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Article:

Aylott, Lauren, Tiffin, Paul Alexander, Brown, Sally et al. (2020) Great expectations: Views and perceptions of professionalism amongst mental health services staff, patients and carers. *Journal of Mental Health*. ISSN: 1360-0567

<https://doi.org/10.1080/09638237.2020.1818195>

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Great expectations: Views and perceptions of professionalism amongst mental health services staff, patients and carers

Journal:	<i>Journal of Mental Health</i>
Manuscript ID	CJMH-2020-0273.R1
Manuscript Type:	Research and Evaluation
Subject Area:	Mental Health Teams
Further Detail:	Professionalism, Expectations, Carers

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Manuscripts

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3 **Great expectations: Views and perceptions of professionalism amongst**
4 **mental health services staff, patients and carers**
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8 **Running Head: Perceptions of professionalism**
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11 Author details are documented on the title page
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16 Word count = 3965 words
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For Peer Review Only

Great expectations: Views and perceptions of professionalism amongst mental health services staff, patients and carers

Background

Numerous studies have explored the concept of 'professionalism' in medicine, yet little attention has been paid to the concept in a mental health services context.

Aims

This study sought to determine how the lived experience of patients, carers and healthcare professionals in mental health services align with medically defined, generic, professionalism standards.

Method

Interviews and focus groups were conducted with patients, carers, nurses, occupational therapists, psychiatrists and psychologists. A framework analysis approach was used to analyse the data, based on the 'Improving Selection to the Foundation Programmes' Professional Attributes Framework.

Results

Fifty-six individuals participated. Data aligned to all nine attributes of the Professional Attributes Framework, however the expectations within each attribute varied from that originally cited. A tenth attribute was devised during the process of analysis; Working with Carers. This attribute acknowledges the need to liaise with, and support carers in mental health services. Situational examples included both online and offline behaviours and the topic of 'black humour' emerged.

Conclusions

Compared to a conventional medical definition of professionalism, additional themes and differing emphases were observed for mental health and learning disability services. These findings should be used to inform the teaching and evaluation of professionalism, especially for staff pursuing mental health service careers.

1
2
3 **Keywords**
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6 Professionalism; mental health; psychiatry; qualitative study; professional attributes;
7
8 behaviours; carers; values.
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12 **Disclosure statement**
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15 The authors have no declarations of interest to declare
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Introduction

What is Professionalism?

Professionalism is a multidimensional concept (van de Camp, Vernooij-Dassen, Grol, & Bottema, 2004). Definitions have tautologically included “upholding professional values, exhibiting professional behaviours or demonstrating professional attitudes” (Aguilar, Stupans, & Scutter, 2011). The context-dependent nature of professionalism has previously been highlighted (Aylott, Tiffin, Saad, Llewellyn, & Finn, 2019; Rees & Knight, 2007). Yet, whilst many studies have sought to explore ‘professionalism’ in medicine, there is a dearth of studies focusing on the concept in mental health services (MHS; Aylott et al., 2019).

Mental health problems are, reportedly, the single largest source of burden of disease in the UK; nonetheless, services are in receipt of inadequate funding, an understaffed workforce, and insufficient training (British Medical Association, 2017). When services are not resourced adequately, the likelihood of unprofessional behaviour may increase.

Each healthcare area has their own regulatory frameworks, as do each of the professions; nonetheless, there are nuances to MHS that warrant further exploration regarding the concept of professionalism. For example, patients may experience impaired mental capacity, rendering them less autonomous and vulnerable to exploitation. This adds complexity to the ethical and professional issues that face mental health professionals.

Professionalism in mental health services

A recent systematic review provided an operational definition of professionalism for MHS (Aylott, et al., 2019). Practitioners are described as embodiments of their profession, possessing intrapersonal, interpersonal and working professionalism. A scarcity of patient presence was observed in the literature. Therefore, this study explored the perceptions of professionals, patients and carers regarding the professional attitudes and behaviours

1
2
3 experienced in MHS. Having reviewed the literature, the authors determined that the findings
4 would be best analysed against the professional attributes framework (PAF), developed as
5 part of the 'improving selection to the foundation programme' project, commissioned by the
6 Medical Schools Council (2011). This was considered a suitable framework, as most of the
7 professionalism literature regarding MHS focuses on psychiatry (a medical profession). The
8 PAF also helped inform the development of the topic guide. The research questions were: (1)
9 what are patients, carers and professionals experiences of, and perceptions of professionalism
10 in a mental health setting? (2) how does this experience align, if at all, with medically
11 defined, generic, professional standards and attributes?
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25 **Methods**

26 *Ethics*

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28 All procedures were approved by the **Anonymous** committee and a favourable ethical opinion
29 was obtained from London - Camden & Kings Cross Research Ethics Committee
30 (18/LO/0630).
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40 *Design*

41
42 Focus groups were undertaken with carers and professionals. Individual semi-structured
43 interviews were undertaken with patients, as the ethics committee expressed that this
44 approach would raise fewer ethical concerns than the use of focus groups.
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50 *Recruitment*

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52 The study was advertised in an NHS Trust using their electronic news bulletin and intranet.
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54 Emails were sent via professional leads, and flyers were placed in community centres, and
55 distributed via a patient and public newsletter. A carers' network was also approached.
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3 Participation was voluntary; however, patients and carers were offered a £20 gift
4 voucher to reimburse them for their time and travel. Purposive sampling was used. Too much
5 heterogeneity within each focus group could inhibit the discussion (Freeman, 2006); thus,
6 separate focus groups were conducted with psychiatrists, psychologists, nurses, occupational
7 therapists (OTs) and carers. Patients that had accessed MHS, within the last two years,
8 participated in one to one interviews. Having had the objective of the study explained, written
9 consent was obtained from all participants.
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21 ***Data Collection***

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23 Interview questions were established based on the critical incident technique (Flanagan,
24 1954) and prior research on professionalism (Burford, Morrow, Rothwell, Carter, & Illing,
25 2014; Medical Schools Council, 2011). The schedule was piloted, confirming that the
26 questions and prompts were fit for purpose (see Table 1). The lead author facilitated all
27 interviews and focus groups; four focus groups were co-facilitated by a co-author. Interviews
28 and focus groups were digitally recorded and transcribed verbatim. Member checking was
29 used during focus groups and interviews to confirm the authors' interpretation of the data.
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****TABLE-1****

46 ***Data analysis***

48 Data were managed using NVivo. As the researchers had apriori themes in mind, framework
49 analysis (Ritchie and Spencer, 1994; Ritchie, Spencer, & O'Connor, 2003) was employed
50 (see Figure 1). During the familiarisation stage, open coding was utilised; it was determined
51 that the data fit the PAF (Medical Schools Council, 2011). Data were subsequently indexed
52 against all nine attributes of the PAF. Codes and subsequent themes were created to portray
53 an accurate description of the data.
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3 Analysis was predominantly performed by two authors (Anonymous, Anonymous).
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5 An iterative process was used by Anonymous to review a transcript against the codes and
6
7 themes created by Anonymous. Data were discussed, and codes amended through
8
9 negotiation, resulting in themes and subthemes; hereby referred to as the professional
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11 attributes and expectations. To improve the validity of the analysis, all authors reviewed a
12
13 sample of coding.
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20 *****FIGURE-1*****
21
22

23 **Results**

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25 In total, 6 focus groups and 13 interviews were conducted between August 2018 and January
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27 2019. Participants included 18 men, 36 women, and 2 individuals that referred to their
28
29 gender as 'other'. The total sample was 56, including 7 psychiatrists, 7 psychologists, 10
30
31 nurses, 10 OTs, 7 carers, and 15 patients. Ages ranged from 21 to 86 years. Professionals
32
33 worked in a range of specialties, across inpatient and community settings.
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37 Data aligned to all nine attributes, however the expectations within each attribute
38
39 varied to that originally cited. A tenth attribute was devised during analysis; 'Working with
40
41 Carers'. The ten professional attributes, which became the coding framework are described in
42
43 turn here, with illustrative quotes provided. Each attribute includes a brief description to
44
45 reflect its overall nature. As each attribute has multiple expectations, it is not possible to
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47 describe each one; an overview of this structure is reported within Table 2.
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53 *****TABLE-2*****
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Commitment to Professionalism

Individuals should be committed to honouring their profession by adhering to guidelines and challenging poor practice. Professionals must have integrity and be a responsible practitioner.

Challenging poor practice can make professionals unpopular, but they have “a duty” to challenge. Social media presented issues, specifically with regards to online dating and platforms such as Facebook, but the work and personal life dichotomy was made clear.

...it's about having clear boundaries as well isn't it, so I've got a Twitter account for purely professional stuff ... but then Facebook, I have strict settings on that... (OT)

I am a single person, but I have got an issue for example with internet dating as well because of that status you have got [as a psychiatrist], I don't do it.... I think there are some unwritten rules you are supposed to follow. (Psychiatrist)

Coping with Pressure

Practitioners must utilise their clinical judgement, particularly in times of uncertainty and ambiguity. Professionals must have resilience and be able to de-escalate situations when others are experiencing distress.

Participants were aware of the need for professionals to separate themselves from the work that they do, to not let this impinge upon their own wellbeing.

Professionalism for me is walking out of here and onto the next thing with a fresh mind, a fresh view...you have got to detach. (Patient)

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3 Acknowledging the need for de-escalation, a carer highlighted that some staff de-escalate
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5 situations better than others.
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11 I have seen physical restraint used detrimentally to the point even when people were
12 saying 'oh should we do your hair' while they are restraining this person on the floor,
13 whereas other staff would be able to talk to that person and dissolve the situation (Carer)
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21 Humour was noted as a means of making light, defusing stress and normalising situations. An
22 example was provided with respect to a suicidal patient who frequently swallowed a specific
23 form of vegetation. After numerous incidents within a shift a staff member made a blasé
24 remark, '*I can't wait for spring, when there are no [vegetation] around.*' Humour was
25 viewed negatively in certain circumstances, such as when one is critical of a patient.
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34 ***Effective Communication***

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37 *Practitioners must communicate effectively, using both verbal and non-verbal*
38 *communication. Professionals should have the ability to build rapport with patients,*
39 *and validate the thoughts and feelings of others.*
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43 Banter can be used to build rapport; however, it was recognised that this can go wrong very
44 quickly, particularly "*if someone feels targeted, especially where they've got trauma*
45 *histories, where they've been humiliated, bullied, and all the rest.*" (Psychologist)
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Learning and Development

Practitioners must possess the appropriate knowledge and skills for their role, utilising professional development opportunities. Professionals should accept feedback and utilise supervision accordingly.

Supervision is a safe forum for discussing the difficulties one may face, particularly when struggling with patients.

You could say the same thing, but in different contexts. And some are professional and some are not professional. (Psychologist)

Organisation and Planning

Practitioners must maintain accurate records and read case notes attentively.

Professionals must effectively manage limited resources, and their time accordingly.

One professional suggested that documentation was a waste of clinician time, whereas a patient commented that sometimes this must take precedence.

All the notes we keep really are litigation proof that's all it is you know (Nurse)

The planning of my care could depend on that, ... If it isn't recorded properly I might lose out on the appropriate care. (Patient)

Patient Focus

Practitioners must possess qualities that enable them to build therapeutic relationships with patients, such as altruism and humility. Professionals, also, must maintain an

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2
3 *appropriate professional distance and not impose their own values on patients,*
4 *delivering person-centered care.*
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7 A service user indicated that, in some cases, respect is not always evident. This finding was
8 supported by an OT's comments.
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15 Just the way someone speaks to you honest they speak to you like you're on their shoe.

16 (Patient)
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20 when people open doors without knocking, or open curtains without getting
21 permission... It's low-grade stuff, but it's poor practice. (OT)
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28 One patient discussed their anxiety at making telephone calls; noting that their nurse
29 challenged them to do this, they felt they should be challenged in this way.
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36 It's finding ... something I need to do or want to do and pushing me to do that, as
37 opposed to pushing me to do whatever they think most people who are depressed or hear
38 voices or whatever do. (Patient)
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44 ***Problem Solving*** 45 46

47 *Practitioners must be able to reason with abstract information. Professionals also must*
48 *understand problems from a wider perspective, having the ability to adapt their*
49 *practice.*
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53 Patients experience mental illness differently; professionals must therefore conceptualise with
54 abstract information.
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3 The word schizophrenia does not describe people with schizophrenia, you know
4 everybody's different and I think you have to ... think outside the box a bit in mental
5 health that you maybe don't have to do so much in sort of medical care. (Nurse)
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10 ***Self-Awareness and Insight***

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14 *Practitioners must possess self-awareness and acknowledge the limits to their*
15 *competence. It is appropriate to disclose some information about self, but professionals*
16 *must recognise and maintain boundaries when doing so.*
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20 Self-disclosure can break down some of the boundaries in a staff - patient relationship.
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23 However, the disclosure must be appropriate for each patient.
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28 It also seems a bit of a balance sometimes because you expect a patient to share so much
29 of themselves... And then you kind of go, but I won't tell you anything about me.
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31 (Psychologist)
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36 Professionals must reflect-in-action.
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42 I've seen a fair few emails that maybe come across as disrespectful and unprofessional,
43 because they're emotive emails about a topic that people have strong opinions on... I
44 think professionalism is about taking a step back and thinking right, I'm quite annoyed
45 about this, maybe I should send this later or ask someone else to look over it.
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47 (Psychologist)
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Working Effectively as Part of a Team

Practitioners must work alongside colleagues effectively, acknowledging people's strengths and capabilities. Professionals must also be a positive role model.

Discussions arose regarding negative role modelling and the detrimental impact this can have on students and newly qualified professionals.

When they're qualified, you can't go home and have a cup of tea and I think that sometimes with students, ... we set the wrong examples. (OT)

Working with Carers

Professionals must involve carers where possible, whilst adhering to the bounds of confidentiality. Carers generally want to be involved and should feel supported in their role.

The study found that professionals were perceived to hide behind policy. Carers want to be supported, yet that support is not always available.

confidentiality, he is using that against me because all he is sees is a carer ... he is not making that connection between if he supports me professionally as a carer, he is also supporting my son in the future (Carer)

Carers feel left to the wayside; professionals should work with carers, where possible, to improve patient care.

1
2
3 the majority of carers want to be involved and want to help and get very fed up of being
4 left in a corner. (Carer)
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9 **Discussion**

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12 Professionalism is widely cited as the basis of a social contract between professions and
13 society (see Aylott, et al., 2019). With regards to medicine, physicians can expect their core
14 activities to be protected and governed by licensing laws (Cruess, 2006); which permit
15 members to practice, and in turn, support their financial interests. Indeed, this may be the
16 primary motivation for the professionalisation of some occupations (Wilensky, 1964).
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24 Professions are permitted and expected to self-regulate (Cruess, 2006). However, in return,
25 the views of the patients they serve, who place their trust in the profession, must be
26 incorporated (Irvine, 1997). Indeed, the social contract must be regularly renegotiated
27 (Bhugra, 2008; Bhugra & Gupta, 2010).
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34 The study sought to explore the professional attributes desired within mental health services.
35
36 The authors hoped to determine how this experience aligned to medically defined, generic,
37 professional standards and attributes.
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42 **Main Findings**

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45 The findings demonstrate that patients', carers' and professionals' views on professionalism
46 in MHS mostly align to medically defined, generic, professional standards and attributes;
47 however, there are differing emphases, and carers must be factored into the equation. When
48 working with clients exhibiting challenging behaviours, it is important that one maintains
49 self-awareness and insight to maintain a neutral, professional stance with patients. Effective
50 communication is paramount across settings, yet this is more challenging in MHS, where
51 patients may be severely unwell and lack mental capacity. As highlighted previously, the use
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3 of banter can go extremely badly when used with patients that have trauma histories.
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6 Whilst carers are not unique to mental health settings, they often play a key role in the
7
8 care of many patients with mental health problems and working collaboratively with them is
9
10 an essential part of modern service delivery (Cleary, Freeman, & Walter, 2006); nevertheless,
11
12 the findings demonstrate that all too often, carers are feeling left to the wayside and
13
14 unsupported in their role. Given that a patient's mental capacity is often impaired in MHS,
15
16 carers fill a vital role, *"if you are really doing the best for your patient, you have to be able to*
17
18 *look at their social network, particularly in mental health"* (Carer).
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23 ***Comparisons with the Existing Literature***

24
25 As demonstrated previously (Green, Zick, & Makoul, 2009), the study found that patients and
26
27 professionals do not always place the same regard on certain professional behaviours; there
28
29 were differing views between a patient and professional regarding documentation.
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31

32
33 In comparison to the medically derived PAF, the study identified a tenth attribute;
34
35 working with carers. The importance of carers being involved in the treatment of patients
36
37 with mental health problems has previously been reported in the Triangle of Care guidance
38
39 document (Worthington, Rooney, & Hannan, 2013). Nevertheless, carers report being
40
41 shunned by professionals, who won't even talk to them, because *"the patient has not given*
42
43 *consent for the carer to be involved"* (Carer). This study adds further evidence to support
44
45 the findings of Cleary, et al., (2005); over 50% of carers reported that information, such as
46
47 that regarding medication, illnesses and community resources is not provided to them.
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52 Similarities are observed between these findings and the definition of professionalism
53
54 proposed by Aylott et al., (2019). The attribute 'Commitment to Professionalism' is
55
56 congruous with 'Intrapersonal Professionalism'; 'Patient Focus' and other attributes align to
57
58 the concept of 'Interpersonal Professionalism'; and 'Coping with Pressure' is harmonious
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1
2
3 with 'Working Professionalism' – the ability to form judgements and act accordingly,
4
5 thinking critically and using reflection in action.
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8 The importance of contextual factors and situational judgement has previously been
9
10 reported by Burford et al., (2014). Whilst their study was not conducted in MHS, their
11
12 findings resonate with the current study; as a psychologist highlighted, "*You could say the*
13
14 *same thing, but in different contexts. And some are professional and some are not*
15
16 *professional*". Similarly, the use of humour and self-disclosure is dependent on contextual,
17
18 patient related factors.
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21 Humour is viewed as acceptable amongst professionals, but professionals must be
22
23 aware of their audience, and they must use humour in a safe setting. Camaraderie and banter
24
25 have been reported on in a study with medical undergraduates, whereby "*camaraderie was*
26
27 *condoned as a legitimate means by which medics can diffuse stress*" (p.819; Finn, et al.,
28
29 2010). Nearly a decade later, the same issues still present. This is a controversial issue, as
30
31 professionals argue that humour is vital for their wellbeing, but many alluded to its context
32
33 dependence and sensitivity.
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37 The need to be a positive role model was highlighted, echoing that previously
38
39 reported with the 'hidden curriculum'; there are discrepancies between what students learn in
40
41 textbooks and classrooms versus what they pick up on placement (Hafferty and Franks,
42
43 1994). Concerningly, the observation of and participation in unethical conduct has been
44
45 shown to result in ethical erosion overtime (Satterwhite, Satterwhite, & Enarson, 2000).
46
47 Problematic behaviour during training has also been found to predict disciplinary action in
48
49 later clinical practice (Papadakis, Hodgson, Teherani, & Kohatsu, 2004).
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53 In many ways, professionalism is ~~like oxygen~~—more noticeable by its absence than its
54
55 presence. Following their evaluation of a Situational Judgement Test measuring integrity, de
56
57 Leng et al. (2018) suggested that there may be a greater consensus regarding what is
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1
2
3 considered inappropriate, as opposed to appropriate behaviour. Certainly, in the current
4 study, participants frequently referred to professionalism as about 'what not to do', as
5 opposed to more optimal behaviours. Healthcare is becoming increasingly bureaucratic and
6 administrative, and in a litigious society, professions are more regulated than ever. Whilst
7 participants seemed open about their professional and unprofessional encounters, some
8 behaviours may not have been disclosed. This is in keeping with what John McLachlan refers
9 to as 'Pious Platitudes' about professionalism; that practitioners, when asked to define
10 professionalism, may respond with what they think they ought to say, rather than with what
11 they have actually observed (Monrouxe and Rees, 2017).
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25 *Interpretation of findings*

26 Various medical specialties suggest that refinements to the concept of professionalism are
27 needed for this to be pertinent to their practice (Woodruff, Angelos, & Valaitis, 2008). For
28 instance, it has been argued that the Physician Charter does not take account of many
29 elements of surgery practice, that pose specific ethical and professional questions for their
30 specialty (Jones, McCullough, & Richman, 2006). Given the nature of MHS, it is not
31 surprising that the study identified a tenth attribute - working with carers. Carers were not
32 directly involved in the development of the PAF. However, there are nuances in MHS that
33 are not present in other specialties; detained patients lose their patient autonomy - one of the
34 three fundamental principles of medical professionalism (Project of the ABIM Foundation,
35 2002); and patients are vulnerable (Department of Health, 2000, updated in 2015), often
36 relying on carers to protect and advocate for them. As stated in the Triangle of Care, "*Carers*
37 *are usually the first to be aware of a developing crisis ... They are often best placed to notice*
38 *subtle changes in the person for whom they care, and usually the first to notice the early*
39 *warning signs of a relapse"* (p.7, Worthington, et al., 2013).
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3 MHS pose many challenges for professionals, as well as professionalism in general.
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5 For example, patients may commit suicide, which undoubtedly impacts upon a professional's
6
7 own wellbeing. Patients, also, may be criminals, yet the professional has a duty of care and
8
9 must do their best by the patient. Discussing the ever-increasing challenges, a psychiatrist
10
11 commented – "*isn't our status because we do, we make good a bad system ... I think we are*
12
13 *regarded at a level that we are regarded because we don't let bad things happen*". The
14
15 current study explored the expectations placed on professionals working in MHS; however,
16
17 we must acknowledge the requirements of the professions themselves, including a properly
18
19 funded and value-driven healthcare system (Bhugra, 2008; Cruess, 2006). The social contract
20
21 places expectations on patients too, such as 'a shared responsibility' for their own health and
22
23 wellbeing (Bhugra, 2008; Cruess, 2006); it is important that patients and carers work with
24
25 professionals, by, for example, returning calls in a timely manner, and turning up to
26
27 appointments.
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34 ***Strengths and Limitations***

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37 This is the first study to explore professionalism from the views of patients, carers, and
38
39 professionals in MHS. The findings are enriched by the opinions of patients and carers; a
40
41 voice underrepresented in the professionalism literature. Some researchers criticise the
42
43 combining of interview and focus group data; however, Lambert and Loiselle (2008) describe
44
45 how the integration of focus group and individual interview data can enhance the
46
47 trustworthiness of findings. Alike Lambert and Loiselle's study (2008), not all prompts were
48
49 used during focus groups to elicit the information. Nonetheless, the topic guide enabled a
50
51 semi-structured approach and minimised the likelihood of interviewer bias.
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56 The study was conducted in a large NHS Trust and there were geographical variances
57
58 in where professionals and patients, had trained, worked, and/or received healthcare
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3 previously. Professionals worked across a mixture of settings and a number of nationalities
4 were represented; it is thus the opinion of the research team that these findings are
5 transferable to and representative of mental health issues nationally. Acknowledging that the
6 interviewer is an active participant in co-constructing meaning during interviews (Holloway
7 and Galvin, 2017), two individuals analysed the data in order to minimise bias. A reflexive
8 approach was taken throughout (Berger, 2015).
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10 11 12 13 14 15 16 17 18 ***Implications for policy and practice***

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21 To promote collaboration between practitioners and carers, the authors support some
22 recommendations proposed by Lloyd and King (2003); managers must openly ask staff about
23 their involvement with carers during routine review meetings; collaboration should become a
24 key feature of performance appraisals; and staff should receive appropriate training on the
25 topic. The authors recommend that the study findings are used to guide training curricula.
26 Unprofessional behaviours were highlighted during the study. It has previously been
27 demonstrated that approximately a quarter of students found the school environment “not
28 very conducive” or “not at all conducive” to the open discussion of ethical concerns
29 (Satterwhite, et al., 2000). The authors would like to reiterate the recommendations of
30 Monrouxe, et al., (2011); that more sense-making opportunities should be made available to
31 students, under the supervision of clinical educators. The findings may be used to inform the
32 development of assessments for the selection of staff into MHS. In addition, it may be fruitful
33 to integrate these findings into the standards and inspection guides of health care regulators.
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51 52 53 ***Implications for Future Research***

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55 The study did not set out, specifically, to identify differences amongst the professions, with
56 regards to the desired professional attributes. Further research could utilise these findings to
57 determine the extent that each profession endorses each attribute. Professionals face many
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3 challenges at work and rely on patients to engage with their treatment in order for the
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5 practitioner themselves, to fulfil their role. The authors suggest that future research explores
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7 the professionalism of patients that use MHS. A greater understanding of the impact that
8
9 patient behaviour has on the clinical care delivered will facilitate the development of more
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11 tailored packages for patients, and more educational interventions for staff. The study
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13 demonstrates that professionals need to fulfil expectations across 10 professional attributes in
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15 MHS; including working with carers. The authors urge practitioners to support carers and
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17 provide a forum for them to air their views. When a patient is in crisis, a carer's words could
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19 be lifesaving.
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Table and Figure Captions

Table 1. Topic guide used to generate discussion on professionalism in mental health services

Table 2. Professional attributes and expectations of staff working in mental health services
(adapted from Medical Schools Council, 2011).

Figure 1. Stages of Framework Analysis (adapted from Ritchie & Spencer, 1994)

For Peer Review Only

Table 1. Topic guide used to generate discussion on professionalism in mental health services

Topic stem	Prompts
Professionalism	<p>What does professionalism, in general, mean to you?</p> <p>What does good 'professionalism' look like, in general?</p> <p>What does 'unprofessional' behaviour look like, in general?</p> <p>What are the most important aspects of 'professionalism' for staff working in 'mental health services'?</p> <p>What skills are important when working in mental health services?</p> <p>What interpersonal attributes are important when working in mental health services?</p> <p>What values are expected of staff working in mental health services?</p>
Professional Behaviours	<p>Is anyone able to discuss an example of professional or unprofessional behaviour, that they have recently observed, especially good or bad practice?</p> <p>What were the circumstances leading up to the incident?</p> <p>Would you please describe the professional's reaction?</p> <p>What did the person(s) do that was (un)professional?</p> <p>- has anyone else got any other views regarding this behaviour(s)?</p> <p>- how else could the professional have responded?</p>
Professional Dilemmas	<p>Has anyone observed any dilemmas that a professional has recently encountered?</p> <p>What were the circumstances?</p> <p>Did the professional(s) behave in a professional or unprofessional manner?</p> <p>What did the professional do?</p> <p>- what was it about the behaviour that was (un)professional?</p>

Table 2. Professional attributes and expectations of staff working in mental health services
(adapted from Medical Schools Council, 2011).

Professional attribute	Associated expectations
<i>1. Commitment to Professionalism</i>	<i>Adheres to guidelines; Behaves according to expectations; Challenges the system accordingly; Challenges poor practice; Displays a commitment to the role; Is trustworthy and has integrity; Maintains confidentiality; Is a responsible practitioner; Possesses confidence and courage; Demonstrates awareness of ethical issues; Upholds the profession's and organisation's reputation; Uses Social Media appropriately.</i>
<i>2. Coping with Pressure</i>	<i>Checks the facts of a case; Utilises clinical judgement accordingly; Utilises de-escalation techniques appropriately; Possesses resilience and manages own wellbeing; Remains calm and in control of situations.</i>
<i>3. Effective Communication, with Patients, Carers and Colleagues</i>	<i>Utilises an appropriate style of communication; Advocates for patients when needed; Builds rapport with patients and is personable; Communicates effectively with colleagues; Is open and honest, whilst communicating in a proactive manner; Communicates sensitively, taking context into consideration; Listens effectively; Observes accordingly; Understands non-verbal communication; Utilises appropriate non-verbal communication; Validates the thoughts and feelings of others.</i>
<i>4. Learning and Professional Development</i>	<i>Is accepting of feedback; Applies knowledge and learning to practice; Utilises supervision; Has the appropriate knowledge and skills for the role; Undertakes continuing professional development and learns from practice; Possesses the relevant qualifications for the role; Undertakes research.</i>
<i>5. Organisation and Planning</i>	<i>Is efficient in the role; Maintains accurate records; Reads patient's case notes; Is able to make appropriate use of limited resources; Manages time accordingly; Wears appropriate attire at work.</i>
<i>6. Patient Focus</i>	<i>Attends to patients' physical healthcare needs; Acts as a human interface for the organisation; Builds therapeutic relationships; Demonstrates compassion; Contains the emotions of others; Does not impose own values on patients; Is friendly, but maintains an appropriate professional distance; Is altruistic and possesses humility; Is approachable; Is empathic and understands the impact of mental illness; Is genuine, honest and fulfils promises, Is non-judgemental, Provides reassurance, Maintains Safety, Treats Patients with respect, Utilises both a person-centered and recovery-focused approach</i>
<i>7. Problem Solving and Decision Making</i>	<i>Is able to reason in an abstract manner, Helps patients to problem solve, Makes appropriate decisions based on all the relevant information, Understands problems from a wider perspective, Uses their initiative and adapts practice, to meet a patient's needs</i>
<i>8. Self Awareness and Insight</i>	<i>Acknowledges one limits, Discloses appropriate amounts of information about self, Has self-awareness and reflects on practice, Recognises and maintains appropriate boundaries</i>
<i>9. Working Effectively as Part of a Team</i>	<i>Able to identify and utilise the most appropriate person for a task, Acts as a positive role model, Maintains appropriate relationships with colleagues, Maintains consistency with colleagues, Supports colleagues, Works with other teams, Works effectively with colleagues</i>
<i>10. Working with carers</i>	<i>Assesses a carer's motives accordingly, Involves carers and makes use of their expertise, Supports and validates the carer's perspective</i>

Figure 1. Stages of Framework Analysis (adapted from Ritchie & Spencer, 1994)

