical process, but involves both logical and intuitive thinking” (Srivastava and Thomson, 2009, P.76)*

I agree with Srivastava and Thomson’s comment, however I would add that only by this laboured process can you begin to appreciate the depth within the data, reduce any unintended bias introduced to the indexing and also make the process transparent for external review.

I returned to my coding analysis at many times during the research journey, to revisit my coding and the original data. I originally coded until I reached a saturation point, when no new themes or categories presented from my data (DiCicco-Bloom and Crabtree, 2006). Coding until a saturation point is reached is reported to positively influence the study’s validity (Fusch and Ness, 2015) however limitations to the scope of saturation in qualitative research are also reported (Saunders et al., 2018). This was demonstrated in my study because occasionally I did change or reword the category based on a new reflection, focus or understanding that had emerged when I returned to the original data later in the research journey.

I decided to use the matrix for all steps in my data analysis structure (Appendix N). I thought adopting a consistent approach would enable my thinking from data to categorisation to be systematic and explicit. However, the matrix was not as easy to use for the open comment boxes in the tutor questionnaire compared to the interview and focus group transcriptions. This may have been because the questionnaire was not a conversation and therefore did not have the context of other participants to shape each contribution (Chadwick et al., 2008).

### **3.13.3.2 Quantitative data analysis**

The tutor questionnaire consisted of some closed answer questions, for example requiring a yes or no response, which resulted in some quantitative data. I used the questionnaire technology to present this data in diagrammatic format. I found bar charts particularly helpful at comparing responses between the different participants (Boynton and Greenhalgh, 2004). From reviewing the diagrams, I used the thematic analysis matrix to describe what the findings showed and produce a category code.

### **3.13.3.3 Triangulation**

As my study was from the interpretivist paradigm and I had been greatly involved in the qualitative thematic analysis process, it was essential to consider how I could ensure validity in the outcome. Validity is referred to by Silverman (2013) as the;

*“Credibility of our interpretations” (Silverman, 2013, P.285)*

Silverman challenges that researchers may frequently focus on particular confirming aspects within their data, rather than considering all the data. He argues that particularly for qualitative researchers, there is the need to ensure that the findings presented and subsequent analysis, stems from all the data collected and not a focused sample. Andrade (2009) advises that qualitative research adopting an interpretative stance, as mine does, needs to explicitly consider how to ensure multiple interactions and perspectives are included in the findings. One approach to address these concerns is by involving others in the analysis process to reduce divergence (Briggs and Coleman, 2007). I achieved this in two ways. Firstly, by sharing all my interview transcripts with my study supervisors, who highlighted comments of interest to the study objectives

before we then had a three way conversation regarding the thematic process and consensual verification and validation of my themes. Treasure et al., (2008) suggest that this process

*“Can make the analysis more rigorous and reduce the element of bias” (Treasure et al., 2008, P. 431)*

The second opportunity to explore the consistency of my analysis with others was a workshop I facilitated at a Yorkshire and Humber HEE School of Medicines Optimisation event (Leeds, September 2017). I presented my research topic to a group of practicing pharmacists from a range of sectors, pharmacy technicians, pharmacy educators and American pharmacy students. I showed participants my raw data and invited them to explore their impressions of the data by recording on post-it notes any words, phrases or terms they felt relevant to professionalism. I asked delegates to then stick their notes onto a series of flipcharts that were themed according to the HEE quality framework domains (Health Education England, 2019b) (Appendix O) .

Together these two triangulation activities allowed me to consider with others what was interesting from my data set, how this related to practice and what may be new knowledge to the field. This helped develop rigor and confidence in my analysis processes by establishing whether others identified the same themes as myself from my raw data. Also the triangulation processes potentiated my reflexive stance by enabling me to be more aware of any assumptions I had made, and therefore any unintended bias I might have brought to the study analysis and interpretation. This awareness has produced a more rigorous study and heightened my insight into research practice.

#### **3.13.4 Charting**

To achieve this, I undertook two steps. Firstly, I transferred the data categories from the four thematic coding frames from each of my data collection steps to post-it notes. Different colour post-it notes were used for each participant group. I then clustered the notes onto a series of sheets of paper based on my research questions (Appendix P). Drever (2003) states researchers find the visualisation of their data helpful. The use of different colour post-it notes allowed me, in one glance, to identify the level of contribution and interest in a study topic from across the groups. However, I decided the paper process

prevented some relationships to be connected across the groups because of the manual and dynamic nature of this process.

For the second step in this process, I transcribed the themes from the post-it notes onto a computer based mind map tool. Here I repeatedly reflected and moved the categories and clusters of ideas around, changing linking relations, adding or removing sub heading sections and considering how the data related to the study remit. I refined and crystallised patterns, with some relationships demonstrating disagreement and others commonality within and between each data step (Richards, 2014). I removed some data that I decided was either not relevant to the study themes that were emerging or did not support the category as fully as other data. I needed to undertake a judgement process to complete these steps, so I regularly saved versions of my mind map changes to illustrate the decision journey taken. Each mind map concept or theme was given an overarching name based on the scope and content of the data within it. The charting process therefore allowed for the study themes to be identified, but also the direct relationship with the raw data from each data collection step to be easily visible and retrieved. This allowed me to still consider its breadth, for example the contrast of perspectives within the data, and also the depth, for example of an insight from one participant and in what context to include it (Chadwick et al., 2008). This process helped me when I was writing up my findings by enabling me to remain accurate to the participant contribution, whilst also suggesting relationships within the data.

### **3.13.5 Mapping and interpretation**

In the final stage of my analysis process, I took each mind map in turn and analysed the diagrams to understand the meanings and importance of the findings with respect to current knowledge. The concise nature of the mind maps helped me situate my work within the current field of knowledge and indicate where new knowledge was proposed. My study suggestions and explanations are discussed in detail in the interpretations chapter.

### **3.14 Summary**

In this chapter, I have explained the ontological and epistemological assumptions that underpin the study and how this informed the methodology I chose. I have justified the order of involving the four stakeholder and discussed

the general ethical considerations for all stakeholder groups. For each participant group, I described the method chosen, sampling, recruitment and data collection setting. Finally, I explained my analysis, why I chose this approach and my role within this process.

## **Chapter 4 Findings and analysis**

In this chapter I present the findings from a semi-structured group interview with members of staff from the GPhC, focus groups with service users and trainees, and a qualitative survey with tutors.

The demographic information from the participant groups is presented as well as the steps involved in the gathering and analysis of my findings and how this process has informed the creation of the overarching concepts within my study. I then discuss these concepts in more detail, using the data to clearly illustrate the logic that underpins the conclusions of my study. The findings highlight some areas of similarity, divergence and difference in the participant group perspectives, which are later discussed in the interpretations chapter.

### **4.1 Group demographics**

#### **4.1.1 GPhC**

Three employees wanted to take part in the semi structured interview. However, on the day, one member was unable to attend. Therefore two employees contributed. This is still a reasonable number of participants for a group interview (Chadwick et al., 2008). Both members of staff had worked for many years at the GPhC, and previously the Royal Pharmaceutical Society of Great Britain before the organisation's regulatory powers were transferred to the GPhC in 2010. The staff members had practiced as pharmacists in a community and/or hospital setting before working at the GPhC. Within the GPhC both members of staff have roles in education standard development, undergraduate pharmacy degree accreditations and/or pre-registration training support. Staff member A was in a more senior role than staff member B within the organisation.

#### **4.1.2 Pre-registration trainees**

Seven trainees volunteered to take part in the single focus group. All participants were female, between 22 and 31 years old and had undertaken their undergraduate degrees at three different universities. Five trainees had

secured a first class classification in their pharmacy degree. One of these trainees was participating in an rotational programme though a hospital, general practice and community pharmacy. Another trainee on an integrated scheme rotated between a hospital and a community pharmacy, this trainee was awarded at 2:1 degree classification. The other trainees undertook mainly hospital programmes with a standard two weeks in community pharmacy during the placement. This gives an insight into which trainees were on more complex programmes and who may also have more than one tutor. All participants were given a form to record their demographic information at the start of the focus group. The trainees were asked to complete as much of the form as they wished. The following, table 4-1 (p.81), summarises the information disclosed:

**Table 4-1: Trainee participant information**

Trainee code	Age (years)	Gender	Pharmacy degree	Pharmacy degree classification	Pre-registration scheme
1	24	Female	Bath	1st Class	50 weeks hospital, 2 weeks community
2	23	Female	Cardiff	1st Class	26 weeks hospital, 13 weeks GP, 13 weeks community
3	31	Female	Cardiff	1st Class	50 weeks hospital, 2 weeks community
4	23	Female	Bath	1st Class	50 weeks hospital, 2 weeks community
5	23	Female	Bath	2:1 Class	39 weeks hospital, 13 weeks community
6	23	Female	Ulster	1st Class	50 weeks hospital, 2 weeks community
7	22	Female	Bath	2:1 Class	50 weeks hospital, 2 weeks community

#### **4.1.4 Service users**

Ten service users were invited to take part in the focus group. Eight service users attended on the day. All participants were given a form to fill out requesting demographic information. Six forms were handed in. Table 4-2 summarises this information. The participants ranged from 55 to 81 years old, and the group included two males. All participants had experience of the NHS; 4 participants had worked for the NHS during their lifetime, 4 had health conditions themselves requiring NHS involvement and/or were a carer for someone with a health condition.

**Table 4-2: Service user participant information**

Participant code	Age (years)	Gender	Ethnicity	Experience of the NHS
1	79	Female	White British	Retired staff nurse. Lectured for nurse training degree and patient governor at hospital.
2	55	Female	White British	Have had ovarian cancer and other cysts removed. Carer for adult daughter who has profound and multiple learning disabilities. Also care for my husband with his long term health conditions.
3	61	Female	White British	Worked as a staff nurse within a hospital in the NHS. Received cancer medication and chemotherapy.
4	65	Female	White British	Frequent user of pharmacies for my nutritional needs – have coeliac disease. Retired NHS physiotherapist.
5	No form handed in			
6	68	Male	White British	Manager of GP practices for 16 years, but none had pharmacists working in them. Now retired.
7	No form handed in			
8	81	Male	British	Worked in the medical division within the British Army. Carer for my wife who has a range of health needs.

### **4.1.5 Tutors**

The training team administrator emailed all 40 tutors with the study participant information leaflet and an electronic link to the questionnaire. I was notified that one email was returned as undeliverable, therefore making a population of 39 tutors.

The e-questionnaire was anonymous; therefore I did not ask the training setting, gender, ethnicity or years on the register as a pharmacist as this may have identified the tutor. I did ask how long the person had been a tutor. The most number of tutors, 5 people, had tutored for 2-5 years, with 3 people tutoring 6-10 years. Two people were in their first year of tutoring, and two other people had also tutored over 11 years.

## **4.2 Data gathering process**

### **4.2.1 GPhC**

I perceived a hierarchy of power to exist between the two staff members, with staff member A having a potential power relationship over staff member B. This was demonstrated by Staff member A using non-verbal cues to direct staff member B to answer questions during the interview. Therefore it may be possible that staff member B did not contribute to the discussions as fully as they may have done if the interview had been done on a one to one basis. Although I feel that through my facilitation of the interview both staff members spoke. Further work could consider potential hierarchical relationships between the participants and if another methodological approach, such as one to one interviews or a focus group with more participants, could have been adopted.

### **4.2.2 Pre-registration trainees**

All trainees already knew each other from the regional training courses and consequently the focus group conversation flowed well. Trainee 3 spoke more frequently than others. This was noticeable when reviewing the transcription but did not come across as dominance during the interview. It is unclear why trainee 3 might have contributed more than the other trainees. One reason could be that trainee 3 was a mature student and may have brought more life experience to their degree and pre-registration training which may have affected their reflections on the focus group conversation. Alternatively they could have

had experience during their pre-registration year around professionalism that they viewed was particularly relevant to the study topic. Trainee 7 was the least vocal during the focus group, with only 19 contributions to the whole of the event and many of these being one word, i.e. “yea”.

### **4.2.3 Service users**

All participants contributed to the conversation, with service users 1 and 4 being most vocal. Service user 5 and 7 were the least vocal during the focus group, however both did contribute non-verbally e.g. nodded and laughed, throughout the event. It is interesting to note that both of these service users did not hand in a background information forms in at the end. This may be because they forgot to on the way out or they may have not wished to share their background information. As facilitator of the focus group, I felt both service users 5 and 7 appeared engaged in the conversation and remained until the end.

Looking at the service user participant information (table 4-2 p.81) , the group had more participants from a healthcare background than I expected, for example a retired physiotherapist, GP practice manager and two nurses. At the start of the focus group I asked participants to talk briefly about their experience of the NHS. Many participants had shared their employment history. Maybe sharing of this background information could have intimidated service user 5 and 7 to contribute to less the conversation, as I did not know anything of their background because as participant information form was not handed in.

Service user 8 left the focus group about 30minutes into the discussion to attend to carer duties. Therefore service user 8 overall had a lower contribution to the focus group. However, during the time the person was present, there was a comparative number of contributions to the conversation to that of other service users.

### **4.2.4 Tutors**

Tutors were asked to complete the e-questionnaire within two weeks. After this time only 3 tutors had responded (8% response rate). I included in my ethics application, the opportunity to re-send the participation information to tutors if the uptake was less than 20%. A reminder email was sent and after two weeks 12 responses had been posted (31% response rate).

I reasoned that sending the questionnaire out at the end of the pre-registration year would provide the greatest insight onto the study area. However, the low initial response rate was of concern. Reasons for this could be the time of year (the first week in August typically the pre-registration cohorts change and tutors could be busy signing off leavers and organising the induction programmes for starters during July), tutors may also be changing (outgoing tutors may not feel they can comment as they are no longer going to be a tutor, and new tutors may feel they cannot comment as they have not supervised a trainee yet, typically three to five tutor changes happen each year) or tutors could be on summer holiday. The final response rate of over 30% is acceptable basis for the analysis. More importantly, I argue that the 12 responses returned I felt demonstrated a good quality. I reached this conclusion because all the tutors responded to the closed questions, many tutors had written several lines of information in the open comment boxes to explain their reasoning and all the tutors that took part fully completed the questionnaire.

Some sections of the e-questionnaire were non-mandatory. Typically seven to nine tutors made comments in the boxes. Although the e-questionnaire was anonymous, when the tutor completed the questionnaire they were automatically assigned a participant reference number by Online Surveys. This allowed me to see if the same tutors were commenting on each non-mandatory question. I found with each question, a different mix of tutors had responded, thus enabling a representation of all 12 tutors to be taken into account in the study. However, I noted that tutor 4 and 7 were most prolific in their comments when completing non-mandatory questions. Tutors 3 and 12 frequently wrote the least or skipped some comment boxes. Some tutors had written “as above” or “see question 2a” as their response. I used the participant reference number to link up individual responses between questions, thus enabling all comments to be included. All tutors finished the questionnaire. Boynton and Greenhalgh (2004) report

*“It is better to collect fewer questionnaires with good quality responses rather than high numbers of questionnaires that are inaccurate or incomplete” (Boynton and Greenhalgh, 2004, P.1373)*

Therefore I concluded the questionnaire responses would be suitable to base my analysis upon and I did not need to complete any further reminder emails.

### 4.3 Analysis concepts

The concepts identified through my analysis framework process were as follows

- Perceptions of professionalism
- Professionalism development
- Judgements on professionalism

I have taken each concept in turn, and described the findings that underpin that concept. Through the analysis process, I have noted some comments made by participants that were considered as being important to understanding the discussion, areas of agreement or variance and meanings that have emerged. I have included these comments as verbatim quotes within my findings. I have also used analysis to extend the study meaning and importance in relation to the study aim.

### 4.4 Perceptions of professionalism

Subsumed within the concept of perceptions of professionalism were a number of illuminating discussions about 'being a pharmacist and being professional', defining professionalism and decision making.

#### 4.4.1 Being a pharmacist and being a professional

All study groups either explicitly or implicitly stated a pharmacist was a professional, and therefore would act as a professional, either by self-want or by seeking to meet the expectations of what may perceive a professional would do.

*"Acting in the manner expected of a professional" Tutor(T) 4*

*"I think pharmacists are generally professional" Service user (SU) 4*

*"People look at you as being a professional and you have to give them reasons to give them that respect." Pre-registration trainee (PT) 3*

*"And you are also a representative for your profession and of the health service which is really important." PT5*

*"Our (GPhC) expectation is that pharmacists behaves professionally at all times." GPhC staff member A (GPhC A)*

Participants reported that professionalism was demanded in the everyday activities a pharmacist undertakes in order to earn the professional status placed on the individual.

*"Professionalism is at the core of what we do" T4*

*"Where I worked pharmacists had professionalism" SU6*

*“Professionalism runs through everything you do... It’s like patient safety” GPhC A*

*“Once a pharmacist always a pharmacist’ is true. You have attitudes towards things and your actions must be professional” PT1*

One service user also welcomed further roles for the pharmacist to undertake.

*“There is a shortage of GPs that is going to come up and pharmacists could fill part of the gap” SU7*

#### **4.4.2 Defining professionalism**

The GPhC, a trainee and service user remarked that the centre of professionalism consisted of meeting patients’ expectations by placing the patient at the centre of practice.

*“So professionalism from a healthcare and a regulator point of view, it’s about ... making sure that they are putting people first as part of their role as a professional in healthcare.” GPhC A*

*“Satisfaction of the customer” SU8*

*“Doing the best for the patient is a big part of it (professionalism)” PT5*

Yet, participants found stating a definition for professionalism difficult. When questioned further, many participants described a range of skills, behaviours and attitudes that combine to provide a patient-centred and patient safe approach, which would consequently show professionalism, this is as highlighted in a conversation extract from the trainee focus group.

*“It’s about trust” (PT3); Reliable (PT6); Responsible” (PT1); Putting the effort in...” (PT2); “For who? (Pause) The patient? The team?” (Interviewer); Yea, for everyone (PT2); It’s about taking on a role and responsibility and being um, being willing to take responsibility for your actions (PT6)”.*

Members of the tutor group, the GPhC and service users also shared how they perceived professionalism presents.

*“The manner and the ability to communicate with patients is a key part of professionalism” T4*

*“Professionalism is something about autonomy and taking responsibility for your own actions and decisions.” GPhC A*

*“I would argue that professionalism is keeping up to date” SU4*

Although there was a high level of consistency in the skills reported as demonstrating professionalism put forward by the different study participant groups, there was one noticeable difference from a service user.

*“No matter how good a communicator you are, if you are giving out the wrong stuff (medicines) then you have failed as a pharmacist”  
SU3*

Six, of the eight, service users viewed accurate dispensing of prescriptions as a fundamental professionalism skill pharmacists must have. None of the other three participant groups mentioned dispensing explicitly. The service users' perspective is grounding because pharmacists are increasingly moving away from the traditional or technical aspects of the pharmacy service, such as dispensing. Pharmacists are currently undertaking more clinically focused patient facing roles such as non-medical prescribing in a range of healthcare settings and with greater cross professional working.

*“But over the years pharmacy has become far more clinical and more in line with a clinician and someone who is there as part of the multidisciplinary team.” GPhC A*

However, this study identified that there is a low awareness of the clinical services currently offered by pharmacists amongst service users, as illustrated by one participant

*“One of the things that amazes me...I got an invitation from my (community) pharmacy to go in and to have a discussion (with the pharmacist) to review my drugs... we had a chat for about 20 minutes...I found it quite useful.... is this going around all pharmacies now?” SU1*

This service user found the experience with the pharmacist positive and was keen to see if the service was more widespread than in their pharmacy.

#### **4.4.3 Decision making**

I found a difference of opinion around decision making and professionalism development. Being able to make decisions was reported by some members in all the participant groups as demonstrating 'good' professionalism. Although some intra- group variability was noted in the tutor participant group. Four tutors did not think professionalism and decision making were linked.

*“Not particularly observed this” T1*

*“I can't really think of an example” T6*

This may be because I asked the tutors if they had experienced a connection between trainee professionalism and decision making. It could be that these four tutors had experienced or could not recall a relationship between decision

making and professionalism in their trainee at this time, rather than a connection not being present.

Whereas the other eight tutors report a relationship between decision making and professionalism. However, many tutors view a correlation between decision making and professionalism development, there is consistency, between the participants groups, as illustrated in the following comments;

*“I believe that someone who exhibits good professionalism will generally make well thought out decisions” T10*

*“So professionalism... But from a healthcare and a regulator point of view, it's about an individual taking responsibility for their own decisions.” GPhC A*

*“But when you are in the working environment, what you say can affect decisions about a patient, or what the patient does, so it's, you have to think about what you are doing” PT6*

*“That's a part of professionalism – deciding when do to things” SU1*

*“Making difficult but ethical decisions” T4*

But the trainee and tutor study participants also recognised that professionalism involves awareness of personal limits of knowledge and seeking appropriate action to help in that situation.

*“Handling yourself in a complex situation and being able to say ‘this is out of my area, let me seek assistance’ is professionalism even if you can't make the decision yourself” T9*

*“Someone who exhibits good professionalism... If they do not have the requisite knowledge or capability they will seek help” T10*

*“I think you have to be confident in what you don't know. If you don't know something, be really honest and say “actually I don't know, this is what I'm doing to do” PT2*

The study identified an interesting finding relating to challenging the knowledge or decisions made by someone else and the link with professionalism. The relationship suggested was professionalism would be demonstrated if a person spoke out regarding concerns about another's decision making ability. Importantly only members of the service user group highlighted this association. This could be because as the GPhC, tutors and trainees are fully aware of the duty of candour for all healthcare professionals and this is implicit in a 'patient-centred approach' or 'doing the best for patients' and therefore did not need explicit mention. Alternatively, it could be that the services users view speaking out as a vital element of professionalism because of concerns raised about

NHS care (NHS England, 2017a). The following quotes from two service users highlight the importance they place on speaking out and professionalism.

*“In the context I was working, pharmacists had professionalism. I thought this was clear when they interacted with GPs particularly. Where you have two professionals, not quite going head to head, but there is a need to be able to demonstrate your knowledge and to have this accepted by someone else who has a similar knowledge, but not quite as good. You know, so the GPs are often the ones handling the medicines, but the pharmacist does know what they are talking about.” SU6*

*“That is part of professionalism, if you notice something, you don’t swallow it” SU1*

One service user suggested that only by gaining knowledge and practicing in real life to appreciate ‘normal’ practice, would the professional be able to make complex decisions well and challenge others regarding their practice.

*“You have to get through the learning and the practicing of what you have been taught, until you find out, ‘well actually, I don’t really agree with that because’ SU4*

Another service user identified the need for pharmacy professionals to have independent thinking and have flexibility on action to different situations.

*“Like all professionals, what you don’t want to do is to turn out clones” SU6*

The potential discourse of knowing what should be done within practice limits and knowing what is the best thing for the patients was identified. It was raised that to act with professionalism, a pharmacist may occasionally need to step beyond the legal frameworks surrounding practice if this is in the best interest for the patient. This area of conversation showed variation in perspectives between the different participant groups. Several service users supported a pharmacist acting outside regulatory requirements, if in the patient’s best interest, as demonstration of professionalism. However, in the following statement from a service user, they highlight how the workplace organisation may influence how a person may demonstrate their professionalism.

*“As far as professionalism goes, I think things have changed a lot in the last 15 – 20 years...People are bombarded with things from management and in every sphere of healthcare ‘if you don’t do that you will end up in court’, and a lot of people, particularly younger practitioners, I think they are scared to go out of, you know they stay rigid to the rules, they don’t have the confidence to step out” SU3*

This viewpoint on the restrictions of the workplace was confirmed by many tutors who reported the need for patient-centred care but for this to remain within the limits of professional guidelines and regulations.

*“The centre of the focus must be the patients and ensuring the best outcome with empathy whilst working to professional conduct codes and the law and ethics is essential” T7*

Yet, in contrast, the GPhC highlight that a pharmacist acting illegally but for the patient’s best interest this could be viewed as professionalism.

*“If it was illegal, from a regulator point of view, we would be saying has that person got treated in their best interest, then the pharmacist would be making the right choice. That’s professionalism. And being accountable for that.” GPhC, A*

Unfortunately the trainees did not discuss clinical decision making outside regulatory requirements and their views of how this links to this debate around professionalism. However, the discourse in this conversation between the service user, GPhC and tutor suggests that professionalism needs to be flexible to each context and not fixed, a pharmacist would need to judge a situation and potentially respond in a different way and that this may depend on their knowledge and experience in practice. This responsiveness to adapt to situations was seen as demonstrating professionalism.

One approach to demonstrating professionalism whilst navigating complex situations was to involve the patients or their carers. Service users suggested that the patient or carer may want to be involved as they may have useful information which could help with care decisions and ultimately know what it is like to have that illness. In other words, they are an expert.

*“I think I have more knowledge than the pharmacist does about my daughter’s medication. And so, I have had many times when pharmacists are telling me one thing and I have to produce evidence to say, ‘actually this is what is happening and this is why she is on it’... some pharmacists are wonderful and will go ‘thank you, I love this information’ whereas others will go ‘oh no’ and walk off.’ SU2*

The comment above by this carer highlights how different pharmacists have responded to the information presented to them and what impression this has left on the carer. It is also important to note that some pharmacists have physically removed themselves from the carer rather than engaged with them.

## 4.5 Professionalism development

Subsumed within the concept of professionalism development are discussions about when professionalism development starts, the transition from the pharmacy degree to pre-registration, the involvement of patients and how the pharmacy practice setting may influence professionalism development.

### 4.5.1 When does professionalism development start?

When considering their career pathway, none of the trainees aspired to be a pharmacist from an early age. This consistency within the trainee group was an interesting finding. Some trainees had pharmacy recommended to them when they considered applying for University courses, while others had undertaken work experience in a pharmacy before starting their degree.

*“Similar to what’s been said already, I wasn’t really aware of pharmacy as a profession through school, and I liked science – biology, chemistry and maths. It was suggested to me about pharmacy, and it went from there and luckily I like it!” PT3*

*“Similar to others, I enjoyed science and had work experience in a pharmacy which I enjoyed.” PT5*

There was a consensus from all the trainees that when they started their pharmacy degree they did not understand what professionalism was. The trainees reported numerous approaches that were adopted within their pharmacy degree to help address this need, from the University signposting to reading matter as part of the programme and presentations to more collaborative and group work style interactions.

*“They (the school of pharmacy) posted the (General Pharmaceutical Council) code of conduct under my room door (in University halls) and I thought “what is this?” and I read it, I had no idea.” PT7*

*“It (professionalism training session) outlined how the public view pharmacists, and that we would be pharmacists of tomorrow and we needed to up hold that view. At first year, this might go over your head a little bit but, having that talk so early did definitely make you think about the future, (PT3); They used a lot of scenarios with us..., (PT1); Yea; (PT2); You were given stuff and asked what do you think about this scenario? They were quite good and it made it stick in your head, the stories, (PT1)”*

Many trainees felt the more interactive and real life the professionalism cases were, the more they were retained by the trainees. The variation in how professionalism was taught at University is important as trainees could potentially start their pre-registration training with varying understandings of

professionalism. This is important because my study found that most tutors built upon the trainees' prior professionalism knowledge during the pre-registration placement. There was also an expectation from the GPhC that took place.

*“The beginnings (of professionalism) should be in place from their studies” T6*

*“I think they have to go into the (pre-registration) placement with the understanding of what professionalism is. Which again should be a thread that runs through the MPharm,” GPhC A*

One tutor stated professionalism also changed and developed during the placement year. This suggests that professionalism is not constant but rather develops, matures and grows over the whole 52 weeks. Therefore we need to consider how the methods used for training and assessing professionalism should take account of this maturation process.

*“At all stages of the (pre-registration) year professionalism must be paramount...I expect it to be there at the beginning and mature though the year” T7*

The study findings identified one tutor who talked about imparting professionalism to the trainee from the start of their pre-registration. The use of imparting here is quite an emotive word. It could suggest a transmitting or telling to the trainee, with little reasoning or learning on the part of the trainee. Alternatively it could mean showing them what professionalism 'looks like' and communicating with the trainee, therefore suggesting a more interactive process. However, what this tutor also confirms is the consistency in viewpoint that professionalism is an essential part of pre-registration training, from day one.

*“Professionalism is inherent from the first day of the pre-reg year and must be imparted to the pre-reg” T1*

#### **4.5.2 Patient involvement and professionalism development**

This study proposes a link between patient engagement and professionalism development. All the study groups linked student and trainee contact with patients as having a positive response on professionalism development. Of particular interest were the GPhC reflections on the difference in patient involvement during the undergraduate degree and how this affected career progression and preparedness for pre-registration training.

*“One of things that I'm finding is the students are engaging with patients earlier. In one of the Universities, patients come in for like a*

*coffee morning and a chat.... One of the things students say is, you know what, I was so scared (to talk to patients) at first...If you do this earlier on, it instils it from the start. Hopefully, by the time they get to pre-reg they are much more confident". GPhC A*

Although patient engagement was welcomed several members of the tutor and trainee groups highlighted that optimum professionalism development was linked to a real life experience. The groups reported that this was not achieved during the pharmacy degree during simulations and role play as these interactions were not real and were therefore considered safe.

*"The degree is too sterile, even when you are doing an OSCE (Objective Structured Clinical Examination) and you are meant to be professional, it's not real...(PT1); Not realistic, (PT5); They try the best they (University) can to make it realistic, so there are consultation room, things like that, but it's just not the same (PT1)."*

*"False situations can help to teach a new skill in a safe environment, but nothing beats a real life scenario for developing and improving what you have learnt; Case studies can be a good introduction for professionalism development, but not as good as real life situations"*  
T9

The implication here is that a real life setting is not a safe setting because if something were to go wrong, a patient's wellbeing would be at risk. The focus on trainees being actively involved with a patient's care, for example communicating with the patient, was noted to develop professionalism.

*"Undertaking communications with patients develops professionalism in the pre-regs" T8*

The lack of patient interaction during the degree was noted by a tutor, who cited the significance of the pre-registration year as to when a trainee develops professionalism.

*"Learning to deal with patients in a professional manner is key, especially because this sort of interaction doesn't happen frequently throughout the pharmacy degree" T1*

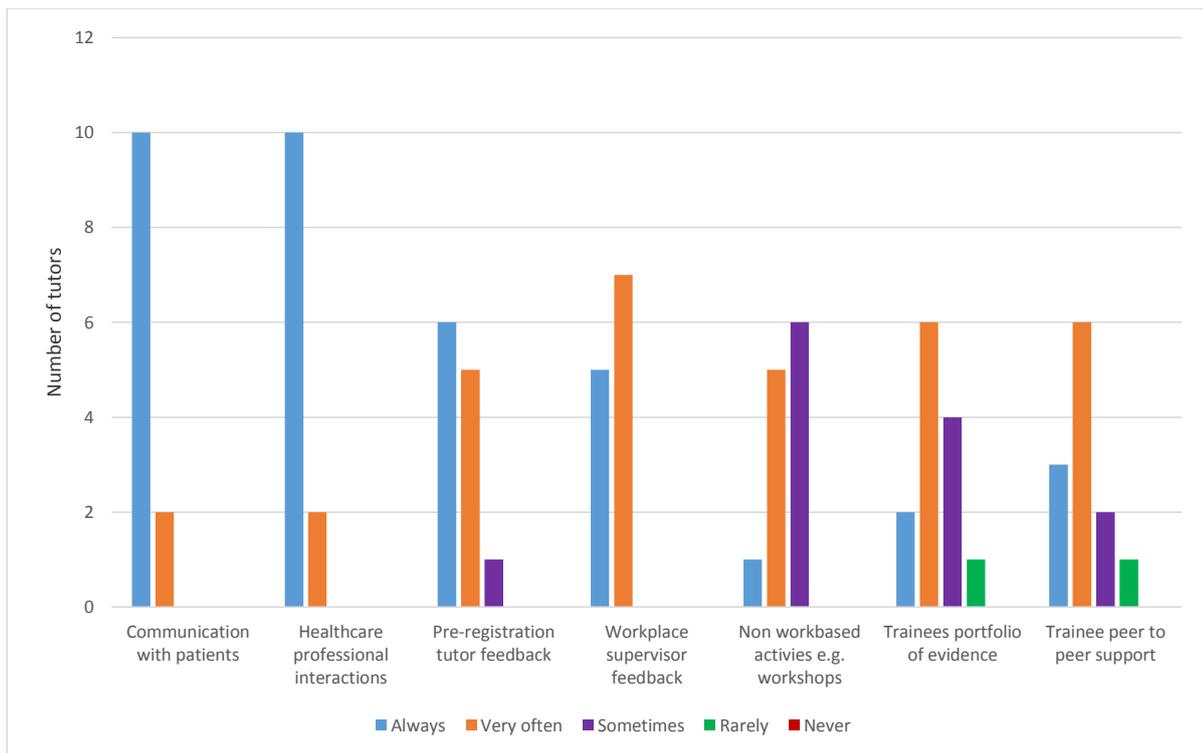
Therefore looking at the pathway to become a pharmacist, the pre-registration placement continues to be the main time patient contact occurs. This puts greater focus on the pre-registration year to provide this real life learning opportunity to observe and develop professionalism.

*"Trainees need to be able to see how things work in practice" T4*

Tutors were also asked to reflect on learning experiences the trainee may undertake to nurture professionalism. Figure 4-1 (p.96) describes the level of

importance each interaction the tutors placed on the development of professionalism. Importantly patient involvement and interactions with the healthcare team was reported as the most helpful. The feedback from tutors was seen as the next important, with fewer tutors reporting that the portfolio of evidence “always” contributed to the professionalism development of the trainees.

**Figure 4-1: Tutor questionnaire responses: Activities that develop professionalism in pre-registration trainees**



However, one tutor remarked that for some trainees talking reflectively may be a more helpful process for professionalism development than writing reflectively. Therefore the written evidence a portfolio may not represent fully the trainee’s professionalism development.

*“Reflection works well if the trainee is a naturally reflective person. Otherwise encouraging them to write reflectively is like getting blood from a stone... reflective talking and getting the trainee to think could be preferred” T9*

The trainees reinforced the importance of communications with patients in the work place setting as being pivotal to their professionalism development. This was illustrated by trainee 4 (quoted below) who highlights that they have adopted their behaviours by seeing for themselves how other professionals interact. The trainee does not define who the ‘people’ around them are so it is

hard to know if they are pharmacists or other healthcare professionals. Interestingly the trainee refers to 'trustworthiness' as a behaviour learnt through this process, which challenges the assumption that trustworthiness is an innate quality. It is also important to note that trainee 5 agrees with trainee 4 and uses the word 'felt' to define their experience, therefore the experiences and reflections shared are not individual to one trainee.

*“Definitely at the beginning of my pre-reg I did not feel that comfortable about speaking to patients, and by, going to work every day and, you, you don't imitate the people you are around, but you take after what they are doing and you learn to become, to be a more trustworthy person.(PT4); I felt this happened in pre-reg (PT5)”*

Of further note, is that trainee 4 reports insight into how their confidence in talking to patients was linked to regularly being in the workplace setting. This finding proposes that learning takes place throughout the year, in the workplace and requires pharmacy colleague and importantly patient interaction.

The focus on patient engagement and its effect on professionalism development is further supported by another trainee. This trainee highlights the positive relationship between patient-centred experiences and professionalism development.

*“I didn't get an awful lot of patient contact... I personally feel we should have a lot more because if we did, we would develop more professionalism.” PT7*

The length of the pre-registration placement was discussed by the GPhC. They highlighted that the development of some patient-centred skills could take differing amounts of times for differing trainees, in other words for some trainees this might be longer than the normal year timeframe.

*“For some people, it doesn't come naturally to have that empathy and that level of understanding about communicating with patients, so although we say a year, it is probably, for some that it might take longer to get there. They might have fantastic clinical knowledge and the tutor might be blown away with what they know, but stick them out on the medicines counter and they crumble“. GPhC B*

It is important to note that both GPhC also identify that excellent clinical knowledge and empathy may not be in a direct relationship. The GPhC emphasise that there is more to practice as a pharmacist than clinical knowledge; being able to utilise that knowledge and engage with patients is essential.

### 4.5.3 Professionalism learning from others

The findings show all tutors report that it is their role and that of others in the healthcare team to help the trainee learn about professionalism. There is also acceptance that different people will show alternative aspects of professionalism. In a quote below, a tutor talks about ‘everyone’ having professionalism. The tutor does not define who everyone is, it could be the whole of the pharmacy team or even the healthcare team. I think there is a community of practice surrounding the trainee from which they can observe professionalism. The tutor also raises the point that ‘seeing’ is not enough, and that through reflection and guidance the trainee needs to consider what elements of professionalism they have seen in others that they wish to adopt, or not. Interestingly the tutor does not mention the reflective written portfolio a trainee is required to build for the GPhC registration process. This may be because the tutor is inherently aware of the portfolio, or it could be that the reflective process mentioned here is something else. Perhaps it would be a reflective conversation between a trainee and tutor, or a self-reflective process within the trainee. Interestingly the tutor also uses the word ‘maximise’ here, this may suggest that reflection has the potential to make the most of, or extend, the professionalism learning.

*“I think they see professionalism from different areas and take the best bits from everyone to maximise their own professionalism. There is a reflective process here for the pre-reg.” T7*

The principle of learning from others could be classified as a role model relationship and was supported as an approach for professionalism development by a trainee.

*“I think there is a transition from when you are a student and you look up to professionals to then becoming it yourself. I think there’s a lot of personal learning, rather than knowledge learning that happens” PT3*

The trainee emphasises that the role modelling relationship greatly helps with the transition from student to professional. The trainee highlights the emergence of their identity as part of the profession and concept of developing into and *becoming* a pharmacist. The role model used to help with change is not defined, therefore could be a pharmacist, pharmacy technician or another health professional. Also the trainee uses the plural ‘professionals’ therefore is implying more than one professional group. Importantly the trainee does not

include patients in their learning from others here. On a different perspective, the trainee talks about ‘looking up’ to others at the start of the pre-registration placement and then *becoming* the professional over this placement. This perhaps means there is an upwards transition to acquire the professionalism of a pharmacist. Also this trainee refers to personal learning, this may link to development of other characteristics, such as trustworthiness mentioned previously, when progressing through pre-registration training.

The significance of a tutor as a role model was agreed by all the trainees. This highlights that tutors may have several roles in the pre-registration year, for example line manager, assessor, mentor, but being a role model was reported as vital by the trainee.

*“You mentioned then, about the role of the tutor in your pre-reg year. How do you think they may have helped your development of professionalism during your pre-reg? (Interviewer); Being a role model is a big thing (PT2)”*

However, tutors reported other pharmacists or others in the healthcare team, regardless of practice location, have an important role model opportunities

*“I always think that observing how other professionals approach a task or situation has a great influence on the development of professionalism” T5*

*“There should be appropriate role models in all sectors of practice” T7*

#### **4.5.4 Degree to pre-registration placement**

The trainees remarked that the focus of the degree and pre-registration placement are different, as stated is in this conversation extract.

*“What you learn at University is so different to your pre-reg year. What you learn at University is all about cramming knowledge. Then when you come to your pre-reg, its knowledge but it’s about being with people too , (PT2); whereas in the undergraduate degree, and I know it’s all about learning then, it doesn’t really matter if you get it wrong, apart from the fact that you don’t pass. I think you become a lot more professional straight away when you start your pre-reg (PT1); You see at Uni the focus is all on you, and you, like you said (in reference to PT1), what you do in your degree does not affect anyone else. But when you are in the working environment, what you say can affect a patient” (PT6).*

This highlights a move from personal focus to being externally aware. The move from knowledge focus to patient focus is vital here. There seems a difference between knowledge and knowledge applied to real life situations in practice and

the implications this action on knowledge has on others. The trainees talk about working with others, this could be the healthcare team or patients, either way, there is an acceptance that knowing things on a personal level is not enough, but rather this knowledge has to be utilised for patient care. The trainees here talk about 'getting it wrong' therefore implying that a decision or action is needed. As previously found, decision making in practice was identified as a key marker for professionalism development. This supports further the discussion and relationship around professionalism, decision making and real life patient care. One finding linking these three factors was stated by both participants from the GPhC. This study identified that exceptional clinical knowledge and being able to demonstrate interpersonal skills are not necessarily linked.

*"There's often a disconnect. Between academic ability and being able to talk to patients, people... So they (the trainees) pass all the things (at University) but they really struggle when they, you see those, those pharmacists that hide behind the dispensary counter and not out there (in the pharmacy)." GPhC, A*

This finding highlights how academic knowledge can be different from the real life experience and that something more than knowledge is needed. One participant from the GPhC also highlights that pharmacists with a lack of skill in this area will seek the physical space of the dispensary away from service users.

The trainees talked about starting their pre-registration placement as being an important milestone in their professionalism development. The trainees particularly noted the moment they were given the title of 'pre-registration trainee'. The trainees spoke how the title was seen as progression, or an increase in, their personal responsibility for others and external awareness and a milestone in their career pathway.

*"They (the tutor) were like 'oh this is the new pre-reg'. And I was like, 'oh, I have a title, this is weird!' (Many participants laugh). I'm not a student anymore! It is a step up. So, you are still learning (in pre-registration), but, the different names, it sounds more... (Pause) (PT6); It's like, the start of your career is actually at the start of your pre-reg, rather than from when you qualify (PT2); When you said a step up, a step up in what? (Interviewer); Responsibility I guess, people expecting more from you. I think, as a student you can get away with not knowing things (laugh) but, you know you can say 'oh I haven't done this yet, I do not know!' (Laugh). (PT6)*

A tutor also reported that they viewed trainees differently to students. The following extract is from a question regarding their views on the integration pre-registration year into the pharmacy degree to make a five year programme.

*“I am concerned this will mean they are treated as students and not as pre-regs and not as separate entities for the pre-reg year. The view of other people has a big effect.” T6*

The tutor makes reference to the impact the title assigned to a trainee or student may have on how others surrounding this person may regard them and that this may affect the learner’s professionalism development. The tutor suggests that the difference may be present in the responsibility and independence given to students compared to pre-registration trainees. There is the suggestion that students would be treated not the same, and potentially less, than trainees. The tutor does not expand on who the ‘other people’ could be, perhaps this refers to pharmacy staff, patients, carers, healthcare professionals colleagues or all or some of these groups.

Taken together, both the trainees and tutor comments expose that the titles used to describe a future pharmacist have both impact on the learner and the way others may view and contribute to the development of professionalism.

#### **4.5.5 Professionalism and its development in different pharmacy practice settings**

The trainees reported that professionalism can be displayed in all sectors of pharmacy practice,

*“The professionalism was the same.” PT2*

When asked to consider if professionalism development was any different in different sectors of pharmacy practice, two tutors reported that areas with less direct patient contact may result in slower development of professionalism

*“Those settings where there is less exposure to patients can decrease the development of professionalism” T1*

Interestingly, one tutor implied that in community pharmacy trainees may be put into a position where they need to take a more responsible role sooner in their placement and this results in the trainee developing professionalism at a quicker rate. Therefore having opportunities for transition moments earlier in the pre-registration placement to develop professionalism.

*“In hospital I think the trainees are a little more sheltered from taking responsibility early in their pre-reg year so maybe their professionalism can take longer to develop than perhaps in community” T2*

However, most tutors reported a trainee experiencing a range of different practice settings, with different challenges and the opportunity to learn from range of other healthcare professionals was helpful towards the pre-registration trainees’ development of professionalism.

*“Professionalism is at the core of everything we do, there should be appropriate role models in all sectors of practice”. T7*

*“Involvement in different healthcare sectors show how to maintain professionalism under different levels of demands” T5*

Both members of staff from the GPhC also implied that professionalism can be learnt across different pharmacy practice settings and welcomed trainees undertaking rotational pre-registration programmes. The staff members linked the trainees’ awareness of their knowledge, capabilities and practice expectations to how professionalism is developed, as illustrated in this conversation extract below.

*“Do you think the newer rotational pre-registration programmes where a trainee rotates around different health settings is welcomed for the development of professionalism? (Interviewer); Yes, most definitely. (GPhC A); Why do you think that? (Interviewer); I think it’s that confidence. That they can transfer those skills....(GPhC B); Yes (GPhC A); To different sectors and meeting with different healthcare professionals as well...This now becomes the norm (in reference to the rotational programmes) that they (the trainees) can go into different settings and know what their capabilities are and know what is expected of them when they are there (GPhC B)”*

## **4.6 Judgements on professionalism**

Subsumed within the concept judgements on professionalism are discussions on who should assess professionalism and how, where challenged with the assessment may exist and the opportunities provided by patient assessment of professionalism and trainee reflections into their own professionalism development.

#### 4.6.1 Role of tutor

The tutor was identified as important for the development and assessment of the trainee's professionalism. The importance of the tutor being a pharmacist and undertaking daily patient facing roles was seen as valuable. This was linked to the tutors ability to understand the daily roles of a pharmacist and therefore assess their trainee.

*"In the hospital you always see your tutor around and on the ward, so you just see them. So you get to know them as a pharmacist, because you see them at work." PT6*

#### 4.6.2 Who should assess professionalism?

All twelve tutors reported the assessment of professionalism was part of their role. Importantly eight tutors identified that the GPhC registration exam does not assess professionalism, therefore placing more emphasis on the tutors' assessment of the trainees' professionalism and ultimate career progression.

*"Professionalism is an important part a tutor should take into account before signing off a pre-reg. The academic merit can be assessed by the GPhC exam" T12*

*"Professionalism is extremely important and not easily assessed by the exam (GPhC registration exam), coursework etc" T10*

One tutor highlighted that poor professionalism was the principal motivation behind them not signing a trainee off for registration, therefore highlighting the importance of professionalism in the tutors' assessment.

*"It's (poor professionalism) the main reason why I have concerns about signing people off at the end of 52 weeks" T4*

Only one tutor linked the final registration sign off process to the GPhC standards.

*"Professionalism is encompassed in the GPhC standards. As pre-reg tutors we are signing off that someone is able to uphold those standards. Therefore assessing professionalism is part of our role." T8*

This was in contrast to most other tutors who stated that they did not use the GPhC standards for pharmacy professionals to assess professionalism.

*"I don't use them to assess their (pre-registration trainees) professionalism". T2*

Other tutors suggested that the standards alone are not enough for a trainee to appreciate professionalism and that seeing the standards applied by others in

practice is needed for the trainee to understand how they need to demonstrate them in practice.

*“These provide the description but they (the trainees) need to be able to see how these work in practice”. T4*

### **4.6.3 How is professionalism assessed?**

The study showed variation in how the tutors carried out the assessment of professionalism in their trainees.

*“I assess professionalism on a very ad hoc basis” T1*

*“I don’t have any specific tools or measures” T12*

*“I often go on gut feeling” T11*

*“Wards visits, case based discussions, feedback from others” T3*

*“Discussions about situations, observations” T6*

The 12 tutors in this study adopted a range of assessment approaches.

Including some subjective and unplanned methods. Yet other tutors stated they used structured and team approaches to help them with the decision making process for the required GPhC registration sign offs.

*“At 39 weeks we have a meeting with all those involved in placements (internal and external) to gain feedback on the pre-regs” T2*

*“On site there is a shared responsibility as the tutor cannot be with the individual all the time. Mostly negative issues are brought back to the tutor – there is the assumption that no news is good news!” T7*

All tutors described their role as being vital in providing feedback and guidance to their trainees on how to develop their professionalism.

*“Tutors have a key role on developing professionalism as these are behaviours that can’t be learnt through a book and require feedback from others to develop” T4*

*“Receiving structure, constructive feedback on all aspects of their professional practice has a significant impact on the development of professionalism” T8*

### **4.6.4 Joint tutoring**

Two of the trainees were undertaking rotational placements and had two pharmacists, working at two different sites of pharmacy practice named as tutors on their GPhC paperwork. Therefore the trainee’s GPhC final declaration sign off could have been expected to be a shared decision between the two tutors. However, this was not found to be the case. The trainees with more than

one tutor shared concerns about how the tutors worked together to review and sign off the trainees' portfolio of evidence.

*"Well I have two tutors. It doesn't quite work...she's (one tutor) somehow had not read as many of my competencies. When I went into having that review, she, she didn't know anything. I felt as if she didn't know anything about me. I don't think it was fair at the time for me not to be getting things signed off because she had not read my competencies..."PT2*

*"It's really fallen on one tutor who has read all of my evidences and the other one hasn't signed off anything really in terms of like, sending things off to the GPhC or my standards. I don't know whether if, that same tutor, would have taken a more active role if it had just been them, or if they, as there has been two of them, they knew someone else was (there)" PT5*

The lack of equal interest and responsibility between the two tutors is an interesting finding. The findings suggest that the variation in tutor input has challenged the trainees' views of professionalism through reflection on their experiences with their tutor role models.

Unfortunately I did not ask a specific question to the GPhC or tutors for their viewpoints on joint tutoring arrangements. No tutor who completed the questionnaire shared concerns in any open comment boxes about how they worked with another to come to these decisions. Nor did the GPhC talk about any reflections they have on the impact of two tutors involved in rotational pre-registration schemes.

#### **4.6.5 Tutor ability to assess**

One member of the GPhC staff welcomed tutors having training to undertake the tutor role, however they were aware of some practical issues this would involve.

*"Ideally... tutors should have some kind of assessment or assessor qualifications. Now, that would put a lot of people off (tutoring). Now pharmacy technicians, they must have an NVQ (National Vocation Qualifications) assessor to review their assessment. Now ideally that should be achieved for tutors." GPhC A*

The study identified that the GPhC do not know how individual workplace tutors make decisions regarding a trainee's sign off. Therefore tutors are independent to make decisions regarding their trainee's attainment of the performance standards and readiness for practice. This puts the focus on the tutor to make this decision.

*“In my mind about professionalism is the outcome for our trainees, the final declaration which is saying that this person is ready and fit to join the register, and, one of the things for them is to have a witness to say they have been professional during their year. What we don’t know and can’t measure is how this measured at a local level.”*

*GPhC B*

A service user also recognised the need for tutors to have support and training as part of the training programme.

*“I think a pre-reg should have a mentor. It should be part of their training system. I thought that happened already? (SU7 in question to interviewer); Yes, they do. A mentor or we call it, a tutor that is named to supervise and assess them (the trainee) over that year (Interviewer); Is there a system to help develop the tutor? (SU7)”*

The study found one tutor asked for more direction and training on professionalism for tutors. This statement could be to enhance the system rather than it being a concern about their own capability. I do not know which tutor reported this, for example if they were a first year tutor, but as all tutors that responded were current tutors with trainees, this then raises potential concerns for how this cohort of trainees were assessed for professionalism during their placement

*“It would be good to have some guidance on the subject (professionalism) and if possible some training for the tutors to know more” T1*

#### **4.6.6 Patient engagement**

Service user participants strongly expected patients to be part of the assessment of professionalism, as patients are the focus of a pharmacist’s practice. In the quote below, it was noted that several service users laughed when a probing question was asked. I did not take this laugh to be for a humorous reason, but as a marker of astonishment that I had questioned why the patient should be asked. Service users suggested that pharmacists service the patient needs and therefore feedback is required from patients on how well these needs are met. This will inform the profession about what service patients want in order to make this happen in the future and sustain pharmacy.

*“So how would you assess pre-registration pharmacists’ professionalism? (Interviewer); “Ask the patient” (SU4); “And why do you think that?” (interviewer); (Several laughs) “Well there is a mutual relationship. They are there by virtue of the other. It’s highly obvious” (SU4); “Without us you don’t have a job (SU2)”.*

#### 4.6.7 Trainee reflection

The trainees showed insight into how their professionalism had developed over the pre-registration placement by being in the workplace, interacting with patients and learning from others. This suggests that one assessment would not be sufficient as it would only capture one point in the timeline of professionalism development. It would not capture changes over time or the rate of change, nor would it identify what events brought about these changes. This indicates that several interventions or measurements during the year would be suitable to influence, monitor and judge professionalism progression.

*“Definitely at the beginning of my pre-reg I did not feel that comfortable... by, going to work every day and, you, you don’t imitate the people you are around, but you take after what they are doing and you learn to become...(PT4); I felt this happened in pre-reg (PT5)”*

This reflection by trainees into their professionalism progression proposes an opportunity for how trainees are involved in the assessment of their own professionalism development.

#### 4.7 Summary

In this chapter I have presented each of the participant groups and shared the characteristics of the groups. I have used quotes from my study participants to highlight how what they have said, has allowed areas of similarity and difference to be explored, and the analysis process to illuminate meaning.

Three key concepts identified in the data have been highlighted and discussed. The ability to define professionalism was challenged, however I proposed that a patient-centred approach demonstrates professionalism.

The challenge of how professionalism develops during the pre-registration placement and how this relates to prior learning or experiences was highlighted. It was noted that there were discrete moments when a trainee’s professionalism was felt to undergo a transformation, as well as longer time periods of gradual professionalism development. Importantly the trainees had insight into these developments. Both the transformative moments and maturation periods were reported as being needed for professionalism development. It was found that professionalism development could take place in any sector of pharmacy practice. However, it was suggested that perhaps there are different rates to

professionalism development in different sectors of pharmacy practice dependent on the level of responsibility bestowed on the trainee.

This study findings highlighted the importance of the tutor in the assessment of professionalism. Tutors identified that a trainee's written portfolio of evidence alone cannot demonstrate the trainee's professionalism development. Therefore tutors have chosen and adopted their own evaluation approaches, tools or colleague feedback mechanisms to inform this decision. Hence there is considerable difference in how different trainees are assessed for professionalism between workplace settings. This has most apparent where trainees have two tutors who had varying levels of familiarity with the pre-registration training requirements and were practicing in different health settings.

The importance of real life patient engagement in all stages of career development is highlighted and their proposed involvement in the assessment of professionalism is a critical finding.

The significance of these findings will be discussed in the interpretation chapter.

## Chapter 5 Interpretation

In this chapter, I use data from my analysis and link this to the relevant literature to more thoroughly explore and interpret the themes within my data. I identify the importance of transformation moments and maturation periods in the trainees' progression to becoming a pharmacist. My decision to include a range of stakeholders in the research project enables me to capture the dynamic nature of this progression, especially the variations in how the development and assessment of professionalism currently takes place.

This study sought to explore what is understood as professionalism within the pharmacy pre-registration year from a range of perspectives, and how professionalism is thought to be taught and assessed during the placement.

The research questions were, in the context of the pre-registration pharmacist placement;

1. What concepts of professionalism do service users, the professional regulator (GPhC), trainees and tutors hold?
2. What approaches to learning and teaching professionalism are experienced and or taken during the pre-registration pharmacist placement?
3. How are judgements made on a pre-registration trainee's achievement of professionalism in their placement?

Through analysis of my study findings, I identified several topics relating to professionalism within the career pathway of a pharmacist. However, after reflecting on my research aim I decided to focus my study interpretation on the following themes (table 5-1 p.110). I have chosen these topic areas because there are most relevant to my study questions and study context.

**Table 5-1: Research questions linking to interpretation topic areas**

Research question	Topic area for interpretation
1	Understandings of professionalism
2	Becoming a pharmacist
2	Transformative moments and maturation periods in the development of professionalism
2	Rate of professionalism maturation
3	Assessment of professionalism

I will now discuss each topic in more detail.

## **5.1 Understandings of professionalism**

### **5.1.1 The pharmacist professional**

The study found all stakeholder groups identify pharmacists are professionals and that this professional status signifies professional identity and respect. All participant groups identified trust and a safe service for the benefit of patients as aspects of professionalism.

The participants reported that professionalism is a core part of everyday practice for a pharmacist and therefore should be displayed in all their daily activities, to the same expectation regardless of pharmacy practice sector. This finding is contrary to other studies that identified the commercial aspects of selling products (Aziz et al., 2009; Rapport et al., 2010) or clinical services (Elvey et al., 2015) within community pharmacies at conflict with demonstrating professionalism. It is though important to note, that these studies were carried out after introduction of the 2005 community pharmacy contract (Connelly, 2010). Consequently the community pharmacies would have had private consultation rooms and offer a range of enhanced clinical services which may

have changed participants' perceptions of community pharmacies, seeing them as more clinical and less commercial.

All study participants expected the pharmacists' to fully understand what professionalism entailed by day one of registration as a pharmacist. This therefore assumes that professionalism is developed during the pharmacy degree and pre-registration training. However, the pre-registration year was reported as the time when learning about and developing professionalism would mostly take place. This puts greater focus on the pre-registration placement as the main opportunity for professionalism development, an observation shared in the literature (Schafheutle et al., 2012).

The first step in my exploration of how pharmacists learn and develop professionalism in their pre-registration year began by understanding what the term 'professionalism' meant to participants and if, and how, professionalism was defined within the context of pre-registration training.

### **5.1.2 Challenges in defining professionalism**

My study analysis identified that professionalism means different things to different people. Therefore I ask; is one definition of professionalism possible? The elusiveness of a definition of professionalism is not exclusive to this study (Erde, 2008).

*"I do not strive for a clear and unambiguous definition of 'professionalism' because I do not believe one is possible" (Erde, 2008, P.7)*

Erde explored the medical profession and discussed that understanding professionalism is complex. He argued professionalism contained both positive and negative influences, and it is not possible to define all these elements in one statement. Erde suggested that there is a constant struggle between these two different influences that make professionalism. Therefore, the lack of a definition, brings into question if defining professionalism is actually important and required, in other words what does having a definition bring to this debate?

All my study participants focused on the positive behaviours, skills and attitudes that a pharmacist with professionalism would show. These characteristics included:

- Doing your best for others
- Reliability
- Decision making
- Trustworthiness
- Keeping knowledge up to date
- Patient safety
- Patient/customer satisfaction
- Accountability
- Responsibility
- Communication
- Making an effort
- Being a representative of the profession
- Accurate dispensing of medicines

There is some consistency between the characteristics presented in this study, and those reported in the literature exploring professionalism (see table 2-1 p.25) and particularly the American Pharmaceutical Association of pharmacy students and the American Association of colleagues of pharmacy Council (Benner and Beardsley, 2000) definition. For example reliability, decision making, trustworthiness, decision making and awareness being part of the pharmacist profession are mentioned in both. There is also consistency between the characteristics listed above and those included in some assessment tools produced to evaluate professionalism (Christou, M. and Wright, 2011). The similarity identified between many of the characteristics reported in my study and those reported in other literature, suggests that although there is no formal agreed definition of professionalism there are working understandings of what professionalism means which have not changed over the last decade despite a definition being elusive.

However, within pharmacist training, although trustworthiness has been highlighted as a feature of professionalism; trustworthiness is not explicitly stated in any of the GPhC performance standards (General Pharmaceutical Council, 2019g). Furthermore, the revised standards for the initial training of pharmacists proposed by the GPhC do not again explicitly reference 'trustworthiness' as a learning outcome (General Pharmaceutical Council, 2019a). As trustworthiness is considered important it is of concern that it has not been stated explicitly in the pre-registration training. Interestingly, the GPhC standards for pharmacy professionals do not list trustworthiness in any of the nine standards, however the relationship between trust and the standards is made clear in the document introduction (General Pharmaceutical Council, 2017c). Therefore, I propose there could be closer mapping between the initial training standards and pharmacy professional standards, and also review of the standard descriptions and introductory information.

This study was unique in formally involving service users in a multi-stakeholder study exploring professionalism and because of this did identify one noticeable difference between the different stakeholders that varies from many definitions of professionalism. Most service users in my study viewed the accurate dispensing of medicines as a fundamental marker of professionalism. Much of the published literature seeking to define professionalism does not explicitly mention 'dispensing' as a sign of professionalism. Elvey et al., (2015) in their study exploring early career pharmacists' views on patient-centred professionalism, identified two community pharmacists, who reported dispensing accuracy as a professionalism attribute. The absence of dispensing accuracy being noted by other stakeholders in my study may be because most of the tutors, trainees and GPhC staff involved have spent more time in practice in a hospital where dispensing is mostly carried out by pharmacy assistants and technicians. Therefore, they may not view dispensing as an essential element of a pharmacist's role. Alternatively, it could be that trainees, GPhC and tutors are focusing on the newer and expanding patient facing roles and services

provided. Therefore I argue that any definition of pharmacists' professionalism must take into account the views of patients.

Pharmacists are increasingly moving away from the traditional or technical aspects of the pharmacy service, such as dispensing, to more clinically focused patient facing roles such as non-medical prescribing in a range of healthcare settings. However, that service users still view dispensing as a core professionalism role for pharmacists currently suggested that as pharmacists' roles continue to change (NHS England, 2019b), it is key to consider how patients are engaged with this process and the new forms of professionalism associated with a pharmacist undertaking a non-dispensing role. Interestingly, my study suggests that patients would welcome pharmacists undertaking more patient-centred consultations and extended services. Some service users spoke positively of non-dispensing experiences from a community pharmacy, for example a medicines use review. My study recruited the service users from a database of patients who had used NHS services in Bristol. It could be argued these service users are more informed by their use of the NHS. Yet, at least one service user was not fully aware of the developments within pharmacy practice. This may be because of the variation in extended services between pharmacies and limited advertising of what services pharmacists can offer. I argue that in defining pharmacists' professionalism the views and experiences of patients in healthcare must be considered. To explore this further I have discussed what patient-centeredness means in relation to the understanding of professionalism.

### **5.1.3 Patient-centred approach and professionalism**

The study found all the participant groups focused on patient care as the core of professionalism, but with a different emphasis. For example, the GPhC linked professionalism to patient safety; the service users associated it with customer satisfaction; tutors to communication with patients and trainees to the respect patients place in the profession. However, all these characteristics could

interlink, for example if a patient feels listened to, they may feel respected, that they had a safe service and may value the pharmacist and overall think professionalism has been demonstrated. The term patient-centred describes the collection of these aspects of professionalism.

'Patient-centred' as a term was only explicitly used in my study by members of staff from the GPhC. This may be because the GPhC are familiar with the wording and its meaning, because the GPhC as an organisation has defined and used it in other documents (General Pharmaceutical Council, 2015). Other participant groups implied professionalism would mean adopting a patient-centred approach, for example, satisfaction of the patient, without actually using the words 'patient-centred'. My study suggests a relationship between adopting a patient-centred approach and demonstration of 'good' professionalism.

My study highlighted every patient has a different life story and therefore differing expectations of what professionalism means and feels like to them. Two service users, with differing experiences of professionalism being demonstrated to them illustrated this. The first service user was a long term carer for her daughter, who had a range of complex health needs. She wished to be actively involved as an equal partner in all conversations regarding her daughter's care. The second service user knew little of the services offered by community pharmacy and was surprised to be invited to a medicines use review service with a pharmacist in a consultation room at their local pharmacy. Taken together, this shows, as Martimianakis et al., (2009) identified in relation to patient expectations of the level of involvement and decision making in healthcare choices, patients have differing expectations of what they want from pharmacy, how they wish to engage with the pharmacist and therefore how a pharmacist would show professionalism towards them.

Furthermore, my study also found a person's view of professionalism can change. For example, the service user who had taken part in the medicines use review spoke positively about the experience and how differently he now viewed

pharmacists. Therefore I argue that an understanding of professionalism is not only individual to each person but also dynamic.

#### **5.1.4 Summary**

In this section I have argued that pharmacists are professionals and require professionalism to be developed ready for day one of practice. I argue that professionalism is dynamic and fluid because professionalism means different things to different people in different contexts. Therefore one definition is neither possible nor desirable. However, there is unanimous agreement that a pharmacist adopting a patient-centred approach to practice is key to displaying professionalism. However, how professionalism is defined differs depending on which lens you look through; that of the GPhC, trainees, tutors or service users and carers. The GPhC focussed on patient safety, services users and carers focussed on patient satisfaction, trainees focussed on gaining respect and tutors focussed on communications. We need to be mindful of all of these perspectives when considering what patient-centred professionalism is.

To consider this in more detail, I now present how participants reported the development of professionalism, and discuss the importance of transformative moments and maturation periods in this learning journey.

## **5.2 Becoming a pharmacist**

In this section, I discuss the pathway to becoming a pharmacist and identify at what points professionalism learning takes place. I argue that teaching about professionalism starts at University and forms part of the undergraduate curriculum, but is fully activated during the pre-registration placement. I also propose that becoming a pharmacist is a personal learning journey for each trainee, and occurs in a series of transformation moments and maturation periods.

### **5.2.1 Aspirations to study pharmacy**

None of the trainees in this study had aspired to become a pharmacist from a young age. Instead, many of the trainees stated another person suggested to them to study pharmacy. This finding resonates with another study I carried out exploring the career development of chief pharmacists within hospitals in the South West (Ireland, 2015).

### **5.2.2 Professionalism learning: When does it begin?**

The study found there are many different ways professionalism was explicitly taught to the trainees at their University, from reading a leaflet, to attendance at case study workshops. Trainees reported finding interactive sessions involving workplace narratives a meaningful learning experience for their professionalism development. They talked about the scenario coming to life through the story and the reflection on it that the University tutors encouraged them to undertake.

The GPhC future pharmacist standards for the initial training and education of pharmacists (General Pharmaceutical Council, 2011) includes professionalism in the indicative syllabus appendix, under the sub heading 'core and transferrable skills'. Hence there is an official need to explicitly include professionalism in the degree programme. However, there is no indication as to what the GPhC understand as professionalism and how this links to other parts of the pharmacy syllabus. It is therefore reasonable that this study found varying approaches in how Universities address teaching and learning professionalism. However, it raises questions about whether this difference is important for the pharmacy student's ongoing career.

My study identified that tutors expected pre-registration trainees to commence their training placement having gained knowledge about professionalism from their undergraduate studies. Tutors would then build upon this knowledge during the pre-registration training placement, adopting a scaffolding approach to teaching. My experience with the South West NHS pre-registration training scheme, is that placements were increasingly recruiting trainees from a variety

of Universities. Universities may have different ways of including professionalism into their curriculum, therefore it is reasonable to propose trainees will start their pre-registration training with differing insights into professionalism. As tutors are seeking to scaffold the trainee's learning on the basis of what has gone before this poses a challenge for workplaces, which need to accommodate differences in their trainees' understandings of professionalism.

### **5.2.3 Becoming a pharmacist: from knowledge to identity transformation**

My data identifies that more than clinical knowledge retention is needed to demonstrate professionalism as a pharmacist. The analysis also suggests that high academic ability and the demonstration of professionalism are not automatically linked. This claim is supported by data from both the GPhC and trainee participants. It is important to note that most of the trainees involved in the study achieved a first class honours degree. However, if something more than knowledge is needed the question is raised; what is this and how can it be developed?

The GPhC has adopted Miller's Pyramid (General Pharmaceutical Council, 2011) to illustrate the progression from acquiring *knowledge* to *doing* in practice, and how this links to the assessment of the trainees' knowledge and competence in pre-registration training and the undergraduate degree programme (Figure 2-1 p.44). The pyramid depicts that the trainee would *know*, *knows how and shows how* to undertake some pharmacy tasks at University, but only during real life experience would many of the future pharmacists skills be challenged by *doing* in the real life workplace. There is the assumption with the pyramid that each step builds on the previous steps and you cannot be *doing* unless you have already *shown how* to do that skill in the classroom or via another simulated activity.

Pre-registration trainees in my study reported a personal learning transformation rather than knowledge learning during the training placement. The study findings suggest that practice-based experience, particularly involving patient engagement and working in a pharmacy team, made the trainees aware of their responsibilities, and the impact of decision making on the patient had the greatest impact on this personal learning journey.

The trainees spoke about *becoming* a pharmacist which was more than simply *doing* a pharmacist's role, but rather adopting the skills, attitudes and behaviours of those around them over time. Hammer (2006) describes *professional socialisation* as the active acquisition by a learner of the culture from the group the learner wishes to become part of. This concept is confirmed by my data with trainees talking about 'looking up' to others, making this transition over the pre-registration placement. The idea of going 'up' suggests a movement towards a higher place or level, in other words a progression.

The trainees indicated that this movement involves personal development over the whole of the placement and, from the study data, involves two types of learning. The first being moments of transformation, when the trainee experienced something that changed their viewpoint or understanding, normally in response to a particular event or realisation. The events often involved emotional connections and an awareness of personal responsibility. This extends to pharmacy education an approach to 'understanding transitions' linked to intensive learning periods previously identified within the medical profession (Kilminster et al., 2011; Neve et al., 2017). The second type of professionalism learning experience highlighted by my study involves 'periods of maturation', when skills, attitudes and confidence seem to be refined and slowly mature over a period of time. Participants suggest both are needed for successful progression to become a pharmacist. However, if *doing*, within Miller's developmental model (Miller, 1990), does not encourage or capture these two types of learning and development, then how can this change in professionalism learning be conceptualised?

Cruess et al., (2016) proposed that the emphasis on a person's professional identity formation, is strongly linked with their professionalism development. They proposed that only by a person adopting, living and feeling the values and attitudes expected of the professional group they aspire to join, does the person achieve a professional identity. Cruess et al., describe this stage as *is* and argue that professionalism is at the core of the person and how they recognise and demonstrate their professional identify. They propose that 'is' should be added as a fifth layer to the top of the Miller's Pyramid (1990). My data problematizes this aspect of the Cruess et al., theory. It does this by highlighting the difference between *doing* and *becoming*. This is a unique finding within pharmacy education.

#### **5.2.4 Tutor influence on trainees becoming a pharmacist**

From my study analysis, trainees reported pre-registration tutors had the most positive impact on their professionalism development to *become* a pharmacist. Tutors who were practicing pharmacists, and therefore seen by their trainees as providing a patient service, were reported as having the most positive influence on the trainee's professional identify progression. There are two possible reasons for this. First, they may be responding to the credibility arising from seeing the tutor actively providing pharmacy-based patient care. Secondly, they may benefit for a tutor who can appropriately support and assess the trainee because they are aware of what is needed for registration.

#### **5.2.5 Summary**

In this section I have discussed where professionalism learning begins, how this relates to the pre-registration placement, where current models of professionalism learning could be extended and the impact tutors have on the trainee becoming a pharmacist. In the next section I will discuss transformative moments and maturation periods in more detail in the professionalism learning journey to *become* a pharmacist.

### **5.3 Transformation moments and maturation periods in the development of professionalism**

In this section, I discuss in detail the unique and principal theme of developing professionalism as a series of transformation moments and maturation periods that take place during the pre-registration training year.

I used the Dreyfus model of skills acquisition (2004) (see section 2.6.5) as a framework to interpret the qualitative data and consider the impact of these findings for practice. I have chosen to apply my data to this model to explore the stage(s) a trainee may progress through during their professionalism development journey, because Dreyfus considers how knowledge is used, the impact real life may have, the complexity of decision making and proposes a role for instructors. I conclude that these topics resonate with themes presented from my data.

#### **5.3.1 Transformation moment: title of *pre-registration trainee***

Analysis of the data identifies a knowledge transition from University to pre-registration training. Trainees viewed knowledge as the focus of University, with the emphasis on gaining and cramming as much knowledge as possible. High knowledge achievement corresponded with high academic grades and poor knowledge led to poor academic marks. Poor marks were seen to directly and negatively affect the student only. My study established that students found patient encounters and simulated consultations at University unreal and therefore they did not act as they would have done in practice, because it was not authentic. In real world environments, students lacked the confidence to talk to patients. Applying the Dreyfus (2004) model suggests the pharmacy student is at the novice step because they have context free knowledge, are detached from any commitment to the individual and rely on rules to make decisions. In other words, a pharmacy student has clinical knowledge but could not necessarily translate this into action when speaking to patients in the real life context.

My data confirms one pivotal transformative moment that triggers a change from the novice stage to advanced beginner, which is when the trainees are called *pre-registration trainees* and not *students*. Dreyfus (2004) highlights the advanced beginner as one who begins dealing with real situations and developing insight into the practice context. For the trainees in this study, the first time they were given the title of pre-registration trainee was considered a threshold moment and an important 'step up' in their responsibility from being a student. The transition was viewed as a threshold between University, when the person is self-centred and the risks of poor knowledge performance would only have an impact on themselves, to being a pre-registration trainee and beginning to have some responsibility and accountability for the wellbeing of others in the clinical setting. In other words, the trainees undergo a realisation that their focus can no longer be exclusively their personal academic achievements but must now also encompass patient-centred care.

Trainees reported that their career did not start until their pre-registration placement. This is an interesting comment, suggesting that gaining the title of *pre-registration trainee*, and thus being formally recognised and identified from within and outside the profession as training to be a pharmacist, is a significant transformative moment.

The trainees reported that having a title was unfamiliar. This could signify that they did not feel ready for this transformation or that they had not previously thought about the impact the title would have on their view of themselves or their role in the pharmacy team as a *pre-registration trainee* compared to a *student*.

However, my study identified that tutors were well aware of the importance of the title *pre-registration trainee* and its impact on trainee's professionalism development. A tutor commented that this transformative moment would be lost if the *pre-registration trainee* title was not used. There were comments about how students and trainees are treated differently. The tutor did not expand on who, when and how others would treat the trainee differently but there was a

suggestion that a trainee would be disadvantaged if they were referred to, or treated as, a student during their pre-registration placement. This is an important consideration for those trainees currently undertaking a split pre-registration programme offered by the University of Bradford, and should also be included in any further debates around the integration of the undergraduate training and pre-registration year for all training places (Smith and Darracott, 2011; General Pharmaceutical Council, 2019a).

As discussed above, my study suggests the importance of referring to a person on a pre-registration placement being as a *trainee* to optimise this transformative moment. This is in contrast to the term *student pharmacist* referred to within the proposed new GPhC pharmacist training standards (General Pharmaceutical Council, 2019a). A possible solution to this could be to change the proposed term from *student pharmacist* to *trainee pharmacist*.

There is something highly significant about the moment the pre-registration trainee is given their title. The change in title signals an identity shift away from student and towards pharmacist and initiates the development of professionalism required to complete their career pathway. Although the title of pre-registration trainee is the catalyst for this change in professionalism development, a pharmacist is not created in this moment. Instead other transformation moments and periods of maturation contribute to shaping the person as they progress on their professionalism journey.

### 5.3.2 Transformation moment: Awareness of knowledge limits and emotional connection

My study identified that, as the pre-registration training year progresses, the trainees demonstrated insight by discovering that pharmacists do not and, crucially, could not know everything about medicines for every event. There was an acceptance by the trainees that they cannot have an answer for every eventuality they may come across in daily practice. Importantly, the trainees showed that by being aware of these knowledge limits, they were also conscious of taking responsibility to act on the knowledge gaps and times of uncertainty. The importance of this awareness to act was linked with an emotional connection with the patient for whom the trainee was providing care. The realisation of knowledge limitations, combined with the need to act responsibly for the wellbeing of others, was a powerful transformative moment for the trainees in my study and influences how they progress with their professional learning. I argue this is the transformation from an *advanced beginner* to a *competent* trainee Dreyfus's model (2004) identifies.

The competent classification of the Dreyfus model describes an individual who has more involvement in the workplace and realises there is not a rule for dealing with each encounter and therefore they need to evaluate and decide on a course of action. The competent level also recognises the learner will need the guidance from a supervisor to tutor. The trainees in my study spoke about the current need to seek help from others in the workplace. This awareness highlights that this cohort of trainees, had progressed to the competence stage of the Dreyfus model by the tenth month in their training year, and may have not reached a more independent proficient stage when tutor guidance would not be needed.

Next I discuss in detail how a trainee independently makes decisions in practice regarding a patient's care and how this relates to a further transformation moment in professionalism development.

### 5.3.3 Transformation moment: Practice rules, decision making and patient-centred professionalism

My study confirms current knowledge that there cannot be a rule for every clinical encounter and also occasionally practice based rules may not and should not be followed in order to demonstrate patient-centred professionalism. Elvey et al., (2015) explored professionalism viewpoints in early career pharmacists. They identified practice situations:

*“Where following the rules might not meet the individual patients’ needs” (Elvey et al., 2015, P. 420).*

My data identified an important debate between the participant groups around decision making and demonstration of professionalism. As the healthcare expert in medicines, pharmacists frequently experience situations that challenge their clinical skills, ethical principles and legal understandings when providing best patient care. In practice, the GPhC regulatory standards (General Pharmaceutical Council, 2017c), RPS professional standards (Royal Pharmaceutical Society, 2019b) and standard operating procedures within a pharmacy direct a pharmacist to know what action to take. Yet, the complex nature of practice may mean that these documents cannot cover explicitly what to do in each and every event but rather provide a framework to help with making these decisions (GPhC, 2018). To complicate matters further, the option directed by the documents may not always be in the patient’s best interests and would therefore be an action a pharmacist may not want to take. For example, should a pharmacist refuse to dispense an end of life medication on a Saturday afternoon because the prescription has minor technical errors and they cannot access the prescriber?

Interestingly the study highlighted some differences with respect to how pharmacists should respond in these situations, which is a further indication of how dynamic and situated definitions of professionalism are. Tutors stated that any outcome decision trainees make must come from within the limits of the legal framework. In contrast, participants who work at the GPhC and service

users reported that it may be a reasonable and professional action for a person to go outside of the legal limits if they were acting in the patient's best interest.

No trainees in this study spoke about situations when they may have considered not adhering to practice standards to deliver patient care. A possible reason for this could be that by the tenth month in their training they had not had to deal with such a situation independently.

The impact of these findings is to challenge how trainees are prepared for day one of registration as a pharmacist when they may be presented with situations where professionalism is challenged (Elvey et al., 2015). My study findings show that the daily practice of a pharmacist is varied and may get more so with the increasingly clinical and autonomous roles pharmacists are undertaking. Therefore pharmacists will not know in advance how to respond in every situation and therefore must learn how to exercise flexibility in decision making and be able to justify their decision. A possible solution could be to encourage the trainees to make emotional connections during their placement to decide if and how practice based rules should be followed in complex situations. This interpretation is based on the service user who described health practitioners who stay within practice rules for fear of being professionally reprimanded. As discussed, a pharmacist may need to go beyond their fear of personal criticism to be able to potentially give a patient-centred service.

#### **5.3.4 Period of maturation: Professional socialisation**

I argue that there are periods of maturation during the pre-registration placement when trainees slowly develop and enhancing their skills within the workplace setting. My study findings suggest these maturation periods take place by being within the working environment every day, observing and being part of different scenarios.

The analysis reported that real life experience, ideally involving patient engagement, had the most positive impact upon the maturation of professionalism. Although a range of different approaches to developing

professionalism such as reflection, class room based case studies and observation, were reported as being useful; real life was highlighted as the most important influencer. This correlates with findings in the literature (Rutter and Khalid, 2010; O'Sullivan et al., 2012; Schafheutle et al., 2012).

The reasons for lived experience having such impact could be the exposure to different events in the workplace, together with support from more experienced colleagues, to develop the trainees' confidence and ability to deal events they will encounter in their working lives. This reasoning is based on a trainee who described in detail the challenges of talking to patients at the start of their pre-registration training year and how the routine of going to work each day enabled them to learn from others to develop their own practice-based approach. Interestingly the focus on learning how to deal with situations after working with senior colleagues and the impact of being in daily real life practice was stressed by the trainee as being important. Other trainees and tutors also identified these two elements for the development of professionalism.

My analysis showed the importance of the workplace mentors to help nurture and guide the trainees before and during this advanced beginner stage. Dreyfus does not explore how the workplace mentors could potentiate or hinder the advanced beginners' learning and development. However, Lave and Wenger (1991) propose how a community of practice facilitates this learning process. Lave and Wenger, describe that by a social interactive process a person (in my study this would be the trainee) joins a community. They may initially undertake less important tasks, but as they become more skilled and competent the person will move to a central or full participatory role. An important aspect of the community of practice model is the support mentors provide to help the learner with their skill development. The mentor could do this in two ways, firstly by facilitating the learner to create their own rules to undertake tasks. Secondly the mentor decides what complexity of task is given to the learner at any time.

I argue the community of practice phenomenon explains the meaning behind the comments the trainees involved in this study made on the importance of

work place mentors early in their pre-registration training, or at the *advanced beginner* stage, to facilitate their development.

The community of practice theory offers a framework for understanding how healthcare staff will develop their professional identity and therefore professionalism from role models who process the professionalism the learners wish to acquire (Cruess, R.L. et al., 2018b). Through a social and enculturation experiential process that occurs in the community of practice, I propose, the trainees learn how to *become* the pharmacist they have aspired to be. The trainees legitimately participate in the community by initially undertaking peripheral activities to, over time, full roles. Therefore the learner not only acquires knowledge and skills but also adapts themselves, through enculturation, to *become*, belong and identify as the community (Morris, 2018; Cruess, R.L. et al., 2018a). Although within the field of medicine, Cruess, R.L. et al., (2018b) suggest curriculum design ideas, such using participation and reflection, to potentiate how community of practice theory can assist with professional identity development. I argue this has important implications for considering how professionalism is developed and also assessed during the pre-registration placement.

I particularly identify the significance of this finding on how to involve trainees in a community of practice in the context of increasingly more trainees undertaking rotational placements, where trainees are enculturated into many different teams or communities of practices, but may not be part of any team for long periods of time. It may be possible that the trainee does not have sufficient time to be accepted and is unable to embed and establish themselves in more than a peripheral role before rotating to another community of practice. A possible solution could be, when trainees rotate round several pharmacy sectors, they return to each setting later during their training. This means the trainee has the opportunity to reconnect with a community of practice they were previously part of and build upon the skills they had developed in that community.

### 5.3.5 Period of maturation: Personal reflection

My study findings highlight that tutors expect trainees to undertake reflection during their pre-registration training to mature their professionalism. The GPhC require the trainees to produce a portfolio of evidence mapped to the GPhC performance standards (General Pharmaceutical Council, 2019d). This portfolio inherently encourages reflection on practice as part of the portfolio building. My results show that eight tutors “very often” or “always” report the portfolio as helping towards professionalism development. As portfolio building is a GPhC requirement and twelve tutors took part in the questionnaire; why did not all twelve tutors report the portfolio as helping towards the trainees’ professionalism development? One possible reason for this was suggested by my study findings. Some tutors stated that some trainees find talking, rather than writing, about their reflections more helpful for their professionalism development. The idea of discussing their reflections implies another person is actively involved in the dialogue. I suggest this could be the tutor. The GPhC welcomes a range of evidence types, for example written, observation, witness or discussion, could be included in the portfolio to provide the best reflection of the trainees’ development (General Pharmaceutical Council, 2019d). However, this study did not explore if the professionalism conversations were included in the portfolio of evidence. Therefore I suggest if the portfolio of evidence is not sufficient to formally capture this professionalism development, is another method needed? Or, alternatively is it reasonable that the trainees’ GPhC portfolio will not contain reference to all the transformative moments and maturation periods that take place during the placement?

From 2018, registered pharmacy professionals need to undertake a new process of GPhC revalidation to continue their registration (General Pharmaceutical Council, 2018b). The new system involves peer discussion, which the GPhC defines as

*“A learning and development activity that encourages you to engage with others in your reflection on learning and practice. Research*

*shows that having another person's view can help pharmacy professionals to reflect on their practice" (General Pharmaceutical Council, 2018b, P.10)*

I reason that peer discussions are informally taking place during the pre-registration year. Although I accept there are differences in the peer to registrant relationship for GPhC revalidation compared to the tutor trainee relationship during pre-registration training. The most notable difference being the tutor is a senior role to the trainee and trainee rarely chooses their tutor whereas a registrant can choose their peer. However, guided reflection is now an accepted part of pharmacy professionals revalidation. Therefore I suggest that the peer discussion approach and documentation should be used and included in the pre-registration portfolio.

### **5.3.6 Challenges in using the Dreyfus model in the context of pharmacy practice**

I have used the Dreyfus model (2004) to illustrate and challenge how professionalism is developed during pre-registration training. Overall, I think the model is a useful comparative framework. However, there is one area where pharmacy practice differs from the contexts described in the model. Dreyfus uses a range of examples to explain the actions a person would do in each of the stage of skill acquisition, with a car driver and chess player often being described. I argue that pharmacy learning and practice are not as simple as driving a car and playing chess. I reason this is because of the patient-centred approach at the core of professionalism. If professionalism can be understood as taking a patient-centred approach then the patient or carer's viewpoint must also be included in the decision making process. Relating this finding to the Dreyfus model (2004), I argue that as the trainee enters the competence stage, and begins to challenge accepted rules, the trainee should explore, with their tutor, how the patient and their carer wishes to be involved in their care. By adopting this practice, the trainee will be able to prioritise options in the decision making process and ensure the outcome is patient-centred and demonstrates

professionalism. Furthermore, it is important not to lose sight of my use of the Dreyfus model to develop professionalism, and not for other learning such as decision making skills. In other words, decision making is linked to one transformation moment which is part of a several transformative moments and maturation moments that underpin professionalism development.

Other studies have challenged the use of stage models, such as Dreyfus, as lacking clarity over what is to be learnt and also focus too greatly on achievement of the individual stages rather than the longer term learning (Dall'Alba and Sandberg, 2006). I think that although it is important to critically evaluate frameworks used to help understand relationships within data, for the purposes of interpretation of the pre-registration placement, I argue the Dreyfus model is an appropriate initial tool. However, if a study aimed to explore professionalism development from pre-registration through to consultant level pharmacist practice, then further critical review would be needed to explore if the Dreyfus model was the most appropriate framework.

### **5.3.7 Summary**

My study suggests there are two different ways professionalism identity and learning takes place during the pre-registration year; transformation moments and maturation periods. I used the theory of enculturation into a community of practice (Cruess, R.L. et al., 2018b) and the Dreyfus model (2004) as frameworks to inform and discuss the relationships and meaning found in my data. Use of the Dreyfus model in particular has helped to unpick the different transformation moments that happen for a trainees to progress in their professionalism learning from an advanced beginner at the start of their pre-registration, to competent towards the end. I argue that understanding transformation moments and maturation periods in more detail may help us to appreciate the trainee's stage of professionalism development and what may have retrospectively and prospectively could or should influence this learning.

In the next section I consider what factors may progress or hinder a trainee's professionalism maturation in practice.

## **5.4 Rate of professionalism maturation**

### **5.4.1 The relationship between different sectors of pharmacy practice and professionalism maturation**

My study data reported difference in the rate of professionalism development between sectors of pharmacy practice. My study found community pharmacy, compared to hospital practice, was highlighted as maturing professionalism within the trainee at a faster rate. This is an interesting finding, because pharmacists from community pharmacy have previously expressed concerns about how they have struggled to demonstrate professionalism due to work force pressures and demands (Rapport et al., 2010; Elvey et al., 2015).

There are several possible explanations for this finding. It could be that the workforce pressures faced by community pharmacist tutors provide opportunities for the trainee to work alongside them to undertake some activities or take on more responsible roles sooner than in other settings, enabling the trainee to develop professionalism at a quicker rate. Alternatively, trainees within community pharmacy normally work within a smaller pharmacy team than they would in a hospital pharmacy. Therefore the community of practice a trainee enters is much smaller, allowing professional socialisation processes to be more focused, enabling the trainee to adapt and adopt the culture of the group more quickly. Or, perhaps, it could be that trainees in community pharmacy enter the group at a more participatory and central role to the group and therefore reach an expert level of practice sooner. Finally, it may be that, as Johnson et al's., (2015) study exploring professionalism within primary care found, relationships built up with a regular patient group over a long period of time result in greater emotional connections to the patients, increasing the rate of professionalism development. It may, of course, be a combination of these reasons, or another reason(s) that my study did not uncover.

#### **5.4.2 The relationship between a rotational pre-registration scheme and professionalism maturation**

My study did find that rotational pre-registration programmes were welcomed by the GPhC and tutors because they help professionalism mature in the trainees. The principle of being involved in real life care in different sectors allowed trainees' knowledge and decision making to be challenged in different ways and for them to experience alternative practice-based issues. I propose that the variations in experience mean the trainee is aware of their knowledge limitations sooner, which leads to a faster rate of professionalism development. Therefore it is likely that a pre-registration training scheme with different sectors of care will have a positive impact on professionalism development.

My study has suggested trainees who have rotations in community pharmacy practice, within their pre-registration programme, mature their professionalism development at a faster rate. Yet, it is important to highlight that other settings, such as General Practice, mental health trusts, clinical commissioning groups and prison pharmacy were not discussed in detail in my study.

However, my study also identified that some trainees may take longer to mature their skills than other trainees. The staff from the GPhC reported examples of some trainees struggling with the maturation of some skills, such as empathy, and consequently needed a longer pre-registration placement. A possible explanation for empathy being given as an example by the GPhC could be related to the time the trainees need to develop an emotional connection and take responsibility for their interventions for the patient in that setting.

An alternative way of understanding this is that the periods of maturation in professionalism development involve reflection and personal learning from the trainee. It could be that not enough experiences have occurred or support and support from their tutor to reflection during short placements to enable them to have an impact on their professionalism development.

One area of the rotational pre-registration programmes that my study explored centred on the impact of having two tutors in differing training sites and the impact of this on the trainee's development. I discussed this in detail in section 4.6.4. All of these considerations are important as they indicate where challenges to professionalism development may exist, for example whether too many rotations may negatively influence professionalism maturation, and how the trainees' professionalism learning journey is supported across different workplaces.

Therefore, I propose that there might be a threshold, or minimum amount of time required in each setting for a trainee to adapt to that setting and progress with their professional socialisation and learning. The exact time, and in which setting, was beyond the scope of this study. However, my study opens dialogue about this area of the pre-registration training programme design. This is particularly important as trainees may undertake pre-registration placements over different sectors of practice and there is increasing support for a five year degree with the 52 week pre-registration placement potentially, divided into smaller amounts of continuous time and spread throughout the five years (General Pharmaceutical Council, 2019a).

#### **5.4.3 The relationship between patient contact, increased responsibility and professionalism maturation**

My study found a direct relationship between patient contact and level of responsibility placed on the trainee, and the rate of professionalism development. Those trainees who had more patient contact and were given increased responsibility were reported to mature their professionalism skills at a faster rate. These findings align with the Dreyfus's model (2004) regarding the development from an advanced beginner to a competent practitioner something Dreyfus ascribes to emotional connection to the real world and responsibility for real patient care.

I argue that this finding has implications for the design of pre-registration training programmes which should include regular and real patient contact learning experiences from the very start of pre-registration training. My reasoning for this is based on some of the trainees' reflections, in which they described how these early experiences were challenging but facilitated their professionalism development and also provided a reference point for them to reflect back upon and note how they had changed.

I also recommend tutors, educators and the GPhC should consider what patient facing activities trainees undertake and how a trainee can emotionally engage with patients' care and therefore progress with professionalism development. Pittenger et al., (2016) explored new ways of developing and the assessment of pharmacists in training within the American health system. The authors proposed a number of entrustable professional activities (table 5-2 p.136) that provide a competence framework to describe the activities any pharmacist would be expected to do at differing levels within any pharmacy setting at different time points over their training.

**Table 5-2: Examples of some entrustable professional activities and level expected an end of year 2 Doctor of Pharmacy degree student will achieve, as proposed by Pittenger et al., (2016, P.4)**

Entrustable professional activity	Level 1	Level 2	Level 3
Develop a patient-centred therapeutic plan.		X	
Provide effective oral communication with patient and other healthcare providers.		X	
Exhibit professional behaviour			X

The American Association of Colleges of Pharmacy has embraced entrustable professional activities and collaboratively developed a series of core basic activities that they reason any recent pharmacy graduate must be able to undertake without supervision in any pharmacy practice setting (Haines et al., 2017). The authors state that professionalism rather than being a standalone concept is embedded and central to every entrustable professional activity, and argue that without professionalism being present each entrustable professional activity would not take place. These core entrustable professional activities therefore provide a consistent standard not only for university teaching and assessments but also for employers of new graduates regarding the baseline skill set their new pharmacists will have achieved.

Within pharmacy in the UK, entrustable professional activities are being incorporated into some undergraduate degrees to potentiate the quality of practice based learning (Hanning, 2017) and develop professionalism (General

Pharmaceutical Council, 2018c). However I am not aware of any pre-registration scheme to date that has embraced and developed entrustable professional activities for the placement scheme. With the GPhC consulting on new approaches to the preparation and assessment of trainees for registration, now is an opportune time to explore how entrustable professional activities could be used to develop and assess professionalism in a robust manner across all pharmacy practice settings. I recommend that the entrustable professional activity statements produced by the American Association of Colleges of Pharmacy (Haines et al., 2017), together with the themes of transformation moments and maturation periods presented in this study, could be used as a starting point for further development as part of the pre-registration placement scheme

#### **5.4.4 Summary**

My study draws attention to the rate of professionalism development across and between different sectors of pharmacy practice during the pre-registration year. This study found that placements in community pharmacy, placements with frequent opportunity for patient engagement, and placements with a reasonable time to allow trainees to emotionally connect with patients and colleagues, will increase the rate of professionalism maturation. The development of entrustable professional activities for the pre-registration placement is proposed as framework to provide a structured approach to developing professionalism in the workplace.

## **5.5 Assessment of professionalism**

### **5.5.1 General Pharmaceutical Council registration exam and assessment of professionalism**

In this study tutors reported that the GPhC registration exam would not assess professionalism and that only the workplace element of pre-registration training and review the trainees' professionalism development. The GPhC also recognised they would like to know more about the approaches used by tutors when making judgements about the final sign off declaration for their tutees. Taken together, these conclusions show the importance of tutors in the assessment of the trainees' professionalism.

### **5.5.2 Tutors in the assessment of trainee professionalism**

The study found all tutors viewed the assessment of their trainees' professionalism as a part of their role and a key part of their responsibility. Also, the study identified that concerns about professionalism were cited by tutors as a main reason for not signing off their trainee for GPhC registration. Taken together, these findings reinforce the responsibility and power the tutors have over the trainees' career progression and how central professionalism maturation is to this process.

The study participants unanimously agreed that professionalism was a core and crucial part of being a pharmacist, so why was there such variation, from a 'gut feeling' to objective measures, in how professionalism was assessed? One reason could have been that many tutors do not use the GPhC performance standards to assess professionalism. Over half of the tutors stated that the performance standards alone, as they are currently, are not appropriate to assess professionalism. A possible explanation for this could be the lack of how professionalism links to the performance standards, as well as different perceptions of what professionalism entails. These could also be the reasons why no tutors reported using other pharmacy specific tools aimed at assessing

professionalism in a standardised manner (Christou, M et al., 2011). Therefore tutors are developing other approaches to assess professionalism.

The GPhC standards for the initial education and training of pharmacists adopt Miller's pyramid (Miller, 1990) to describe how each of the section 10 learning outcomes will be assessed during pre-registration training (General Pharmaceutical Council, 2011) and in the proposed new pharmacist training standards (General Pharmaceutical Council, 2019a). Miller's pyramid is a popular and influential framework for assessing clinical competence. It proposes four hierarchical stages, with 'knows' at the base, then 'knows how', 'shows how' and 'does' (Miller, 1990) (see figure 2-1 p.44). *Does*, or showing independent practice in the workplace, as the apex of the Miller's pyramid, is frequently used to describe the desired outcomes. However, this study identifies that tutors report the current performance standards, and therefore the mapping to the four stage Miller's pyramid, is not sufficient to assess professionalism demanded in daily practice as a pharmacist. The tutors indicate that the *does* apex of the Miller's pyramid fails to fully capture the values and attitudes that are part of *being* a professional. Therefore the GPhCs dependence on the Miller's pyramid could be seen to be hindering the formative and summative assessment of professionalism. As there is a current GPhC consultation on changing the initial education and training standards of pharmacists (General Pharmaceutical Council, 2019a), there is timely opportunity to explore if and how alternative assessment frameworks and/or amendments to Miller's pyramid could be undertaken to inform judgements on a trainees professionalism achievement. This study particularly supports entrustable professionals activities, previously discussed, and the work presented by Cruess et al.,(2016). Cruess et al., (2016) proposed that a fifth stage be added to the Miller's pyramid (1990) to describe achievement of professional identity. The fifth stage, *is*, illustrates someone who consistently demonstrates the values, attitudes and behaviours of that profession. As highlighted, the trainees and tutors in my study talk about the transformation and professionalism maturation process that

takes place over the whole of the pre-registration year leading to the trainee *becoming* a pharmacist. My data supports this aspect of Cruess et al's., theory. Cruess et al., do not state how *is* can be assessed but suggest that it will be difficult to assess directly and may involve observation of behaviours and feedback from members of the community of practice within which the learner is developing their professional identity.

An explanation of or solution to the challenge with how to assess *is* could be seen in the diversity of the approaches tutors in my study used to evaluate professionalism. Some tutors have either used their personal judgement, or have chosen several methods to help them with this process. My study highlighted that several tutors involved other the members of the pharmacy team to help them with their assessment, in structured and unstructured ways. The assumption was that because the tutor cannot be, and maybe should not be, with the trainee at all times, others within the team should feedback on the trainees' professionalism progression. For example, one tutor held a week 39 meeting with all those involved in the training programme to discuss the trainee. In summary, these findings suggest that involving others in the decision making is a valuable element of judging a trainee's professionalism.

However, trainees wanted one tutor to make the overall assessment of professionalism.

#### **5.5.2.1 Two tutors involved in the judgement on professionalism**

Two of the trainees involved in this study were undertaking rotational training schemes. These trainees had two tutors, with, for example one tutor in a hospital setting and one in community. The trainees reported that joint tutoring provided challenges for them as learners as some tutors did not take an equal role in the professionalism development of the trainee. The trainees gave examples of tutors not being aware of what assessments needed to be undertaken or the importance of the assessments. The suggestion from the

trainees was that this negatively influenced their view of the tutor(s) as professionalism role models.

In the GPhC joint tutoring arrangement, one tutor is a 'lead' and another a 'support' tutor. The learning contract that accompanies the tutoring form, describes the agreement made between the tutors and trainee (General Pharmaceutical Council, 2017a). The tutor declaration is the same, regardless of whether the tutor is in the 'lead' or 'support' role. Therefore it is a reasonable assumption that both tutors show an equal level of interest in the trainees' development and are responsible for carrying out reviews. However trainees reported this was not the case; with one tutor mainly assessing and giving feedback to the trainee. The trainees spoke negatively about the tutor who showed less interest in their development and reported concerns that this may have had a harmful effect on their professionalism progression.

Importantly, one trainee spoke about one of their tutors not knowing anything about them. This reflection by the trainee perhaps suggests that an emotional connection between the trainee and tutors(s) needs to take place to enable the trainee's professionalism journey to be understood. In other words, the tutors understand the transformation moments and maturation periods the trainee has experienced as part of their professionalism development during their pre-registration. Without knowing the trainee, the tutor would not be able to make judgements on the trainees' professionalism progression to become a pharmacist.

As more rotational pre-registration programmes are developed trainees may have a designated tutor at different training sites and consideration is needed as to how tutors work together supporting and assessing their trainee. Tutors report that formative assessment and feedback to trainees is pivotal to professionalism development, therefore, it is essential that both tutors work as a team to help their trainee.

As the tutor questionnaire was anonymous it is unclear if anyone who jointly tutors took part and, if so, whether their insights into how professionalism was judged differed from sole tutors.

An alternative solution to help quality assure and support tutors with the assessment of professionalism, would be to require all portfolios to have an independent check of evidence and feedback given. HEE has undertaken a pilot study using a panel to remotely review trainee portfolios (Health Education England, 2017). It was hoped this process would allow for a consistent minimum check that trainees are undertaking activities that would enable them to demonstrate professionalism in the work place and, additionally, the nature of the tutor assessment of this activity. However, the panel review process was only a pilot and many pre-registration training places nationwide are commissioned outside of HEE funding and without e-portfolio's. Furthermore, it has been identified that the portfolios may not always reflect the trainees' full professionalism development, for example some verbal reflections shared by a trainee with their tutor were not documented. Therefore consideration needs to be given to how to encourage trainees to make the portfolio fully reflective.

#### **5.5.2.2 When do tutors assess professionalism?**

The only tutor in this study to specifically state a timeframe for their assessment of their trainees' professionalism reported that this was at week 39. As the number of rotational programmes increase, with trainees undertaking shorter placements across different clinical settings and under the supervision of a variety of workplace mentors, there is a greater need to have structured and timely feedback processes designed into the timetables. A way to do this could be the inclusion of a comment box on the quarterly progress report form for the tutor(s) to feedback specifically on the trainees' professionalism development (General Pharmaceutical Council, 2019d). This suggestion correlates with other literature that suggesting professionalism should be assessed throughout placements (Kelley et al., 2011) and include both formative and summative elements (Elliott et al., 2009).

### 5.5.2.3 Tutor training for the assessment of professionalism

My study highlights that tutors have a vital role in the development of the future pharmacist workforce yet; there is no formal requirement for training or assessment of a tutors skills to undertake this role (General Pharmaceutical Council, 2019f). The GPhC has a tutor development resource, which provides suggestions on preparing to be a tutor, supporting and assessing the trainee (General Pharmaceutical Council, 2017b). However, use of the resource is not mandatory and none of the tutors involved in this study voluntarily mentioned the resource in the e-questionnaire.

The study highlighted that the GPhC only would welcome a formal accreditation process for pre-registration tutors, to bring them in line with other areas of the pharmacy, for example pharmacy technician training. The assumption was that this accreditation for tutors would potentially drive up the quality of the training offered to pre-registration trainees. However, the GPhC highlighted in my study that a formal application route for tutor training and assessment may deter some people from the tutoring role. This dilemma is not restricted to pharmacy education. Mills et al., (2013) in their study exploring medical foundation training stakeholder's experiences, emphasise the vital role played by clinical education supervisors in quality management systems.

*“The selection and performance management of clinical education supervisors remained an area that was problematic... those who teach and assess learners must be formally recognised and allocated the necessary time to undertake this work”. (Mills et al., 2013, P.80)*

However, the authors offer some caution in order to not deter people from stepping forward to be tutors. Jee et al., (2016) also recognised that there is no formal qualification or training needed to become a tutor and proposed that regardless of the sector a tutors is in, consideration should be given to how to train and support tutors in this role.

As all the tutors that participated in my study were current tutors and actively judging their trainees; there is an urgent need to have a deeper debate on how

tutors are prepared for their role, how trainees are assessed for professionalism and if there is more that could be done to support this.

One possible solution could be for tutors to use the peer discussion framework found within the GPhC revalidation process (General Pharmaceutical Council, 2018b).

The benefits of pharmacy education staff reflecting on the support they provide their students has been reported by Akiyode (2016). She explored how faculty staff within American pharmacy schools taught professionalism and highlighted faculty should engage with self-reflection to be able to better support the pharmacy students. The GPhC peer discussion requires the individual to share and discuss their reflections with another person. I would encourage the GPhC to consider whether future changes to the revalidation policy should include the requirement for all tutors to use the peer reflection in revalidation to reflect upon their learning and development with respect to their tutoring role.

Since the data for this study was collected, HEE has worked with CPPE in the South West to commission voluntary tutor training events for tutors from any pharmacy sector (Centre for Pharmacy Postgraduate Education, 2019). The workshops have sought to develop the tutors' planning, assessment and feedback skills. Although assessing professionalism was not stated as an intended learning outcome, it could be argued professionalism underpinned the course programme, for example the workshop included the assessment of evidence in portfolio. I am aware an independent evaluation of the workshops is taking place. It will be interesting to see whether the tutor feedback from this event makes any links to professionalism development.

### **5.5.3 Trainee reflection on their professionalism**

My study found that the trainees had insight into their professionalism development and maturation by the tenth month of their training placement. The trainees spoke about being aware of the transformation they have undergone

from being a student to wherever they are on the professionalism learning journey to become a pharmacist.

This finding explains that the trainees involved in this study have a personal awareness of their professionalism. A possible explanation could be the trainees have a good insight into reflecting back and considering how this relates to their current knowledge, perceptions, skills and attitudes. I propose that this self-realisation of their identity change from being a student to becoming a pharmacist, is vital in the transformation and maturation of their professionalism. Neve et al., (2017) also problematized this concept in their study exploring professionalism understanding in medical students. The authors proposed that peer reflection together with audio-diaries, provided a safe space for students to discuss their experiences and the impact this had on the future professional role they wished to undertake. Neve et al., also suggest that providing the space, time and structure for the students to reflect helped them progress with thresholds of professionalism learning.

Cruess et al., (2016) stated the assessment of *becoming* would be difficult to measure and may need a different and more complex approach to the assessment of *does* for example. A possible solution for this assessment could be to ask the trainee to reflect and share their understandings and how they feel their development to become a pharmacist has progressed. My study found that some tutors reported trainees often did not wish to write reflective accounts in their portfolio of evidence, but rather having a reflective conversation enabled the trainee to talk through their perspective. I suggest that the GPhC peer review process for revalidation, which links to the standards for pharmacy professionals, could be used as a template to help structure these reflective conversations. I also highlight that use of e-portfolios provides the digital opportunity for trainees to upload an audio-diary of their own verbal reflections. Trainees should be encouraged to produce personal reflective accounts in this format. I propose that the trainee's response in both the reflective conversation

and audio-diary may provide insight into the transformations moments and maturation periods the trainee may have personally undergone.

#### **5.5.4 Service user feedback in the assessment of trainees professionalism**

The analysis reports that service users expect to be involved in the professionalism assessment of pre-registration trainees, but this was not found to be the case in practice. None of the tutors or trainees actively reported that service users contributed to the assessment of professionalism. Other studies have explored the development of patient-centred professionalism within pharmacist (Elvey et al., 2015), but did not include service users. Therefore, because of this study's unique design, this has led to this novel knowledge that patients expect to be included in the assessment of trainees' professionalism.

The General Medical Council (GMC) currently requires all doctors to receive formal formative feedback from patients, or those who used their service, and to reflect upon these comments when they revalidate their practice. The GMC state that involving patients and/or service users

*“Will help you understand their experience as a patient and how they view your practice. Reflecting on this type of feedback will help you identify changes you need to make to your practice to improve the care or services you provide. It will also allow you to identify your strengths so you can build on these further” (General Medical Council, 2018a, P.20)*

The GMC provide a sample questionnaire for doctors to give to patients (General Medical Council, 2018b). This questionnaire asks the person to provide feedback on a range of factors relating to the patient's experience with the doctor. It is important to note that some questions asked about the doctors' trustworthiness, communication skills and how involved the patient was invited to be in the consultation. I argue that there is a link between these markers and the indicators my study found as demonstrating patient-centred professionalism. However, what impact has feedback from patients had on the doctors' professional development?

Baldie et al., (2018) reviewed published studies between 1971 and January 2015 exploring the use of patient feedback within medical primary care practice. Baldie et al., concluded by recognising a range of factors that affected if and how patient feedback made any impact on the practitioner or team. These factors included the staffs' view of feedback and the type of data collected. It is important to note, that patient evaluation included in the Baldie et al., study was based mainly on the general feedback reports, for example practice questionnaires, rather than comments given as part of the revalidation process. Therefore, the comments could have been more general, for example about the surgery setting, rather than the experience they had with the doctor and hence the positive impact of the patient feedback was limited. Also the study only involved the medical profession, so it is unclear if the results and the impact made would be applicable to trainee pharmacists.

Within pharmacy, the GPhC does offer that patient feedback could be included in a trainees portfolio as a witness statement (General Pharmaceutical Council, 2019d), however there is no explicit need to include any patient feedback. Likewise, with GPhC revalidation, an expert patient is stated as a possible option to have a peer discussion with, but patient involvement in any stages of the revalidation is not mandatory (General Pharmaceutical Council, 2018b). It appears from my study that patients are not regularly and routinely involved in the assessing the trainees' professionalism, but, a tutor or another person assesses the trainee.

Gallagher (2010) highlights in his study exploring how medical, nursing and physiotherapy students are assessed for professionalism that an assessor will inherently bring bias to any assessment they are observing in practice. Gallagher suggests that an assessor observer may have a different perception of professionalism displayed between a patient and student, than how the patient felt the experience to be.

My study has shown that professionalism centres on values such as trust between a pharmacist and patient. Therefore, I argue that the patient is the only

person that can provide the patient's insight into whether professionalism has been displayed to them. Furthermore, the service users in my study stated that they anticipated and wanted to be involved in this assessment process.

Therefore I advocate formative patient feedback on how trainees have performed in practice should be routinely and regularly included throughout the placement. I suggest a questionnaire, like the GMC use, could be developed to help with this process

I propose this would allow for patients to give their unique insight into what professionalism means to them. I recommend several patients should be invited to give feedback because of the dynamic and context specific nature of professionalism. This would provide a range of perspectives of professionalism to be presented from each context and episode. By allowing different patients to contribute across the whole of the placement, this may provide a valuable insight into how a trainee's professionalism has matured. This is different to the GMC approach, which has focussed on patient involvement at a certain time point, rather than over a period of time (General Medical Council, 2018a) .

From the findings in my study, I also propose that the trainee uses the formative feedback from service users when they formally self-reflect or reflect with facilitation from their tutor. I suggest this may help the trainees explore their behaviours, where there maybe differences between the trainees' and service users' reflections on professionalism demonstrated and how the trainee's professionalism is maturing.

### **5.5.5 Summary**

In this section, I have highlighted that the tutor led assessment of a trainee's professionalism is the only way professionalism has been reported to be judged during the pre-registration placement. I have proposed that tutors should include service user feedback and trainee reflection on their professionalism development to support their assessment. I have also proposed that tutors should have further training to support them with their role and suggested the

GPhC peer review conversation used as part of revalidation may also be an approach that could be adopted.

## **5.6 Illustration of how this study contributes to existing theories presented in the literature**

Figure 5-1 (p.150) uses the timeline of the pre-registration placement to illustrate the relationship between the different concepts proposed by this study. Miller's pyramid (1990), the Dreyfus model (2004) and Cruess et al., (2016) suggestions to extend the Miller's levels for assessing clinical competency are referred to directly, as these frame and situate my research contribution. The right hand column illustrates briefly the unique additions this study brings to the understanding, development and assessment of professionalism within the pre-registration placement.

**Figure 5-1: Illustration of how this study contributes to existing theories presented in the literature**

Time line – career progression	Pharmacist career pathway	Emotional focus	Miller (1990) and Cruess et al., (2016)	Dreyfus (2004) model	<b>This study adds</b>
	Undergraduate student	Self	Knows, knows how, shows how	Novice	
	Start of pre-registration training ↓ End of pre-registration training	Self ↓ Patient - centred	Show how ↓ Does ↓ Is	Advanced beginner (A) ↓ (B) Competence (C)	Transformation moment: role title (A), knowledge limits (B) and practice rules (C)  Maturation period (dashed line): responsibility, influenced by patient engagement, sector(s) of practice, time in different sectors, tutor support.
	Pharmacist	Patient - centred	Is	Proficient	

## 5.7 Summary

In this chapter, I have sought to show how my study findings have informed understandings of professionalism and, how the training and assessment of professionalism is experienced during pre-registration training from a range of perspectives.

I argued that professionalism is core to the daily role of being a pharmacist, but there are several challenges to defining, teaching and assessing it. In the context of the pre-registration pharmacist placement, various and dynamic concepts of professionalism are held by service users, the GPhC, trainees and tutors. A shared definition of professionalism is elusive due to the dynamic nature of professionalism. Although there were many common terms used between the study groups, the service users' focus on accurate dispensing as a marker for professionalism was noticeably different to the other three participant groups. I reason this variation is important when considering how pharmacist roles are changing and how patients are informed and involved in this process.

I have argued how the pre-registration training placement contains several transformative moments and periods of maturation that lead to the trainee learning professionalism. I propose that each of these events need to occur to allow the trainee to progress 'up' to *becoming* a pharmacist. The transformation moments and maturation periods have been linked to the Dreyfus model of skill acquisition (2004) and the concept of 'becoming a professional' as an *is* state as proposed by Cruess et al.,(2016) as an extension and alternative assessment approach to the Miller's pyramid (Miller, 1990).

I have proposed how the rate of learning maturation may be influenced by real life authentic patient contact, the role of tutor(s), sector of pharmacy practice and time within each sector during the pre-registration placement. I have proposed how these insights have implications for current and future pre-registration programme design to potentiate or deter the professionalism development of the trainee and proposed the benefit of developing placement wide entrustable professional activities.

The study reported that the GPhC registration assessment did not assess professionalism, but rather professionalism was only assessed in the workplace

during pre-registration training. This places a high level of responsibility on a tutor, who may have not received any training for this role and may or may not use assessment tools to assist them with this assessment. This study did not show that having two tutors was beneficial to the trainee's professionalism development, but rather may provide negative challenges for the trainees professionalism development. A possible solution to support the tutor(s) in their assessment on the trainee's professionalism could be the use of trainee led verbal reflections and formative service user feedback.

## Chapter 6 Discussion and conclusion

### 6.1 Introduction

The aim of this research was to illuminate understandings of professionalism, as well as its development and assessment, from a range of stakeholder perspectives in order to inform the debate about how to support future pharmacists' professionalism learning journey.

The research questions I set out to explore were, in the context of the pharmacy pre-registration pharmacist placement;

1. What concepts of professionalism do service users, the professional regulator (GPhC), trainees and tutors hold?
2. What approaches to learning and teaching professionalism are experienced and or taken during the pre-registration pharmacist placement?
3. How are judgements made on a pre-registration trainee's achievement of professionalism in their placement?

I adopted an interpretive paradigm approach and therefore cannot, and did not aspire to, make generalisable laws or strong predictions on the basis of my findings (Tavakol and Sandars, 2014a).

The pre-registration placement is an accepted tenet for professionalism development in the career pathway to registration as a pharmacist. My study makes a significant contribution by adopting a novel approach which involved trainees, tutors, GPhC staff members and service users together in one study and allowed for a distinctive and original insight into the subject by comparison within and across each of the stakeholder groups.

After mapping and interpreting the data, I identified three themes; perceptions of professionalism, professionalism development and judgements on professionalism. The following section presents and discusses the key findings within these themes.

## 6.2 Key findings

### 6.2.1 Perceptions of professionalism

The study did not produce a shared definition of professionalism, but rather challenged the aspiration towards such a shared definition. Stakeholders understood professionalism in ways that were dynamic and subjective. Professionalism was perceived to be specific to the context, time, and person. That being said, some similarities between the stakeholders' understandings of professionalism were noted, for example the link between trustworthiness, adopting a patient-centred approach and professionalism.

An important finding was that patients viewed accurate dispensing of medication as an indicator of professionalism, whereas no other stakeholder group reported dispensing when discussing professionalism. It could be that the other stakeholders involved in this study assume professionalism will be demonstrated by pharmacists who can accurately dispense and therefore accurate dispensing was not mentioned. However, this lack of explicit reference may mean dispensing is at danger of not being valued by the GPhC, tutor and trainee stakeholder groups. Furthermore, I argue that, as pharmacists increasingly undertake non-dispensing roles, this difference in how patients and pharmacy professionals characterise professionalism has implications for how professionalism is developed, assessed and maintained across pharmacist careers pathway.

The lack of an agreed or comprehensive definition of professionalism across the stakeholder groups was because people had slightly differing ideas of what constitutes professionalism, as highlighted by the difference noted in the viewpoints around accurate dispensing of medication. In seeking to define professionalism, stakeholders needed to also describe how they perceived professionalism would be demonstrated to others. There was consensus between all stakeholders that a pharmacist adopting a patient-centred approach would be one way to demonstrate professionalism. However the stakeholders had differing examples of what adopting a patient-centred approach would be, from involving the patient/carer in healthcare decisions to personal accountability for actions for the care of another person. The study findings propose that in order to develop a patient-centred approach, a trainee must

have awareness of an emotional responsibility to others, the ability to make decisions in complex and uncertain situations and the realisation of the limits of personal knowledge.

### **6.2.2 Professionalism development**

Trainees, the GPhC and tutors all viewed the pre-registration training placement as vital for the development of professionalism. It was here that real life experiences and responsibilities in particular, act as a catalyst to change a trainee from a self-centred student to an outwardly looking professional. A significant contribution to understanding how trainees' professionalism develops over the training placement year comes through the detailed account of the trainee's learning journey which my findings provide. I identified how trainees experience a series of transformation moments and periods of maturation. The transformation moments were linked to a specific event or moment in time when the trainees realised something about themselves or their practice. Once the trainee was aware of this, they could not 'go back' to being unaware. The periods of maturation were times of slow and gradual change when a skill or personal insight steadily developed and became embedded.

In my interpretation, I used the Dreyfus model of skills acquisition (2004) to illustrate how a trainee may progress from novice to competent during their pre-registration training. I was also able to map a series of transformation moments and maturation periods that may take place during the training placement. I identified what factors may enhance or hinder professionalism change, including how different sectors of pharmacy practice may influence the rate of professionalism development. The positive influencing factors for professionalism development included: the trainee being given the title of *pre-registration trainee*, the amount of real life patient engagement a trainee actively participates in, the trainee's awareness of the limits of their knowledge and their emotional responsibility towards patient care which can, at times, legitimate acting outside of practice guidelines. This was exemplified by the GPhC and service users involved in this study. The contributions from trainees, tutors and the GPhC each seem to suggest that only by a trainee progressing through each of these transformative moments and maturation periods, does the individual develop the professionalism of a pharmacist.

My study suggested that where there may be conflict between two pharmacists jointly tutoring a trainee, particularly when they work in different pharmacy practice settings. This challenged the trainee's viewpoint that the tutor(s) is a good role model and may negatively affect the rate of the trainee's professionalism maturation. My study findings could be a symptom of a potentially bigger issue with how multiple tutors work together to nurture and assess a trainee's professionalism. This finding shines a light on the need to study more closely joint tutoring arrangements and in particular how tutors are trained and selected to work together. This is a timely suggestion as more trainees are undertaking rotational schemes and there is greater emphasis from the GPhC for an integrated degree and pre-registration placement (General Pharmaceutical Council, 2019a), which may result in more complex tutoring arrangements and relationships.

The trainees demonstrated an awareness of their professionalism journey during the training year, commenting how they had become like the pharmacists they had aspired to be when they started their placement. All study groups indicated that becoming a pharmacist was more than simply *doing* the job of pharmacist, but rather demanded skills such as empathy, awareness of limitations, responsibility and ability to act outside guidelines if this was in the patients' best interest. The concept of *becoming* and identifying as a pharmacist through enculturation into a community of practice, and this being linked to a series of transformative moments and maturation periods during the placement, is a critical contribution this study makes to the debate into pharmacy professionalism, pre-registration training and post-registration education.

This study proposes the production of core entrustable professional activities, specific to the pre-registration placement, to facilitate the development and assessment of professionalism within all pharmacy workplace settings. The current GPhC consultation into the initial training and education standards of future pharmacists (General Pharmaceutical Council, 2019c) provides a timely opportunity to include core entrustable professional activities across the whole of the pre-registration training scheme.

### 6.2.3 Judgements on professionalism

This study identified perceptions that GPhC registration exam does not assess professionalism; the final decision to sign off a trainee for registration is delegated to the pre-registration tutors. I discovered the tutors used a range of approaches to assess professionalism. The methods varied in scope, amount of collaboration with others, reproducibility, timescale, and objectivity. The lack of any commonality in how tutors assessed trainees' professionalism demonstrates how difficult professionalism is to assess and that current approaches are not suitable.

I argue that current pharmacist training over relies on pharmacists *doing* in the workplace. Consequently, *does* has become the principal objective of the GPhC outcomes for the initial education and training of pharmacists (General Pharmaceutical Council, 2011). I argue this is not enough to assess if a trainee demonstrates professionalism. Miller's pyramid (1990) uses a four level framework to propose how clinical competency can be assessed. The lowest level assesses *knows*, moving to *does* at the top. However, Cruess et al., (2016) studied how professionalism is assessed within the medical profession, and proposed the existence of an *is* or *becoming* level. The *is* level encompasses both professionalism and professional identity and is the fifth level or apex on the top of Miller's pyramid (1990). My study is the first to provide evidential support for the existence of an *is* level within pre-registration pharmacist training. This finding challenges the current and, more importantly, proposed GPhC initial training and standards for pharmacist training by highlighting the need for alternative assessment frameworks to be included. This study recommends that the policies are revised to include some *is* assessment targets. Drawing on the data and findings from this study I suggest learning outcome 2.1 in the proposed GPhC standards (General Pharmaceutical Council, 2019a) could be one example. This states:

*“Demonstrate the values, attitudes and behaviours expected from a pharmacist – does” (General Pharmaceutical Council, 2019a, P.21)*

I propose a change to *is* would enable the trainee to actively demonstrate how they have become a pharmacist and have embedded professionalism within their daily practice. This would ensure future pharmacists had been appropriately assessed to confirm they had achieved the professionalism

required for the greater variety of roles that pharmacists currently undertake, or aspire to, in practice.

The study conclusions also extend the published work by Cruess et al.,(2016) by suggesting how the achievement of *is* could be assessed. I propose two approaches; trainee reflection and formative patient feedback. I will discuss these in more detail.

The study found trainees have insight into their professionalism development to become a pharmacist. Yet it was also highlighted that the current portfolio may not currently epitomise the trainees reflective professionalism development journey. Therefore it is proposed that other assessment strategies, such as audio-diaries and documented tutor facilitated verbal reflection, could be used to stimulate and document the trainees' insights.

Few patients were formally and regularly involved in the assessment of trainee professionalism throughout the placement, even though patients wanted to be involved. Patient contact and working with patients was found in this study to be vital for the maturation of professionalism. This contact was linked to the trainees making emotional connections with patients and taking responsibility for their actions. It is therefore proposed that patients should be regularly involved in the assessment process.

### **6.3 Conclusion**

This thesis has provided further insight into the concepts of professionalism held by service users, the GPhC, trainees and tutors. Professionalism was perceived to be specific to the context, time, and person and therefore a shared definition of professionalism was elusive. This study went further than previous studies by challenging the need for such a shared definition, and proposed that professionalism maybe better understood by considering how professionalism could be demonstrated to others. Adopting a patient-centred approach was reported by all stakeholder groups as one way to understand and demonstrate professionalism.

The most significant finding from my study is my proposition that trainees learn professionalism via a series of transformative moments which are then consolidated through periods of maturation throughout their placement; with both being equally important for the trainee's professionalism development. The

transformation moments identified in this study included; receiving the title pre-registration trainee, realising knowledge limitations and challenging practice based rules. Transformation moments were associated with a specific event, or moment in time, when the trainee gained a new personal insight or knowledge and could not return to the state of not knowing or being unaware of this insight. The maturation periods describe a different pattern of professionalism development. Whereas transformation moments are intense and can be brief, maturation periods are associated with the gradual change of responsibility and focus from self-centred student to over time becoming an emotionally engaged and accountable for others. The Dreyfus model (2004) was used contextualise the triggers that prompted this development.

The study also identified factors that may negatively or positively influence the rate of professionalism development, this includes the degree of responsibility offered a trainee in different sectors of pharmacy practice and the extent to which tutors prioritise the trainee's professionalism development. These findings have significance for placement design and tutoring.

As the concepts of professionalism were found to be varied, subjective, context specific and dynamic, this study found the assessment methods adopted to assess professionalism were diverse. This included some tutors not using the GPhC performance standards to assess a trainee's professionalism. There was a view that professionalism cannot be assessed by a written exam, but only assessed within the workplace.

This study supports and extends the work by Cruess et al.,(2016) regarding the extension of Miller's pyramid (1990) by suggesting three ways to assess the achievement of *is* in pre-registration placement. These include: formative feedback from patients on the trainees professionalism, tutor facilitation of trainees verbally self-reflecting on their own professionalism awareness and progression and a trainee led audio-diary. The study findings argue adopting these assessment approaches throughout the training placement would facilitate greater insight into the trainee's professionalism development.

At a time when the GPhC is consulting on the revised standards for the initial education and training of pharmacists (General Pharmaceutical Council, 2019a), my study makes a critical and propitious contribution to how professionalism is understood, how it develops through a series of

transformation moments and maturation periods and how it is assessed. My study proposes changes to the draft policy which will provide a greater opportunity to generate and recognise the pivotal transformative moments and maturation periods that need to exist along the professionalism development pathway.

## **6.4 Overarching strengths and limitations of the research**

My study design was located within an interpretivist paradigm and consequently involved mainly qualitative data. Historically, the quality and rigor of qualitative studies has been challenged, particularly around the transparency of the analysis process, and this has challenged the importance that could be placed in the findings (Richards, 2014).

Long and Godfrey (2004) developed a tool to assist with the evaluation of the quality of qualitative studies. They argue that qualitative studies, particularly within health and social care, have an important contribution to make towards understanding and directing policy and practice. The tool promotes reflexivity in the researcher by encouraging justification of the judgements made during the research process. I was central to all stages of my study, for example I was a participant in the focus groups and interviews and I used my evaluation skills to make judgements during the theoretical framework mapping and charting analysis process. Therefore, I am acutely aware of the intentional and possible unintentional influence I may have had on the data. Consequently, the Long and Godfrey's evaluative tool was used as a systematic approach to structure my reflexivity and assessment of my study in relation to the research aim. A summary of the principle strengths and limitations of my study is given below. My full assessment using Long and Godfrey's evaluative tool during can be found in appendix R. I will now discuss some of the overarching strengths and limitations presented by this evaluation process.

My study design was able to provide a unique synthesis of the views and experiences of multiple stakeholders. The involvement of the GPhC, trainees, tutors and services users was a unique aspect of this study. However, it is accepted that my study focuses on trainees and tutors from the South West of England only. However, despite this, the exploratory nature and qualitative approach of this research has provided some rich and varied insights into the understanding of professionalism, development and assessment within the pre-registration placement.

Participants from all the four different study groups volunteered to take part in my study. For my interview and focus groups, I did not need to sample those who wished to take part, as the number of people that volunteered corresponded to the number of people needed. However, the voluntary

recruitment of the study means if a different mix of people had volunteered then the conversations and nature of reality socially constructed may have been different. This is because the participatory format of the data collection often resulted in participants sharing their encounters and feelings that had been shaped by their personal experiences. This may have been most apparent with the trainee group as all those that volunteered were female, had mostly achieved a first class honours degree and only two trainees had more than two weeks in community pharmacy during their pre-registration. It is therefore possible that my study findings are particular to these participant characteristics. Also, all the service users that submitted a participant background information form, were 55 years old or older, white British in ethnicity and with a higher than expected number of service users who had previously worked in healthcare. The study was also limited by the number of participants in the GPhC and tutor data collection steps; two and twelve respectively. Further work could include encouraging participants with more variation in characteristics to take part.

As the researcher, I have been greatly involved in the generation of the data and the analysis steps. This may introduce bias into the research as my values and assumptions would be present. However, to try and reduce this impact I have adopted a reflexive stance to consider how I may have impacted on the study. This has been achieved by the use of an observer during the focus groups and by involvement and sharing of my data and thematic coding process with others. This has allowed my involvement and interpretations to be challenged and thus built rigor and confidence into the data.

As a pharmacist, I had access to communication networks to involve the four stakeholder groups and I was aware of the pre-registration training scheme, pharmacist workforce changes and what day to day practice maybe like for a trainee and pharmacist. However, my professional standing may have influenced who took part in the study and the behaviour of those participants that did volunteer. Yet, I mitigated these concerns by using third parties to cascade study invitations, involving an observer in the focus groups and the tutor questionnaire being anonymous.

The study findings from the trainees focused on the contributions and importance of the tutor. Consequently, I feel it is a limitation of this study that the tutors were involved by e-questionnaire only. Although this was felt to be the

best approach at the time because of the geography of the region and the complexity of seven day working patterns which meant a face to face meeting may have had low attendance. I accept now that a focus group or one to one interviews to be carried out after the e-questionnaire may have been helpful to explore in more detail the themes and ideas expressed in the e-questionnaire.

## **6.5 Implications for practice**

This study showed that one definition of professionalism is not possible, and involving the patient in the training and assessment of professionalism is strongly recommended. Therefore patient engagement and regular formative feedback from patients should be a constant feature of pre-registration programmes.

The study interpretations give insight into current practice and provide direction for changes that could be made to the present training programmes, before any new pharmacist training standards are possibly introduced, to optimise professionalism development and assessment. The suggestions include; the need for all trainees to have opportunity to take on more responsibility and autonomy during their placement, improved working arrangements when two tutors are jointly tutoring a trainee, encouragement for trainees to use e-portfolio's and to embrace innovative ways to record their reflections for example audio-diaries and involving patients formally and directly in the formative feedback on a trainees professionalism.

The development of pre-registration training placements across different sectors of pharmacy practice are encouraged, particularly programmes that enable the trainee greater autonomy, such as placements within community pharmacy, which was reported as accelerating the rate of professionalism maturation. Going forward, placements in all pharmacy sectors should be well planned to allow reasonable time for trainees to mature their professionalism skills, with more opportunities for independent decision making and autonomous practice to mature the rate of the trainee's professionalism development. However, placements should also have flexibility in their design to account for trainees who may take longer to mature professionalism.

Trainees and tutors should be encouraged to use the GPhC revalidation peer reflection tool (General Pharmaceutical Council, 2018b). For both groups the

tool will help develop their reflective skills to gain critical insight need to either transform to become a pharmacist or how to support to provide trainee.

## **6.6 Implications for the GPhC consultation on the new standards for the initial education and training of pharmacists policy**

The GPhC consulted on new standards for the initial education and training of pharmacists January – April 2019 (General Pharmaceutical Council, 2019a). I contacted the GPhC and met with Director of Education and Standards, on the 19<sup>th</sup> February 2019 to inform the GPhC of my key findings and to discuss their implications for the consultation and policy. A copy of the presentation can be found in Appendix S.

The new standards propose a learning domain on professionalism with a range of learning outcome statements linked to Miller's pyramid (1990), with the current 76 performance standards being removed. The standards also support integrating the degree and pre-registration year to produce a five year programme. My study makes a timely contribution and challenges how the proposed policy considers how professionalism is developed by the trainees and how professionalism is assessed during the placement. The following sections summarise the training standards proposed and the main contributions my study brings to debate.

### **6.6.1 Terminology used**

The proposals use the title *student pharmacist* only replacing the terms pre-registration trainee, or pre-registration pharmacist. I suggest the new title should be changed to *trainee pharmacist* to facilitate a transformative moment for the trainee, their awareness of professional responsibility to others and encourage workplace mentors not to view the trainee as a student.

### **6.6.2 Learning outcomes**

Part 1 of the draft consultation describes what pharmacy student or trainee will be able to achieve by the end of the training programme (General Pharmaceutical Council, 2019a). Four domains are used to cluster the learning outcomes into different themes. Each domain has an overarching title such as person-centred care or professionalism. Below each domain several learning

outcome statements are stated. Each learning outcome is linked to the one of the four stages of Miller's pyramid (1990).

My study supports the importance given to professionalism in the training of future pharmacists by awarding one domain to be titled professionalism. My study also welcomes the clarity in understanding professionalism that is brought by stating the learning outcomes that underpin the professionalism title. However, my study found patient-centred care was a founding principle for the understandings of professionalism. Therefore patient-centred care and professionalism are intrinsically linked. By separating patient-centred care and professionalism into different domains, it could be viewed that these are discrete, which my study findings does not support. I would therefore recommend the GPhC highlight that each learning outcome domain cannot be standalone and review the categorisation of the individual learning outcomes within each domain.

All the learning outcomes in the GPhC proposal are mapped to one of the four stages of Miller's pyramid (1990). This study critiques Miller's pyramid and proposes that *does* is not enough to describe the embedding of professionalism. Therefore, I recommend a review of the professionalism learning outcomes and consider if *is*, rather than *does*, should be the aim of some of the learning outcomes.

The GPhC does not mention how future pharmacists will evidence their achievement of all the learning outcomes for registration. Currently many trainees use an e-portfolio system to record their evidence of achieving the performance standards, although some trainees continue to use paper formats. The e-portfolio systems allows for a broader range of evidence types to be used than paper, for example audio and video recordings. I recommend all trainees should use an e-portfolio to enable capture of a wider range of evidence types that may demonstrate more clearly the trainee's professionalism development, for example an audio recording of a reflective discussion between a trainee and tutor.

### **6.6.3 Standards for the initial education and training of pharmacists**

Part 2 of the draft consultation contains nine standards and criteria that will apply to organisations, such as Universities and workplaces, providing training

for future pharmacists. The standards are given an overarching domain title name, such as assessment, with a range of criteria required to meet that standard. I will now summarise the domains relevant to my research and the implication by study has on the proposals made.

Domain 4: Managing, developing and evaluating initial education and training. The GPhC mentions that the views of patients are important in the design of the education and training programme. However, patients are not mentioned in domain 6, which explores formative and summative assessments. This study recommends patients are regularly and actively involved in the assessment of trainee professionalism throughout the placement. Therefore I suggest the routine involvement and explicit mention of patients is included in the assessment of future pharmacists.

Domain 7: Support and development for student pharmacists and people delivering initial education and training. This domain considers how future pharmacists' learning is planned and includes a list of support systems. Unfortunately trainee reflection is not stated. My study suggests oral reflections, either by a trainee self-recorded audio-diary or facilitated conversation with a tutor, provide opportunity to nurture the trainee insight into the transformation moments and maturation periods within professionalism development.

Domain 8: Learning in practice. This domain focuses on criteria that would have previously related to pre-registration training. The criteria welcome organisations from different sectors of pharmacy practice being involved the future pharmacists learning in practice experience. The findings from this study support this approach, for example the need to include opportunity for the trainee to take autonomy for their practice, as exemplified by community pharmacy in this study, the importance of emotional connections to real patients within the workplace setting to potentiate the professionalism development. This study proposes the development and use of entrustable professional activities in the pre-registration placement as a competency based framework to assess professionalism in any pharmacy practice area.

Domain 9: Learning in practice supervision. This considers the standards of what are currently referred to as pre-registration tutors. My study welcomes the proposed criteria that supervisors must be appropriately trained and supervised. However, the GPhC do not define the level of training what would be suitable.

This study suggests the use of formal peer review could be used to support those involved in the delivery of the training. The GPhC does not mention joint tutoring arrangement within domain 9, and I argue this is an oversight because the number of rotational placements as increasingly, therefore more training placements are involving two tutors working in different sectors of pharmacy practice. The responsibilities on both the lead and support tutor towards their trainee needs clarification to make sure trainees know exactly what support each tutor is providing for their development. A possible solution for this could that each tutor has a separate learning contact with the trainee, as well as a learning agreement between the tutors. This would ensure all parties are aware of their working relationship, contributions and responsibilities to provide consistency within the training scheme. Therefore I think careful consideration is needed, particularly with joint tutoring schemes, to balance the opportunity for trainees to learn professionalism from a range of sectors of care, and also the skill of the tutor to be able to scaffold, support and assess the trainee as they progress throughout their placement.

## **6.7 Implications for further research**

My study sought to gain a deeper understanding of how professionalism is understood, taught and assessed during the pre-registration placement. By nature of being an explorative study, I have also illuminated areas for further research which could be explored to develop knowledge, policy and debate about how professionalism develops in the health care professions. I outline some of these ideas for further research below.

The study participants were trainees, tutors and service users based within the South West. The study could be widened to include other areas of England in order to explore if there are similarities or differences in the findings. It would be particularly interesting to include trainees and tutors involved with the split pre-registration placement offered through the University of Bradford. The students at Bradford University have the option to undertake a 5 year degree that integrates the pre-registration year into two 6 month blocks, one in the 4th year and one in the 5th year. This would provide an interesting context in which to further explore the findings from this study which centre on the transition from being a student to trainee and then pharmacist. Also to explore the impact the number, length and timing of the work-place experience has on professionalism

development. Such studies would ideally purposively sample participants to include male trainees and pharmacy graduates with a 2:1 or lower classification, or this predictive grade for University of Bradford trainees as their pharmacy degree and completion of pre-registration training are co-terminus.

This study proposed several transformative moments that occur during the pre-registration placement. By including a wider sample, it could be explored if the transformative moments this study identified are comprehensive. Therefore further research could explore transformative moments in more detail to scope the type, nature and factors influencing these events occurring in different sectors of pharmacy practice.

Periods of maturation of professionalism were identified in this study, with some account of the factors affecting the rate of maturation. Future research could investigate maturation periods in more detail, and with a larger and more varied sample. This would consider if there are any other influences on professionalism maturation, whether there is any interdependency between the influences identified, and if there is an optimal time needed for professionalism maturation in the different pharmacy practice sectors that offer pre-registration training.

Since the study was completed, there has been an expansion in the number of trainees undertaking rotational pre-registration training programmes in different healthcare settings, such as within mental health and prisons. The study could be broadened to include trainees and tutors from these placement settings. This would enable to explore if the concepts of professionalism and how professionalism is transformed, matured and assessed identified in this study also are present in these pharmacy services.

Further work could explore the role of the pre-registration tutor. Firstly, the pathway to becoming a pre-registration tutor could be researched, particularly with a focus on how pharmacists are selected for this role, what training and experience they had before they started tutoring and how being a tutor affects their professionalism development. Secondly, the views of tutors who specifically joint tutor a trainee with another pharmacist should be researched. This study identified that different tutors have varying approaches to how professionalism is understood and assessed. Therefore, a future study could investigate how tutors are chosen to work together and in more depth the

impact joint tutoring may have on the professionalism development and assessment of a trainee.

The exploration of more patient views could be sought, particularly on the possible development of a tool for patients to use to assess a trainee pharmacists' professionalism in the practice setting.

Finally, the design of many undergraduate pharmacy programmes have changed, with more work placements being undertaken during the degree. Graduates from these schemes may have a different insight into professionalism development and start their pre-registration training with a different skill set. The study questions could be explored with recent graduates and compared to the findings from this study.

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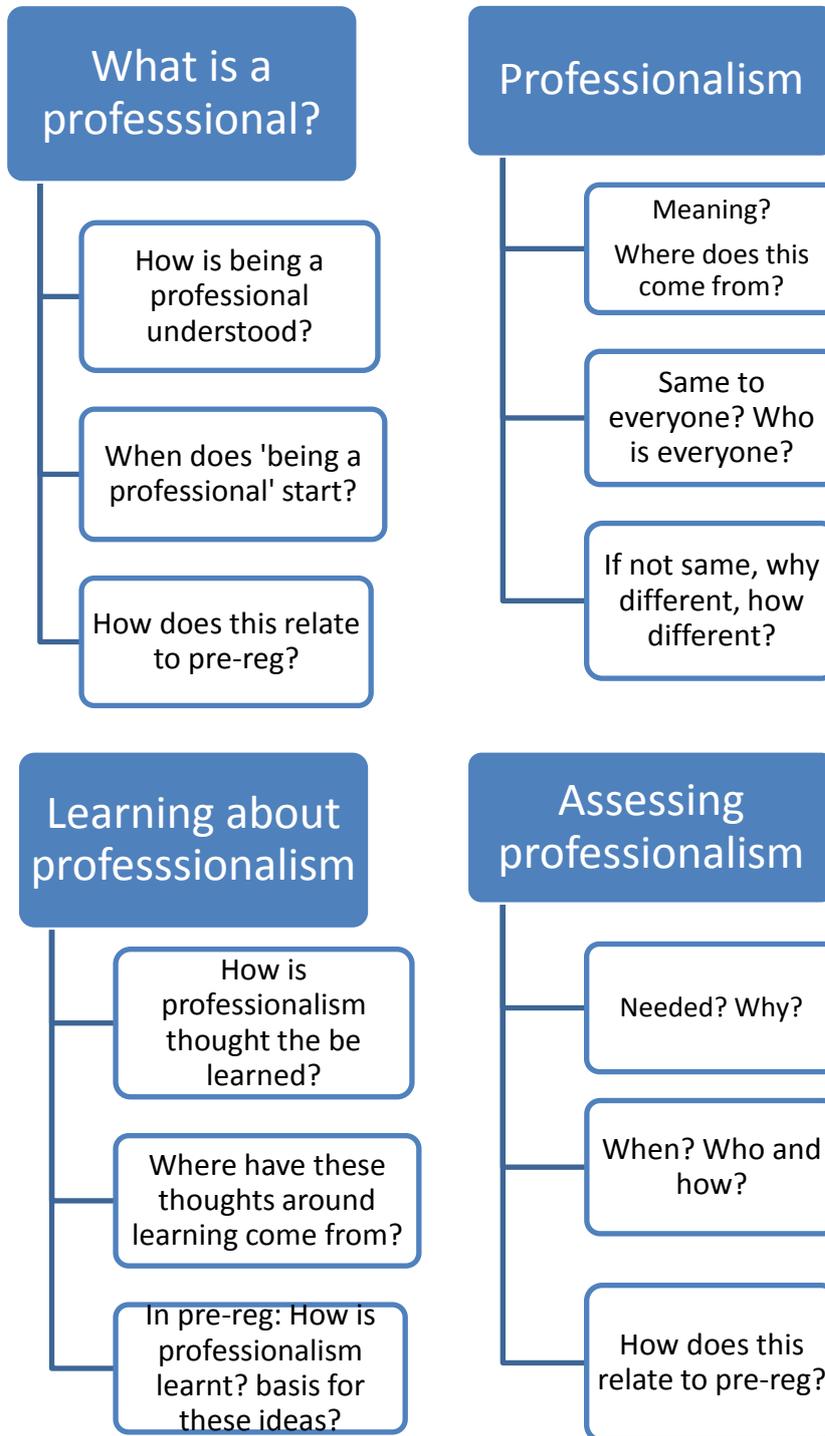
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## Appendix A: Initial concept mapping at start of literature search



**Appendix B: SPIDER concept map used for literature search**

S	Sample	Pharmacy, pharmacist, trainees, pre-registration, tutors, patients, service users, healthcare staff, professional regulator
P or I	Phenomenon or interest	Professionalism, Professionalism development, Professionalism teaching, professionalism assessment
D	Design	Qualitative, interview, focus group, case study, observation
E	Evaluation	Understanding, experiences, perception
R	Research type	Qualitative, interpretative

**Appendix C: Literature search results (from July 2015)**

Resource type	Database or website	Number of articles found
Academic	HDAS – EMBASE	861
	HDAS – MEDLINE	106
	PsycINFO	440
	PubMed	1296
	Web of Science	1223
Professional	GPhC website	1022
	HEE Website	296
	RPS Website	1244
	The Department of Health	755
	<i>The Pharmaceutical Journal</i>	401
e-Thesis online	ETHOS website	122

**Appendix D: Email invite sent to Pre-registration training facilitator at GPhC**

Dear XX,

Many thanks for your interest into my study exploring of the development and assessment of professionalism during the preregistration pharmacist placement across healthcare settings.

The study has now received University of Leeds approval to proceed with the data collection.

Please find attached an information sheet about the study.

It is hoped that up to three members of your pre-registration training team will be able to participate in the study. Please could you read the attachment regarding the study and what participation will involve.

If anything that is not clear or more information is required, please direct queries to myself, Helen Ireland.

If you would like to take part, please can you reply to this email ([ed08hjb@leeds.ac.uk](mailto:ed08hjb@leeds.ac.uk)) to arrange a time suitable to you to take part.

Kind regards,

Helen

## **Appendix E: GPhC participant information leaflet**

### **Information leaflet on study exploring the development and assessment of professionalism during the preregistration pharmacist placement across healthcare settings**

*You are being invited to take part in a study. Before you decide it is important for you to understand why the project is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask Helen Ireland if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.*

#### **What are the objectives of the project?**

To explore what you understand as professionalism and how you think pharmacist trainees can best develop, and be assessed for, professionalism during their training year.

Helen Ireland is a student at the University of Leeds as this study is towards a doctorate in education qualification.

#### **Why have I been chosen?**

A range of people have been asked to contribute their views in order to give the best insight into how professionalism is understood amongst preregistration pharmacists and the people they interact with during their training. In addition to talking to service users, the project will also consult preregistration pharmacist trainees, their tutors, and a member of the General Pharmaceutical Council (GPhC) preregistration team.

#### **Do I have to take part?**

It is entirely up to you to decide whether or not to take part. If you do decide to contribute but later change your mind, you can still withdraw at any time. You do not have to give a reason. However any contributions you will have made to the study, for example expressing your views during the interview, cannot be removed.

### **If I want to take part, what do I have to do?**

- You have been asked to contribute to the project by taking part in semi-structured interview
- Helen Ireland will provide an outline for the interview and ask you questions. Your responses to the questions will direct the interview.
- It is expected the interview will last 60 – 90 minutes

### **What type of information will be sought from me and why is the collection of this information relevant for achieving the project's objectives?**

You will be asked what you understand by the term professionalism in the context of pharmacy and pharmacy training and also to reflect upon how you think preregistration pharmacists should be helped to develop professionalism across their training programme and health settings. You will also be asked to consider how you think professionalism can be assessed during the preregistration year.

### **Will the conversation be recorded?**

Yes, two digital voice records will be used. The recordings will be written up word for word (transcribed).

### **Will I be identified in the final report?**

No. A code will be given to each person taking part. This will enable all the comments you made to be linked together in the transcription and enable the flow of the conversation to be understood. The key to the coding system will be known only by the researcher and the code will be destroyed once the tape recordings have been transcribed.

**What will happen to the data?** The interview responses will be reviewed and analysed by the lead investigator (Helen Ireland). Anonymous comments of particular interest maybe quoted in the final write up.

### **What will happen to the results of the project?**

Your interview will be analysed with data from the other aspects of the study, for example focus groups and e-questionnaire. The data collected will be evaluated to consider what is known about professionalism, how pharmacists in training can develop, and be assessed for, professionalism skills, and to suggest an action plan for any learning needs identified.

If it is felt that the conclusions from the study may be of interest to others, the study will be published in a journal or at a conference. You will not be identifiable from any report or publication. If the study is published and you wish to be notified, so that you have the opportunity to obtain your own copy of the publication, please inform Helen Ireland.

**What are the possible disadvantages of taking part?**

The only expected disadvantage to taking part is the time required to participate.

**What are the possible benefits of taking part?**

There are no immediate benefits for those people participating in the project. The project seeks to improve understanding of professionalism, and to inform debate and training in this area.

**Who is supporting the study?**

South West Medicines Information and Training

Bristol Royal Infirmary

Marlborough Street

Bristol, BS2 8HW

**Contact for further information - Helen Ireland**



[ed08hjb@leeds.ac.uk](mailto:ed08hjb@leeds.ac.uk)

## Appendix F: Participant consent form

<p>Consent to take part in a study exploring of the development and assessment of professionalism during the preregistration pharmacist placement across healthcare settings</p>	<p>Add your initials next to the statement if you agree</p>
<p>I confirm that I have read and understand the information sheet dated [_____] explaining the above research project and I have had the opportunity to ask questions about the project.</p>	
<p>I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.</p> <p>I am aware that if I wish to have my data removed at a later time I need to contact the Lead researcher: Helen Ireland <a href="mailto:ed08hjb@leeds.ac.uk">ed08hjb@leeds.ac.uk</a> . I am also aware than If you wish to remove any data at a later time please contact that once data has been anonymously coded it will not be possible to remove my data from the rest of the study findings.</p>	
<p>I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.</p> <p>I understand that my responses will be kept strictly confidential unless a report of concern is expressed, for example regarding patient safeguarding. In this example the finding will be referred to the appropriate authority as per normal processes.</p>	
<p>I agree for the data collected from me to be stored and used in relevant future research in an anonymised form.</p>	
<p>I understand that other genuine researchers will have access to this data only if they agree to preserve the</p>	

confidentiality of the information as requested in this form.	
I understand that other genuine researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date*	

\*To be signed and dated in the presence of the participant.

## **Appendix G: Email invite sent to pre-registration trainees from SWMIT administrator**

Dear trainee

Helen Ireland is currently undertaking a part time doctorate at the University of Leeds which explores what is understood by professionalism, and how professionalism is taught and assessed, across the pre-registration pharmacist placement.

The study involves seeking the views of tutors and those of pre-registration trainees, service users and staff from the General Pharmaceutical Council pre-registration division.

The study has now received approval to proceed with the data collection and is recruiting participants. The purpose of this letter is to invite you to participate in Helen Ireland's study.

Please find attached an information sheet about the research study. Before you decide if you would like to take part, it is important for you to understand why the project is being done and what it will involve. Please take time to read the attached following information carefully and discuss it with others if you wish. Ask Helen Ireland ([ed08hjb@leeds.ac.uk](mailto:ed08hjb@leeds.ac.uk)) if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

If you would like to take part, respond to me at this email address. The focus group is planned to take place during your next regional course event, after your training day has finished.

If you do not wish to take part, simply ignore this email.

Kind regards,

## **Appendix H: Feedback form for service user focus group**

Thank you for taking part in the focus group. This feedback form is to enable me to understand how the focus group felt for you. The questionnaire is anonymous. Please leave on the chair by the door before you leave. If you have any particular questions, concerns or feedback after the focus group please feel free to also raise these with Helen.

### **Please circle your agreement with the following statements**

#### **I felt I was able to contribute to the group discussion**

Strongly agree                    1      2      3      4      5                    Strongly disagree

#### **I felt I was given enough time to share my views with others in the group**

Strongly agree                    1      2      3      4      5                    Strongly disagree

#### **I felt I was listened to**

Strongly agree                    1      2      3      4      5                    Strongly disagree

#### **The facilitator encouraged participation**

Strongly agree                    1      2      3      4      5                    Strongly disagree

#### **A focus group was a good way of discussing this topic**

Strongly agree                    1      2      3      4      5                    Strongly disagree

Is there anything that you would have liked to say but did not get the chance to say?

Any other comments

*Thank you for completing this feedback form*

# Appendix I: Service user pre focus group leaflet



**WHAT WE DO**

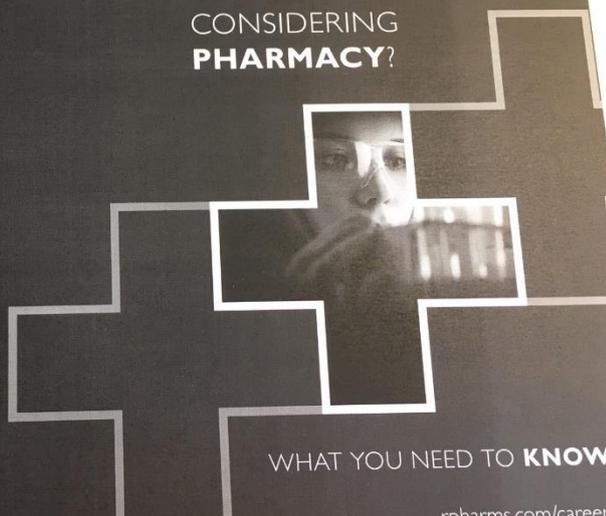
- We are proud to be the professional body for pharmacists and pharmacy.
- We promote pharmacy to ensure pharmacists are recognised within the NHS and wider society, as the experts in medicine.
- We make sure the voice of the pharmacy profession is heard in the development of healthcare policy.
- We promote the advancement of science practice and education in pharmacy.
- We provide our members with the support and development they need to fulfil their professional potential.

**HOW WE WORK**

We put our members at the heart of everything we do working collaboratively with stakeholders across the profession to enhance the reputation and develop the role of pharmacy and through this meet the needs of our members.



## CONSIDERING PHARMACY?



**WHAT YOU NEED TO KNOW**

rpharms.com/careers

For all enquires  
0845 257 2570  
support@rpharms.com  
rpharms.com/careers

16/11/2015 17:43

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## EXPERTS IN MEDICINES



Pharmacists are experts in medicines and as one of the fastest growing areas of healthcare play a key role in improving the health of the nation, and ensuring patient safety.

**WHAT DO PHARMACISTS DO?**  
Pharmacists are experts in medicines and their use. They have a unique set of skills and knowledge they train as scientists and clinicians. They use this scientific knowledge to advise patients how to take their medicines and make recommendations on the best medicine for particular conditions and diseases.

Pharmacists are the third largest healthcare profession in Great Britain. They work in a number of different settings, developing new medicines, supplying medicines, providing advice about medicines, and offering health services. Some pharmacists are also prescribers, and like doctors can prescribe medicines on prescriptions. They also work within the wider healthcare team, ensuring that patients receive the best possible care. Pharmacists also work in other roles where there may be less direct contact with patients, for example in universities, regulation, government organisations, research, publishing and the pharmaceutical industry.

Pharmacists must have very good communication skills, as they are required to translate technical medical information to patients. They often work in busy environments and must be organised, logical, be able to manage multiple tasks, and remain calm under pressure. They should also have a good eye for detail and be thorough and accurate in what they do. Pharmacists work in teams and are often involved in education and training others, so good people skills are also essential.

## QUALIFICATIONS



**TO QUALIFY AS A PHARMACIST**  
You must take a four-year Master of Pharmacy (MPharm) degree course followed by the successful completion of a year of preregistration training within a pharmacy workplace (for which you get paid).

At the end of preregistration training, you must pass the General Pharmaceutical Council (GPhC) registration exam after which you will be able to register and practise as a pharmacist. In Northern Ireland you must be registered with the Pharmaceutical Society of Northern Ireland (PSNI). Pharmacists must renew their registration with these organisations on an annual basis in order to be able to continue to work as a pharmacist.

**SCOTLAND**  
In Scotland, students require Highers in chemistry and English plus two of either mathematics, physics or biology.

**OTHER QUALIFICATIONS**  
Approximately one third of students admitted to schools of pharmacy have other qualifications. These include the Irish School Leaving Certificate, National or Higher National Certificates or Diplomas, International Baccalaureate or Access qualifications.

**ENGLAND, WALES & NORTHERN IRELAND**  
Although most courses are geared to those with A-levels (Highers in Scotland) in chemistry and two of biology/mathematics/physics, students may also be considered with chemistry and one of biology/mathematics/physics (and one other subject). You need basic literacy and numeracy skills (e.g. GCSE in English language and mathematics).

**You can find details on UK School of Pharmacy at [www.rpharms.com/careers](http://www.rpharms.com/careers). All UK MPharm degrees are accredited by the GPhC. Please remember it is vital that you check the precise entry requirements of your chosen school of pharmacy.**

**If you're wondering what courses or options to take at school, sixth form or college, and are thinking of studying pharmacy at university you'll find the information in this leaflet useful to help you plan and decide your next steps.**

To find out more visit [rpharms.com/careers](http://rpharms.com/careers)

add 34

16/11/2015

## Appendix J: Service user focus group

Discussion length: Approximately 75 minutes

Facilitator: Helen Ireland

Assistant:

Date:

Time:

---

### Pre focus group planning

- Chairs arranged in a circle, with space to move between and around chairs. Enough chairs for volunteers plus Helen Ireland and observer
- Refreshments to be available outside room, water and cups in room.
- Materials to take: cards for activity one, pens, flip chart paper and board, post it notes.
- Name badges – make available for all people. Write a number of each badge, volunteer welcome to also write name if wish.
- Two verbal voice recorders to be placed in centre of circle of chairs. Recorders to be placed on low table.
- Facilitator to sit amongst volunteers. To have note book to make notes to help with facilitation role.
- Assistant to sit to side of circle/back of room in non-threatening manner. Assistant role to make brief notes of conversation, record non-verbal communications, points of reflection and any learning /feedback points for facilitator. Assistant to also be on hand for any issues, e.g. if participant need direction to toilet.
- Other things – travel claim form. Extra consent forms, study information forms and Royal Pharmaceutical Society document. Copies of the feedback form for every participant.

- HI to identify location of toilets and procedure for fire alarm. HI to create/identify a 'safe place' near room to direct participants to if wish to leave focus group at any time.
- HI and assistant to have room set up ready to welcome participants as they arrive, collect in signed consent forms and answer any questions.

#### HI introduction

- Thank you for volunteering to take part in this study. Thank you for signing the consent form. Any questions about the consent form?
- Reminder that audio recording this interview. Purpose: Accurate record the interview at a later time and allow your contribution and others to be analysed. The focus group assistant and I will also make some extra notes. Recording will be deleted once interview transcribed. Confirm agree.
- Format: I have three broad themes to ask around the study topic. The questions are only an outline. I am keen to hear your views on the topic and for you as a group to discuss and share your experiences as you feel comfortable. I am keen to hear your reflections and to understand things from your point of view. Informal and conversational.
- Reminder that study questions are
  - In the context of the preregistration pharmacist placement, what concepts of professionalism do service users, the professional regulator (GPhC), trainees and tutors hold
  - What approaches to learning and teaching professionalism are experienced /taken during the preregistration pharmacist placement and across placement settings
  - How are judgements made on a preregistration trainee's achievement of professionalism in their placement
- Any questions or wish to stop the interview at any time please let me know. Need toilet (location), fire alarm process and location of safe place.
- I expect the conversation will take about an hour and a quarter depending on our discussions.
- Does everyone understand? Are you all pleased to proceed?
- HI welcome all participants to say their number (and name if they wish) for a sound check

Approximate timing	Action	Materials needed	Probe	Link to GPhC data collection step
00.00	Hi introduction as above			
00:05	<p>Start – Roles and actions of a pharmacist – see below (Icebreaker). Group to work in pairs/threes. Hand out 2 cards with roles on each. Ask groups to discuss the roles – what do you think about the action taken by the pharmacist? What was good? Could they have done anything differently?</p> <p>Discuss as a group for 5 minutes then feedback to group – 10minutes</p>	Dicaphone to move to each group		Professionalism definition
00:20	What do you expect from your pharmacist?	Take feedback on flip chart		Expectations
00.25	How would you define professionalism?		Why/how do you think this is a 'good'	

			<p>definition of professionalism</p> <p>How does professionalism impact on health/patient outcomes? Why important to consider?</p> <p>Does this change in different health settings?</p>	
00:40	<p>Now going to look more closely at pharmacists in training and particularly the pre-registration year which is the year training programme before they register as a pharmacist.</p> <p>How do you think pre-registration pharmacists could develop professionalism?</p> <p>When during placement? Across different settings?</p> <p>Role of undergraduate degree on this?</p>		<p>How does this support the learning of professionalism?</p> <p>Role of patients/service users?</p> <p>Role of other healthcare professionals? Learn with others?</p>	<p>Learning approaches</p> <p>Patient engagement</p> <p>Interprofessional learning</p> <p>How professionalism links with other areas of practice?</p>

			Confidence and professionalism? Need to be explicitly taught/timetabled?	Formative/summative?
01:00	<p>A preregistration pharmacist has to develop a portfolio or collection of reports about what they have seen or done over their year. This is reviewed</p> <p>How do you think judgements on a trainee's professionalism are made?</p> <p>Role of patients/user users in assessment and feedback?</p> <p>Influence of different health settings on assessment of professionalism?</p>		<p>Why do you think this?</p> <p>Anything that you feel should be included in the judgment but might not be considered currently?</p> <p>Training of tutors?</p>	
01:15	<p>Close: other questions/not been able to cover – make notes on post it notes</p> <p>Thanks.</p> <p>Hand out feedback form</p>	Post it notes and pens		

### Prompts for me during the interview

- Watch for biased/leading questions!
- Watch for double questions
- OK to leave silences!
- Encourage person to talk about them!
- Check opinions: 'What do you think of that?' 'Do you believe that?'
- ask for clarification ('What do you mean by...?' 'Can you say a little more about...?' 'In what way?' 'Can you give me some examples?');
- ask for explanations, pose alternatives ('Couldn't one also say...?');
- seek comparisons ('How does that relate to...?' 'Some others have said that...');
- ask for further information ('What about...?' 'Does that apply to...?');
- aim for comprehensiveness ('Have you any other...?' 'Do you all feel like that?' 'Have you anything more to say on that?');
- put things in a different way ('Would it be fair to say that...?' 'Do you mean...?' 'In other words...?');
- summarise occasionally and ask for corroboration ('So...?' 'What you're saying is...?' 'Would it be correct to say...?');

Roles and actions of a pharmacist: in any sector – hospital, GP or community.  
 Themes addressed here – responsibility, autonomy, respect, putting patients first, role model, leader.

## **Appendix K: Email invite sent to pre-registration tutors from SWMIT administrator**

Dear Tutor,

Helen Ireland is currently undertaking a part time doctorate at the University of Leeds which explores what is understood by professionalism, and how professionalism is taught and assessed, across the pre-registration pharmacist placement.

The study involves seeking the views of tutors and those of pre-registration trainees, service users and staff from the General Pharmaceutical Council pre-registration division.

The study has now received approval to proceed with the data collection and is recruiting participants. The purpose of this letter is to invite you to participate in Helen Ireland's study.

Please find attached an information sheet about the research study. Before you decide if you would like to take part, it is important for you to understand why the project is being done and what it will involve. Please take time to read the attached following information carefully and discuss it with others if you wish. Ask Helen Ireland (ed08hjb@leeds.ac.uk) if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

A link to an e-questionnaire will is found in this email below. If you would like to take part, please click on the link. If you do not wish to take part, simply ignore the email link. The questionnaire will not ask for your name or location, therefore it will not be possible to identify who has taken part or declined the study.

Kind regards,

## Appendix L: Pre-registration tutor questionnaire

This questionnaire seeks to explore your views on the development and assessment of professionalism during the pre-registration placement. All responses are anonymous- your name and training site location are not requested.

The questionnaire consists of a range of question types. Some questions may require a tick to illustrate your response, while other questions contain a comment box to give you the option to answer in more depth and in your own words. All the questions are optional.

The survey will take between 25 and 35 minutes to complete.

I am seeking your views as part of a research project which will contribute to my studies towards a Doctorate of Education at the University of Leeds. More information about the study was described in the participant information leaflet which is included as part of the e-mail invitation you received.

By clicking on the link and completing the questionnaire it is accepted that you consent to participate in the research project and that you have read and understood the participant information leaflet.

1. How long have you been a pre-registration tutor?

- 1 year
- 2 - 5 years
- 6 - 10 years
- Over11 years

2. Which of the following experiences or activities have a role in the development of professionalism in pre-registration trainees across the training year? Please state the contribution you feel each experience or activity brings.

	Always	Very often	Sometimes	Rarely	Never	Please comment on the reasoning for your chosen response
Communication in the workplace setting with patients	<input type="checkbox"/>					
Communication in the workplace setting with other healthcare professionals	<input type="checkbox"/>					
Feedback and support from pre-registration tutor	<input type="checkbox"/>					
Feedback and support from day to day workplace supervisors	<input type="checkbox"/>					
Non workplace based activities, such as case studies and workshops	<input type="checkbox"/>					
The trainee's reflective portfolio of evidence	<input type="checkbox"/>					
Trainee peer to peer support	<input type="checkbox"/>					
Information provided from the GPhC, for example the standards for pharmacy professionals	<input type="checkbox"/>					

2a. Do you feel that any experience or activity is missing from the above selection? If yes, please describe the experience or activity and how you feel this is helpful in the development of professionalism?

3. Thinking about your role as a pre-registration tutor, how do you think a pre-registration trainee develops professionalism during their training placement?

4. How do you think undertaking pre-registration training in different sectors of pharmacy practice impacts on trainees' development of professionalism?

5. Interim findings from the project suggest a link between pre-registration trainee confidence and professionalism. How, if at all, have you experienced this?

6. Thinking about your role as a pre-registration tutor, do you think it is part of your role to assess professionalism?

ic

- Yes
- No

6a. Thinking about your role as a pre-registration tutor, do you think it should be part of your role to assess professionalism?

sho

- Yes
- No

6b Please explain your response to the above two questions

7. If, as a pre-registration tutor, you assess professionalism, please use the comment box below to describe the way(s) in which you do this by outlining any techniques, tools or approaches that you use

8. Interim findings suggest a connection between professionalism and how pre-registration trainees present themselves, especially in terms of what they wear in the workplace. How, if at all, have you experienced this?

9. Interim findings suggest a connection between professionalism and decision making in complex and difficult situations. How, if at all, have you experienced this?

10. Are others involved in contributing to the assessment of your pre-registration trainees?

- Yes
- No

10 a. If you answered yes, please state the people or groups that contribute towards this assessment and describe the ways in which the other assessors are involved?

11. Thinking about the final declaration you make the GPhC regarding your trainee. What must your trainee have demonstrated to enable you to feel comfortable signing them off as ready to enter the GPhC register of pharmacists at week 52?

12. Combining the pre-registration training and 4 year pharmacy degree to produce a 5 year degree with integrated workplace based placements has been suggested. What are your views on this proposal?



13. What does the work 'professionalism' mean to you?



14. Is there anything else you wish to say regarding the development and/or assessment of professionalism during the pre-registration placement?



Thank you

Thank you for your time to complete this questionnaire and for your reflections.

Helen

## Appendix M: Ethics approval letter

Performance, Governance and Operations  
Research & Innovation Service  
Charles Thackrah Building  
101 Clarendon Road  
Leeds LS2 9LJ Tel: 0113 343 4873  
Email: [ResearchEthics@leeds.ac.uk](mailto:ResearchEthics@leeds.ac.uk)



**UNIVERSITY OF LEEDS**

Helen Ireland

School of Sociology and Social Policy

University of Leeds

Leeds, LS2 9JT

**ESSL, Environment and LUBS (AREA) Faculty Research Ethics Committee**

**University of Leeds**

1<sup>st</sup> March 2016

Dear Helen

**Title of study:** Exploration of the development and assessment of professionalism during the preregistration pharmacist placement across healthcare settings.

**Ethics reference:** AREA 14-129

I am pleased to inform you that the above research application has been reviewed by the ESSL, Environment and LUBS (AREA) Faculty Research Ethics Committee and following receipt of your response to the Committee's initial comments, I can confirm a favourable ethical opinion as of the date of this letter. The following documentation was considered:

Document	Version	Date
AREA 14-129 Helen_Ireland_Leeds_ethics_form_final_March_2016[1].docx	3	01/03/16
AREA 14-129 Helen Ireland - Timeline March 2016	1	01/03/16
AREA 14-129 Helen_Ireland_participant_consent_form_final_March 2016.doc	3	01/03/16
AREA 14-129 Helen_Ireland_Leeds_ethics_form_5 10 15 final.docx	1	09/10/15
AREA 14-129 Professionalism_study_-_Email to service users_5.10.15.doc	2	09/10/15
AREA 14-129 Professionalism_study_-_Email to tutors_5.10.15.doc	2	09/10/15
AREA 14-129 Professionalism_study_-_participant_information_leaflet_-_GPhC 5.10.15.doc	1	09/10/15
AREA 14-129 Professionalism_study_-_participant_information_leaflet_-_service user 5.10.15.doc	1	09/10/15
AREA 14-129 Professionalism_study_-_participant_information_leaflet_-_trainees[1]_5.10.15.docx	1	09/10/15
AREA 14-129 Professionalism_study_-_participant_information_leaflet_-_tutors 5.10.15.docx	1	09/10/15
AREA 14-129 Helen_Ireland_participant_consent_form_5.10.15.doc	1	09/10/15
AREA 14-129 Professionalism_study_-_Letter to GPhC 5.10.15.doc	1	09/10/15
AREA 14-129 Helen Ireland fieldwork-assessment-form-low-risk-2013.doc	1	09/10/15

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval, including changes to recruitment methodology. All changes must receive ethical approval prior to implementation. The amendment form is available at <http://ris.leeds.ac.uk/EthicsAmendment>.

Please note: You are expected to keep a record of all your approved documentation. You will be given a two week notice period if your project is to be audited. There is a checklist listing examples of documents to be kept which is available at <http://ris.leeds.ac.uk/EthicsAudits>.

Yours sincerely

Jennifer Blaikie

Senior Research Ethics Administrator, Research & Innovation Service

On behalf of Dr Andrew Evans, Chair, [AREA Faculty Research Ethics Committee](#)

CC: Student's supervisor

## Appendix N Example of the coding progress from the trainee focus group transcription

Text from transcription	Description	Preliminary thoughts	Initial categories
I think, well people look at you as being a professional and you have to give them reasons to give them that respect.	Respect for profession from public	Professionalism indicators linked to professional role	Becoming/being a professional
Yea, like being trustworthy and, I think there is a transition from when you are a student and you look up to professionals to then becoming it yourself.	Trust  Professionalism not constant, changes from student 'up' to professional  Trainee 'become' a professional  Trainee insight that they have moved 'upwards'	Professionalism indicator'  'Upwards' change in professionalism over year  Transition moves to becoming  Trainee aware of becoming a professional	Understanding of professionalism  Maturation of professionalism  Becoming  Insight to maturation
I think there's a lot of personal learning, rather than knowledge learning, that happens.	Professionalism linked to personal learning and (less so) knowledge	Knowledge not as important as personal learning for professionalism	Personal learning is different to knowledge in professionalism development

## **Appendix O: Notes from the flipcharts created at the HEE quality event: Leeds: 28<sup>th</sup> September 2017**

### **1) Learning environment and culture**

*GPhC:* Influence of patient contact, professionalism is a concept that runs through everything you do – instil from day one, influence of interprofessional contact,

*Service user:* Concept of transition from student to professional, Communication, flexibility, mentorship, friendliness, patient-centred,

*Trainee:* Patient contact leads to professionalism, perceived sterility of the degree course, showing professionalism can vary in settings, actions impact on others, fairness needs a more consistent approach to tutors assessment of prereg,

*Tutor:* Importance of learning from others in developing professionalism, professionalism is at the core of pharmacy and should be consistent across all the sectors of practice,

### **2) Educational Governance and leadership**

*GPhC:* The GPhC are waffling because they are out of touch and don't understand, tranastical, lack of clarity, "now they have to do it" (universities teaching of professionalism) externally driven rather than internal, importance of standards, evaluating each other/peer review,

*Trainees:* Inconsistency between pre reg tutors results in poor training, lack of concept of professionalism before starting Mpharm, requirement to be confident in what you don't know,

*Tutors:* Competency, how to assess professionalism – do tutors know what it is bit hard to define therefore assessment based on gut feeling.

*Service users:* Enhancing the profile of the pharmacist, working proactively, you are the publics face, public not always aware of the services offered by community pharmacy

### 3) Supporting and empowering learners

*GPhC* – confidence, coffee morning meeting with patients to help students be more comfortable talking to patients, Confidence is a key element to professionalism, professionalism is a mind-set, patient contact/dementia friends, understanding the needs of patients, undergraduates leaving because image is not the reality,

*Service users*: Using your professional judgements, pharmacists are cool and relaxed, accessibility/approachable increases the value of being professional,

*Trainees* – Increased confidence, personal learning, confidence = professionalism, responsibility increasing with increasing ability and confidence, Contact with patients leads to the development of professionalism, customer v patient in different sector settings, personal guidance and pastoral care from tutors, increasing responsibility relates to increased professionalism, more placements during degree might help develop professionalism sooner, supporting and empowering, honest/candour,

*Tutors*: Opportunity and exposure to challenges/ownership, positive experiences of cross sector exposure, network/support, link between confidence and professionalism – is this a proxy for ability to take responsibility, confidence and self-belief, establish threshold level of confidence associated with the development of professionalism, tutors set an example, know your limits, confidence ‘normal distribution’ graph and do not want those at lower and higher ends, responsibility trustworthy, reliable,

### 4) Supporting and empowering educators

*GPhC* - Lack of clarity

*Service users*: Value in applying knowledge base

*Trainees*: tutoring more than one trainees was difficult, tutors not having full understanding of the requirements

*Tutors*: Objective tools needed to support tutor assessment of professionalism

## 5) Delivering curricular and assessments

*GPhC* – practical learning, inter-professional learning, course content

*Trainees*: confidence built on increasing ability and feedback, recognition of undergraduate experience having limited patient contact

*Tutors*: Difference and informal methods (could be inconsistent), observation is vital to assess professionalism, observation of behaviours, discussion, feedback from others, assessment of professionalism a key role to sign off, objective/subjective tools to support tutor assessments

## 6) Developing and sustainable workforce

*Service users*: Communication, ability, make time for the patient, changing role and workforce transformation, Expert technical knowledge v tacit awareness and “knowing when to do things”, the public's face – respect and completeness, fear of litigation, rigidity to the rules,

*Trainees*: Actions out of work too, transition from a student

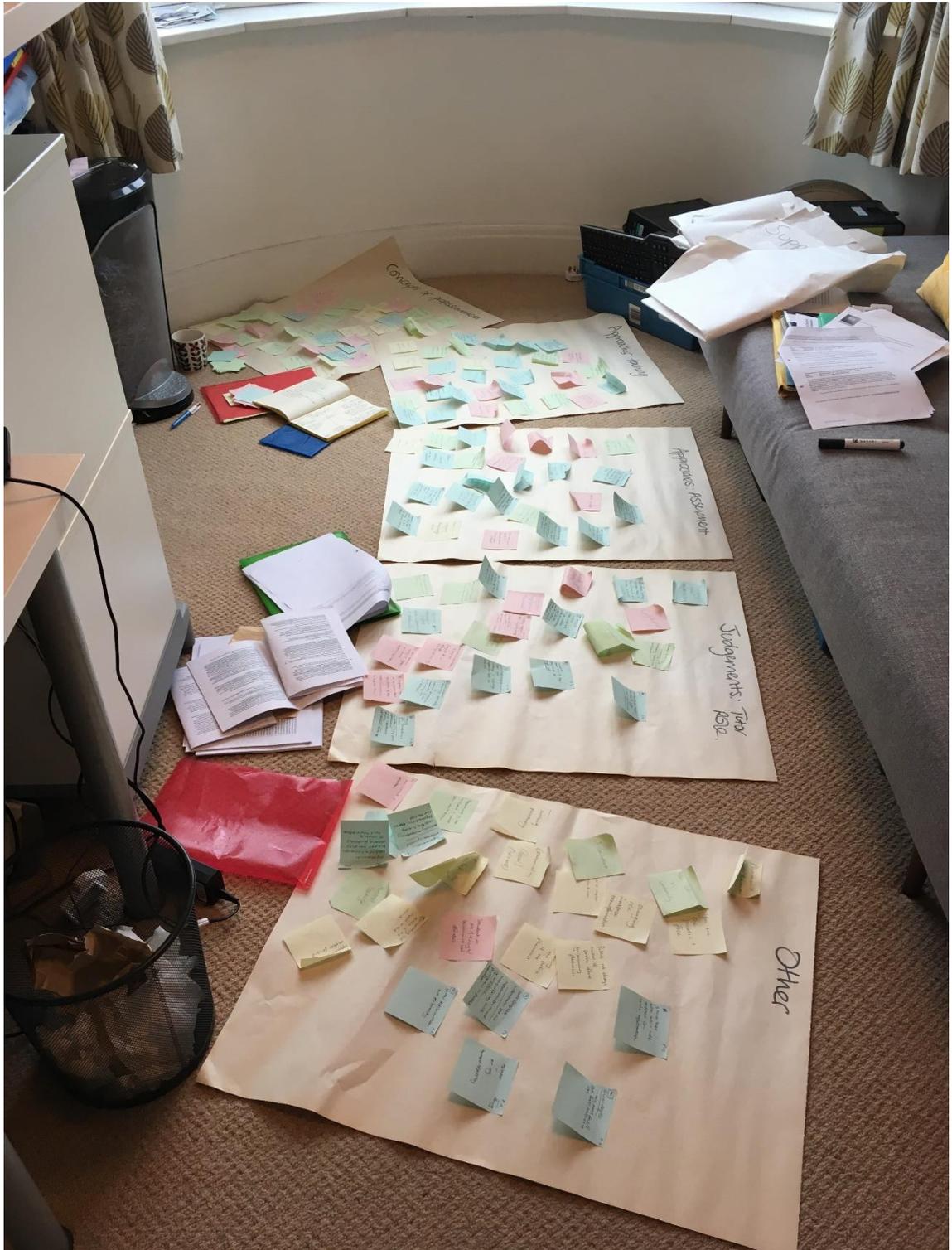
*Tutors*: patient care/expectations

## Other

*Trainee*: Professionalism = confidence = communication skills, responsibility increasing over time, always a professional (not 9-5), professionalism varies depending on audience, more reference to confidence than I expected.

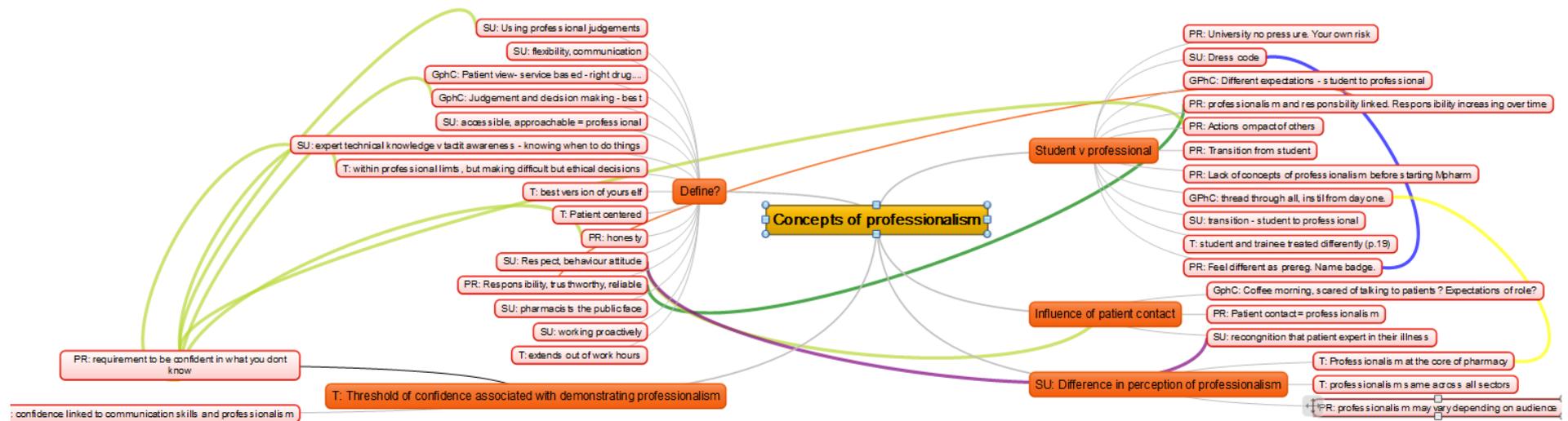
*GPhC*: communication, standards as set of things/behaviours and attitudes,

**Appendix P: Photograph of post-it notes attached to flipcharts**

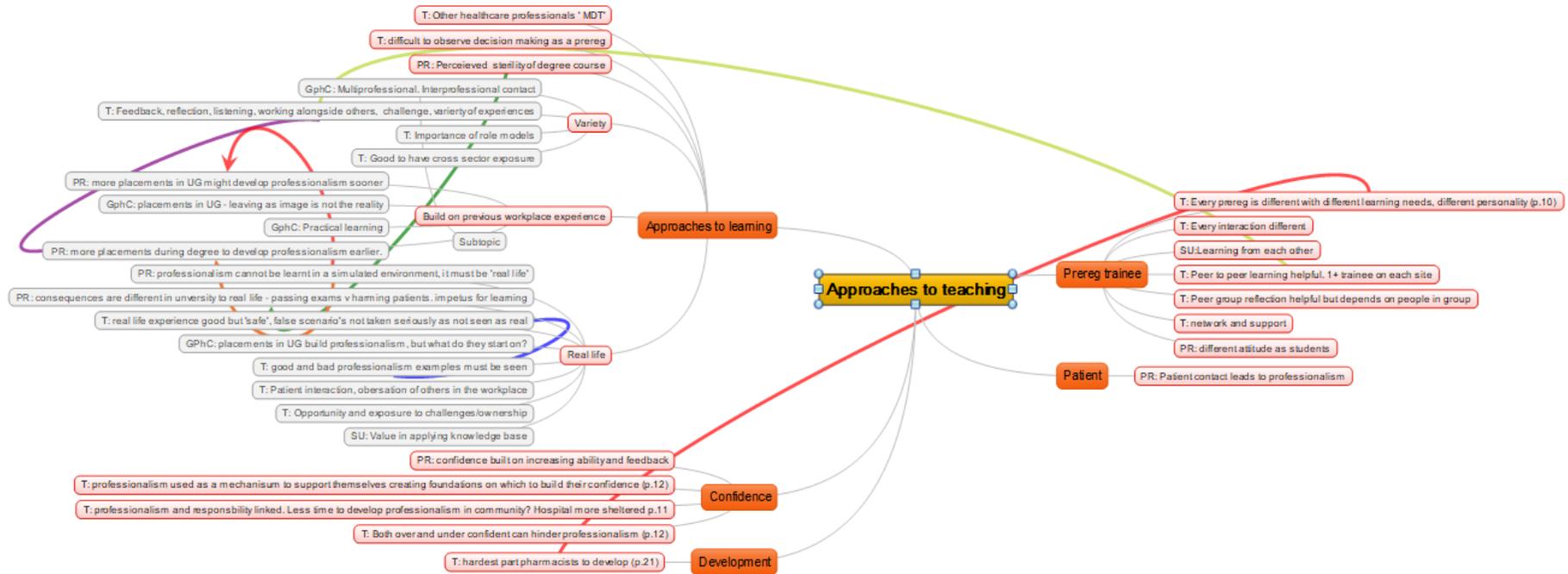


## Appendix Q: Mind Maps showing findings and theme relationships

Early mind map showing themes around concepts and understandings of professionalism



Early mind map showing themes around approaches to learning and teaching of professionalism



### Appendix R: Evaluation of research using the Long and Godfrey (2004) tool

Review area	Key questions	My statement
1) Phenomenon studies and context		
Phenomena under study	What is being studied? Is there sufficient detail given of the nature of the phenomena under study?	The understanding of professionalism from a range of perspectives, insights into how professionalism learnt and assessed during the pre-registration placement.  Detail given into the pre-registration year,
Context 1: Theoretical framework	What theoretical framework guides or informs the study? In what ways is the framework reflected in the way this study was done? How do the authors locate the study within the existing knowledge base?	Dreyfus (2004) and Cruess et al., (2016) have been used to problematize the data from this study. These models were chosen based on the themes that were identified from the qualitative data. Neither of these concepts have been included or discussed in any pharmacy specific researched published. This study refers to a range of studies from the Centre for Workforce Studies, Cardiff University and Swansea University who have explored professionalism within pharmacy education and practice. However, notable

		gaps within these studies was identified and the original contribution this study makes proposed.
Context 2: Setting	Within what geographical and care setting is the study carried out? What is the rationale for choosing this setting? Is the setting appropriate and/or sufficiently specific for examination of the research question? Is sufficient detail given about the setting? Over what time period is the study conducted?	The South West of England. The choice was based on the work location of the researcher. The number of potential applicants involved, e.g. 40 trainees, was reasonable for the study design. The study data was collected May 2016 – July 2017.
Context 3: Sample	How is the sample (events, persons, times and settings) selected? For example theoretically informed, purposive, convenience, chosen to explore contracts? Is the sample (informants, settings and events) appropriate to the aims of the study? Is the sample appropriate in terms of depth (intensity of data, collection, settings and events) and width across time, setting and events (for example to capture key persons and events, and to explore the detail of inter-relationships). What are the key characteristics of the sample?	Sampling was not needed for any of the four stakeholder methods. This was because a suitable number of people volunteered to take part.

Context 4: Outcomes	What outcome criteria are used in the study? Whose perspectives are addressed (professional, service user, carer)? Is there sufficient breadth (e.g. contrast of two or more perspectives) and depth (insight into a single perspective)?	All participants had equal opportunity to be represented in study outcomes. I also manually checked the group interview and focus group transcription and all participants have been represented at least once. Analysis process allowed for thematic representation of agreement/contrast. The coding process provided clear route back to the original data.
Ethics	Was ethical committee approval obtained? Was informed consent obtained from participants in the study? Have ethical issues been adequately addressed?	Yes – Leeds University (NHS concluded study service evaluation). All groups given study information in advance. Consent forms provided and signed before data collection started. Service user and trainee participants invited by third party to avoid power relations. Tutor questionnaire anonymous.  Concern given to power relationships, confidentiality of information, any wellbeing issues that may arise, safe storage of data was discussed, anonymous participants.
2) Data collection, analysis and potential researcher bias?		
Data collection	What data collection methods were used to obtain and record the data? (for example provide insight	Range of different methods adopted, due to interpretative nature focus groups and interviews were preference. However, practical concerns regarding

	into data collected, appropriateness and availability for independent analysis	tutor involvement lead to an e-questionnaire for this study group. Decision made to keep groups discrete to avoid any power concerns. Voice recordings made, with full transcription to paper records for independent view.
	Is the information collected with sufficient detail and depth to provide insight into the meaning and perceptions of the informants?	Key information collected on GPhC participants to avoid identification. Background information provided on focus group study participants. Feedback form also offered to study participants (see appendix H) highlighting their thoughts on the event.
	Is the process of fieldwork adequately described (for example account of how the data was elicited; type and range of questions; interview guide; length and timing of observation work; note taking)	Semi-structured schedules developed (also see appendix J). Independent observer present at focus groups.
	What role does the researcher adopt in that setting?	I describe my central involvement in all steps of the study. This includes being a member of the interview and focus group events.
	Is there evidence of reflexivity? That is, providing insight into the relationship between the researcher, setting, data production and analysis?	Highlighted challenge with NVivo, at the time reflective accounts from each method step discussing potential impact (included researcher power relationship concerns by GPhC), plus also what changes I may make to my approach going forward (e.g use of

		phones). Evidence of analysis approach bias discussed in the (analysis) together with steps employed to promote multiple triangulation approaches. I highlight my transcription of the events and the greater level of familiarity this brought to the analysis. Frequent reflections carried out by researcher along study journey to document thoughts and highlight potential researcher influences.
Data analysis	How are the data analysed?	Thematic framework analysis approach. Involved stepwise and initiative approach for analysis. Similar approaches used in other qualitative studies.
	How adequate is the description of the data analysis? (for example does it allow reproduction; steps taken to guard against selectivity)	Detailed description of each of the analysis steps, where others have been involved to discuss the approach and data produced.
	Is adequate evidence provided to support the analysis? For example included raw/original data extracts, evidence of iterative analysis, representative evidence presented; efforts to establish validity – (searching for negative evidence, use of multiple sources, data triangulation), reliability/consistency (over	Mind maps and data analysis process documented and shared with supervisors (see analysis)  Original data collected included (see analysis), also used a range of tables and illustrations to highlight other aspects of the data and to avoid selectivity.  All participants have been given a unique code to allow for identification of who contributed what. Mention of

	researchers, time and settings; checking back with informants over interpretations.	when no participants from a group contributed, or a disagreement between views expressed.  Did not check transcriptions with informants – challenges of contacts (service users) and leaving prereg (trainees), Also personal changes (maternity leave started July 2016).
	Are the findings interpreted within the context of other studies and theory?	A broad range of healthcare and pharmacy focused studies, together with practice examples and policy documents discussed. The study results and impact linked to these.
Researcher potential bias	Are the researchers own position, assumptions and possible biases outlined? (indicate how these could affect the study, in particular the analysis and interpretation of the data)	I make my role and background clear (intro) and highlight the potential influence this may have.  Bias may have existed – for example by awareness of local tutors and training programme timetables.
3) Policy and practice implications		
Implications	To what setting are the study findings generalizable? For example is the setting typical or presentative of care setting and in what respects?  If the setting is atypical, will this present a stronger or weaker test?	Study is not generalizable as from the intreprisit perspective. This is explained in detail (methods).  However argument is made about the contribution this study brings to the debate into professionalism.

	To what population are the study findings generalizable?	The study results are not generalizable, however themes from this study could be explored in other areas.
	Is the conclusion justified given the conduct of the study? (for example sampling procedure, measures of outcome used and results achieved)	Yes. The study conclusions centre on the key and unique insights presented through the study data. There is a clear pathway for how these justifications have been made.
	What are the implications for policy and for service practice?	The study suggests implications for practice and policy, as well as suggestions for practice.

## Appendix S: Presentation slides delivered to the GPhC, February 2019

### Helen Ireland Thesis presentation to Mark Voce, GPhC

19<sup>th</sup> February 2019

#### Plan

Background  
Research questions  
Method  
Findings and interpretations  
Considerations for the consultation on the standards for the initial training and education of pharmacists

#### Intellectual property

Thesis yet to be published

My intellectual ideas and property

Original contribution

Viva in September 2019

#### Background

What is professionalism? Why is it important? Need for this research?

America  
Medical  
Within UK  
Patients

My role

South West Medicines Information and Training pre-registration training lead  
2014-15 first spiral integrated scheme; hospital, GP, community pharmacy

#### Research questions

1. In the context of the pharmacy pre-registration pharmacist placement, what concepts of professionalism do service users, healthcare professionals, the professional regulator (GPhC), trainees and tutors hold
2. What approaches to learning and teaching professionalism are experienced and/or taken during the pre-registration pharmacist placement
3. How are judgements made on a pre-registration trainee's achievement of professionalism in their placement

#### Methods

Interpretative qualitative approach

- GPhC – group interview
- Pre-registration trainees – focus group
- Service users – focus group
- Pre-registration tutors – qualitative e-questionnaire

Ethics approval obtained

Thematic analysis to evaluate patterns and meaning across the whole data set

## Findings and interpretation

Definition of professionalism  
 Elusive  
 Dynamic  
 Context  
 Time dependent

Some similar aspects: trustworthiness  
 "It's about trust" (T3); *Reliable* (T6); *Responsible* (T1); *Putting the effort in...* (T2); *"For who? (Pause) The patient? The team?" (Interviewer): Yes, for everyone (T2). It's about taking on a role and responsibility and being um, being willing to take responsibility for your actions (T6)*.  
 Differences: patients viewed accurate dispensing as an indicator of professionalism  
 "No matter how good a communicator you are, if you are giving out the wrong stuff (medicines) then you have failed as a pharmacist." SJS

## Findings and interpretation

How do trainees learn professionalism?

Series of transformative moments

Defined as an insight or change, cannot go back, learn something about yourself or others

• Title pre-registration trainee

"They (the tutor) were like 'oh this is the new pre-reg'. And I was like, 'oh, I have a title, this is weird' (Many participants laugh). I'm not a student anymore! It is a step up. So, you are still learning (in pre-registration), but this different names, it sounds more... (Pause) (T6). It's like, the start of your career is actually at the start of your pre-reg, rather than from when you qualify (T2). When you said a step up, a step up in what? (Interviewer), Responsibility I guess, people expecting more from you. "I am concerned this will mean they are treated as students and not as pre-regs" Tutor 6

• Limits of knowledge – shift from 'knowing' at university

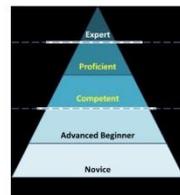
"Handling yourself in a complex situation and being able to say 'this is out of my area, let me seek assistance' is professionalism even if you can't make the decision yourself" Tutor 9

## Findings and interpretation

• Responsibility shift – self centred to patient facing

"What you learn at University is so different to your pre-reg year. What you learn at University is all about cramming knowledge. Then when you come to your pre-reg, it's knowledge but it's about being with people too, (T2); whereas in the undergraduate degree, and I know it's all about learning then, it doesn't really matter if you get it wrong, apart from the fact that you don't pass. I think you become a lot more professional straight away when you start your pre-reg (T1); You see at Uni the focus is all on you, and you, like you said (in reference to T1), what you do in your degree does not affect anyone else. But when you are in the working environment, what you say can affect a patient" (T6).

## Dreyfus model of skill acquisition



## Findings and interpretation

Learning professionalism

University experience varies, how does this relate to start of pre-reg?

"They (the school of pharmacy) posted the (General Pharmaceutical Council) code of conduct under my room door (in university halls) and I thought "what is this?" and I read it, I had no idea." T7

"I think they have to go into the (pre-registration) placement with the understanding of what professionalism is. Which again should be a thread that runs through the MPharm, GPhC A

"Professionalism is inherent from the first day of the pre-reg year and must be imparted to the pre-reg" Tutor 1

## Findings and interpretation

How do trainees learn professionalism?

• Maturation periods

Defined as: Gradual changes. Linked to

Autonomy

Decision making

"I believe that someone who exhibits good professionalism will generally make well thought out decisions" Tutor 10

## Findings and interpretation

How do trainees learn professionalism?

Patient engagement – real, authentic

*“Learning to deal with patients in a professional manner is key, especially because this sort of interaction doesn’t happen frequently throughout the pharmacy degree” Tutor 1*

Rate of professionalism development – patient contact and community pharmacy faster rate

*“Those setting where there is less exposure to patients can decrease the development of professionalism” Tutor 1*

*“In hospital I think the trainees are a little more sheltered from taking responsibility early in their pre-reg year so maybe their professionalism can take longer to develop than perhaps in community” Tutor 2*

## Spiral/rotational programmes

*“Interviewer: Do you think the newer spiral pre-registration programmes where a trainee rotates around different health settings is welcomed for the development of professionalism?”*

*Staff A: Yes, most definitely.*

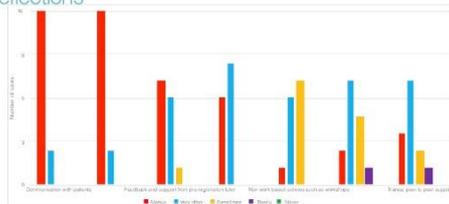
*Interviewer: Why do you think that?”*

*Staff B: I think it’s that confidence. That they can transfer those skills ...*

*Staff A: Yes*

*Staff B: to different sectors and meeting with different healthcare professionals as well ... This now becomes the norm (in reference to the spiral programmes) that they (the trainees) can go into different settings and know what their capabilities are and know what is expected of them when they are there”*

## Activities to develop professionalism: Tutor reflections



## Findings and interpretation

How are judgements made on a trainees professionalism?

• Pivotal role tutors have in the assessment, registration exam does not assess

*“Professionalism is an important part a tutor should take into account before signing off a pre-reg. The academic merit can be assessed by the GPhC exam” Tutor 12*

*“It’s (poor professionalism) the main reason why I have concerns about signing people off at the end of 52 weeks” Tutor 4*

• Current performance standards not enough

*“I don’t use them to assess their (pre-registration trainees) professionalism”, Tutor 2*

• Variety of assessment methods adopted by tutors – range, subjective, type

*“I assess professionalism on a very ad hoc basis” Tutor 1*

*“I don’t have any specific tools or measures” Tutor 12*

*“I often go on gut feeling” Tutor 11*

*“Wards visits, case based discussions, feedback from others” Tutor 3*

*“Discussions about situations, observations” Tutor 6*

## Findings and interpretation

How are judgements made on a trainees professionalism?

• Two tutors – spiral programmes – challenge for assessments

*“Well I have two tutors. It doesn’t quite work ... she’s (one tutor) somehow had not read as many of my competencies. When I went into having that review, she, she didn’t know anything.” T2*

*“It’s really fallen on one tutor who has read all of my evidences and the other one hasn’t signed off anything really” T4*

## Findings and interpretation

How are trainees assessed for professionalism?

Role of patients – Expect to be involved

*“So how would you assess pre-registration pharmacists’ professionalism? (Interviewer): “Ask the patient” (SU1). “And why do you think that?” (Interviewer), (several laughs). “Well there is a mutual relationship. They are there by virtue of the other. It’s highly obvious” (SU4). “Without us you don’t have a job” (SU2).”*

Trainees – have insight into their development

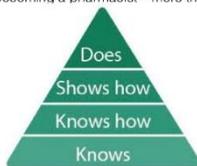
*“Definitely at the beginning of my pre-reg I did not feel that comfortable about speaking to patients, and by going to work every day and, you, you don’t irritate the people you are around, but you take after what they are doing and you learn to become, to be a more trustworthy person.(14); I felt this happened in pre-reg”*

Written reflection not full picture – role of verbal reflection

*“Reflection works well if the trainee is a naturally reflective person. Otherwise encouraging them to write reflectively is like getting blood from a stone ... reflective talking and getting the trainee to think could be preferred” Tutor 9*

## Findings and interpretation

How are trainees assessed for professionalism?  
Becoming a pharmacist – more than 'doing'



## Implications for the consultation

- Welcome professionalism learning outcome, but some elements in other learning outcomes e.g. patient-centred
- Welcome detail in the professionalism learning outcome – but some elements not supported in my study e.g. infection control
- 'Student pharmacist' – hinder transformation? Suggest: 'trainee pharmacist'
- 5 years – importance of work place learning – affect professionalism maturation?
- Trainees see professionalism development over bigger period of time, but trainees need help reflecting to appreciate their development? Verbal reflection? Revalidation?
- Professionalism assessment regularly and throughout the five years, More regular progress meetings? How professionalism assessment to be recorded? 'satisfactory'?

## Implication for the consultation

- Achievement of professionalism – some learning outcomes change from 'does' to 'is' E.g. Demonstrate the values, attitudes and behaviours expected from a pharmacist
- How assess? Conflict of more than one tutor? Involvement of Universities in this?
- How assess? Role of patients? Can patients assess 'becoming'?
- Tutor requirements? New roles – can these people be tutors?
- Importance of the tutor – 'learning in practice supervisor' enough to cover this role?

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