Original Article

Good doctor and bad doctor: a qualitative study of first year medical students' views on professionalism

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Received: 21-MAY-2018 Accepted: 16-AUG-2018 Published Online: 23-NOV-2018

Abstract

Introduction: Professionalism is emphasized in medical school curricula; however, there is lack of consensus on what constitutes professionalism. This study aimed at exploring incoming medical students' views on professionalism through student constructs of the 'good' and the 'bad' doctor. Methods: After Institutional Ethics Committee approval and informed consent, all (n=150) incoming first-year medical students were asked their reasons for pursuing medicine and their perceptions of the attributes of a 'good' and a 'bad' doctor. Following the anonymous survey, we used nominal group discussions to achieve consensus about the desirable and undesirable attributes that emerged from student responses. After an iterative theming process, a list of themes were derived from the written reflections of students. Results: Competence, communication, and professionalism were some of the percieved attributes of a good doctor, while being money-minded, having inadequate knowledge or competence, and rudeness were some of the reported attributes of a bad doctor. We identified six themes for the question 'Why pursue medicine?': affective / humanitarian response; thoughts about further pursuits; fulfillment; traits of the profession; ability to contribute to society; and personal experiences. Conclusion: Our results suggest that first year medical students have a fair idea of the behavior expected from a good doctor. Formal reflection on these expectations may hone the concept of professionalism for new entrants into the profession. The teaching of professionalism could incorporate such activities to allow students and educators to articulate and explore tensions between what is taught and what is experienced as they progress through the profession.

Keywords: Ethics; Good doctor; Professionalism; Qualitative research; Reflective practice

Cite this article as: Dinesh Kumar V, Murugan M, Prasad B, Devi R. Good doctor and bad doctor: a qualitative study of first year medical students' views on professionalism. RHiME. 2018;5:58-68.

Introduction

Since the days of Hippocrates and Maimonides, the foundation of medical professionalism is said to be primacy of patient interest and subordination of self-interest.[1] In contrast to the previous view that professionalism should be 'caught' by students from observing their role-models, recent research indicates the need for it to be 'taught' to medical students as a part of their curriculum.[2,3] Indeed, it is argued that the concept of professionalism must be periodically addressed throughout the duration of the entire curriculum.[4]

The components of professionalism being abstract and culture specific, they vary according to the different phases of the medical course. Both personal and environmental factors play a role in shaping the physician's professionalism.[5] This professional identity formation is a dynamic, inter-personal and subjective process that influences future doctor-patient relationships.[6] These facts make it cumbersome to develop and assess a set of universal essential attributes to be acquired by medical students.[7,8]

For professional identity formation in professionalism education, researchers suggests that "lists of values and behaviors" be generated by students themselves. [9] The principal component in developing the professional identity of future physicians is self-reflection and self-awareness.[10] This valuable tool allows students to explore their own values, beliefs, and biases within the realities of societal norms.[11,12] As we have students from varied cultural contexts and socio-economic backgrounds, their perception of the medical profession might differ from that of people in the community at large. Considering the ability of students who have freshly joined the medical college to internalize professional values, we decided to explore the behaviors that students themselves expect from a doctor. The study used self-reflective transcripts of first year medical students' perceptions of the constructs of 'good doctor' versus 'bad doctor'.

Methods

After Institutional Review Board approval, first year medical students, who had just completed their orientation program at the Pondicherry Institute of Medical Sciences, were requested to volunteer to participate in the study. After explaining the objectives of the study and obtaining informed oral consent, a questionnaire was handed out to the students. It was to be self-administered, left anonymous, and students were advised that submission of a completed questionnaire would be taken as indirect consent to participate in the study.

The questionnaire, based on the concepts of professional identity formation, was developed using frameworks from the existing literature on the subject.[8,13,14] It had several trigger questions to generate self-reflection (see Box). Students were asked to complete the questions individually based on their perceptions about the medical profession and the completed questionnaires were collected by the authors on the same day.

In the second phase, which took place on the same day and at the same venue, the students were divided into six sub-groups of 25 students each for the purpose of nominal group discussions. We chose nominal group discussion over focused group discussion (FGD) for more than one reason: we wanted to expose all students to the process of reflection; FGD would

Box

Questions that first-year medical students were requested to respond to in writing

1. What were the reasons (any two) that you decided to pursue a career in medicine?
2. In what way do you think you can contribute to society by becoming a doctor?
3. Think of a doctor whom you consider to be an example of professionalism. Describe the admirable features in him / her.
4. Reflect on personal experiences that have been critical in fostering your ambition to become a doctor.
5. What specific characteristics that you would you like to find in a doctor? Mention two most important ones.
6. What specific characteristics would you NOT like to find in a doctor? Mention two most important ones.

have required 7 or 8 trained facilitators for 150 students; we had limited time for development of uniform guidelines and for conduct of FGDs. Besides, nominal group technique has the potential to induce discussion that can help in constructing knowledge from varied perceptions. When students interact in groups, a comment from one person can generate an additional response.[15]

Each sub-group was facilitated by a faculty member who normally served as a small-group tutor for the students. Students were invited to freely share their views during the discussion which was divided into five steps. In step one (individual reflection) the students in each subgroup were asked to reflect individually on two constructs: desirable traits they would like to find in a doctor and undesirable traits they wouldn't like to find in a doctor. In step two, the faculty facilitator asked each student to contribute one response each to the two constructs so as to collate the views of the students and to develop a list of universal attributes. In step three (rationalizing), the compiled list was discussed within the sub-group and overlapping or similar points were rationalized. In the fourth step (setting priorities), the subgroup members reviewed the final list individually to make sure that the most important points were listed. In the last step, the points generated from individual groups were written on the black board, collated and a final list of attributes was developed.

Qualitative analysis: This comprised the third stage of the study and involved analysis of the completed and returned questionnaires over the following one month. To maintain anonymity, any information that could lead to personal identification was inked out. Confidentiality was strictly adhered to and identification from the transcripts could not be made by any means. The questionnaires were subjected to qualitative analysis following a grounded theory approach. Data analysis was largely inductive and consisted of thematic analysis based on the four steps identified by Green et al., immersion in the data, coding, creating categories and identification of themes.[16] Using an iterative theming process, coding was done independently by three of the authors (DK, MM, BP), who repeatedly coded until no further themes emerged from the transcripts (saturation).[17] The authors then sat together to iron out discrepancies in coding. Connections between codes were sought so as to identify analytic categories and develop overriding explanations.[16] We adopted an aggregate sorting matrix to remove the subjectivity in our analysis. This

method is similar to algorithms used in commercially available qualitative analysis software.[18]

Results

The 150 first year medical students who participated in the study were aged between 17-20 years; 64.5% were women. Table 1 lists the attributes of a 'good doctor' and a 'bad doctor' as derived by nominal group discussion after removal of overlapping responses. Table 2 shows thematic analysis of students' responses to the open-ended question 'What are the reasons for your decision to pursue a career in medicine?'. The six themes identified are detailed in the table along with exemplary quotations from student responses.

'Humanitarian response' refers to the feeling of general satisfaction or contentment that comes with practicing medicine. The theme of 'thoughts about further pursuits' refers to the things which the student believes that he can do as part of the entitlement of being a doctor. For example, a student interested in performing surgery can do so after qualifying and training for it; or a student who intends to settle well in life has his eyes on the economic aspect of medicine, including job security and the

Table 1: The list of attributes of a good doctor and a bad doctor generated after nominal group discussion with 150 first-year medical students

Attributes of a 'good' doctor	Attributes of a 'bad' doctor
1. Friendly	1. Money-minded
2. Honest	2. Lacking in knowledge/competence
3. Hope-giver	3. Rude/impatient
4. Competent	4. Keeps patients waiting (non-punctual)
5. Healthy	5. Disrespectful
6. Committed	6. Poor communication skills
7. Selfless attitude	7. Unethical
8. Respectable personality	8. Negligent
9. Socially aware	9. Misuses professional priveleges
10. Impartial	10. Advertising / boasting
11. Updated / life-long learner	11. Accepting bribes for doing his / her duty
12. Handles stress effectively	12. Egoistical in professional relationships
13. Good time manager	13. Vengeful
14. Open-minded	14. Showing bias based on gender
15. Has presence of mind	
16. Responsible / accountable	
17. Passionate towards job	
18. Acts as a motivator for others	
19. Keen observer	
20. Punctual	
21. Curious to learn newer things	
22. Optimistic, but not overconfident	
23. Able to work as a team member	
24. Systematically organized in work	
25. Committed to listen, even if tired	
26. Sporting	

Table 2: Thematic analysis of student responses as to their reasons for opting for a career in medicine

Theme	Exemplary Quote
Humanitarian / Affective response	a. “self-satisfaction” b. “curious to know about human body” c. “feeling I would get, after helping a person” d. “capable of taking part in people’s pain”
Thoughts about further pursuits	a. “able to deal with life and death of persons” b. “able to serve people” c. “safe and comfortable way of serving mankind” d. “fantasy to do surgeries” e. “pleasure of delivering a baby” f. “settle well in life”
Fulfillment	a. “inspired by doctors in my family” b. “unfulfilled dream of our family” c. “admiration of others to people in this profession” d. “inspired by an article about the medical profession” e. “passionate about this profession”
Traits of the profession	a. “never ending learning experience” b. “nobility of the profession” c. “demi-god in minds of people” d. “ability to give second chance of life” e. “to know how disease happens and provide answer for suffering of patients” f. “loss of a person could terribly affect a family - it could be prevented to an extent”
Personal experiences	a. “death of my relative’s child due to improper medical care” b. “mother’s ailment” c. “a doctor who treated his patients with empathy” d. “death of friend’s father due to oral cancer”
Contribution to society	a. “provide affordable health care in remote areas” b. “can spread awareness to society" c. ‘"to listen’ is possible in this profession” d. “could be able to find cure to genetic diseases” e. “can be a ray of hope and inspiration to future generation”

high standard of living.

The theme of 'fulfillment' refers to the primordial desires they have which could be fulfilled by becoming a doctor. It includes the sense of pride in being a doctor. The theme of 'traits of the profession; includes inherent characteristics of the profession which may result in contentment. For example, the medical profession requires never-ending learning and poses an intellectual challenge that could have attracted the student towards the profession. The theme of 'personal experiences' reflects on the positive or negative personal experiences with a physician earlier in life or positive shadowing opportunities with a physician which prompted the student to pursue a career in medicine.

The last theme, 'ability to contribute to society' reflects on how students believe that a physician can be an expert, an agent of change and, thus, be responsible for the betterment of society.

The other questions: 'How do you think you can contribute to society on becoming a doctor?', 'Think of a doctor you consider an example of professionalism. Describe the admirable features in him / her' and 'Reflect on personal experiences that have been critical in fostering your ambition to become a doctor' were part of the self-reflective exercise. The responses were amalgamated into three major themes:

1. The responsibility of the doctor to serve the under-served: students felt that medical services should reach the underprivileged areas where medical services were scarcely available.

2. Responsibility of the role models (physicians) who provided uncompensated care: Students recounted numerous motivating physicians whom they had met in their life and from whom they learned to help those in need, regardless of payment or recognition.

3. Role of a doctor in social advocacy: students envisioned that physicians could be agents of change.

For the questions 'What specific characteristics would you like to find in a doctor?' and 'What specific characteristics would you NOT like to find in a doctor?' the responses were collated in the form of concept maps. Concept maps are visual presentations which help the viewer understand the presented information and its relationship to other presented information.[19] We generated two concept maps (Figures 1 & 2) of the final themes for these two questions to illustrate the developed

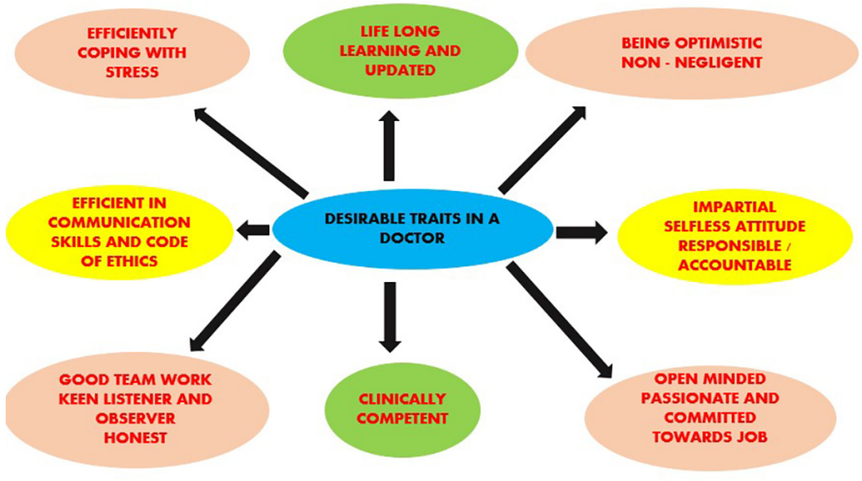

Figure 1
Concept map of amalgamated responses of 150 medical students to the question - what makes a good doctor?

themes and also to provide a framework for conceptualizing the themes. The desirable and undesirable traits was conceptualized into three clusters namely; patient centered, physician ability and professional behaviors.

In the physician ability domain, students perceived competence as one of the important attributes of being a good doctor. A doctor should be clinically competent and a life-long learner and he should seek advice at times of dilemma. In contrast, a bad doctor would pretend to know everything and would jump to a conclusion without adequate confirmation. In patient-centered domain, students perceived two-way communication as the most important attribute for a good doctor whereby he should explain the disease in a way the patient can easily understand and should be a good listener as well. Being biased, short-tempered and not attending to the patient's needs were viewed as bad attributes. In professional domain, adhering to professional guidelines, and being open-minded and passionate towards the profession were considered as desirable traits, while money-mindedness, being dishonest, and deflecting personal anger on to patients were considered as undesirable traits.

Discussion

Using a qualitative study design, we recorded the perspectives of first year medical students on behaviors expected of a good and a bad doctor. The ultimate aim was to determine whether reflective discourse on professional challenges in groups at the beginning of medical school could be used for professional development. When students enter medical college, they have pre-existing visions and beliefs about medicine as a career. Medical educators, who wish to frame methodology for teaching professionalism, should take these predispositions as a critical baseline for professional development.[20] The real objective of teaching professionalism is to help students develop their own identity as physicians.[1] It can be said that the rhetorical question of asking 'who they are' would guide 'what they do' in future as physicians. The important task of the medical educators is to help students transform into social justice oriented, altruistic physicians.[21-23]

There is considerable literature on the negative aspects of professionalism i.e., bad attributes of a doctor [24,25], while a few studies have also documented student's perspectives on the positive constructs of being a 'good doctor'.[26,27]

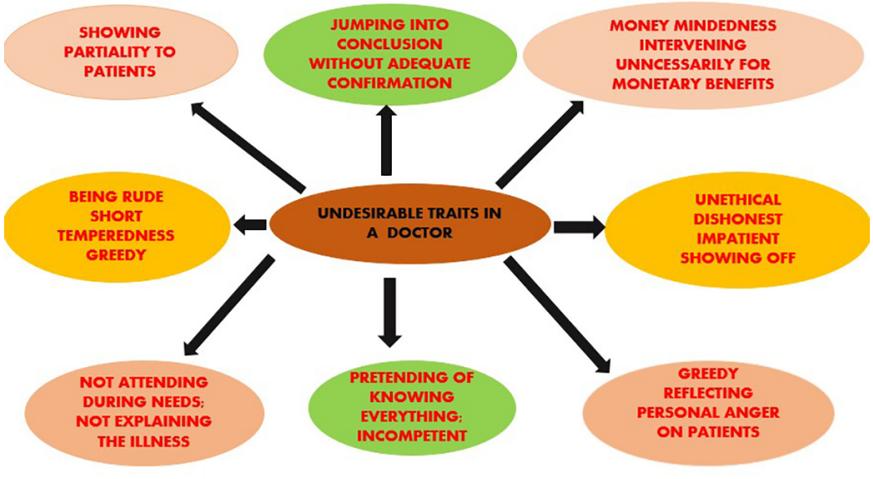

Figure 2
Concept map of amalgamated responses of 150 medical students to the question - what makes a bad doctor?

One school of thought guiding the teaching and learning of professionalism is to outline list values and desirable professional behaviors.[1] Rather than listing out a set of abstract attributes and framing them as teaching objectives, expected behaviors, being more measurable and observable, can be used as learning outcomes.[28.29]

The reasons given by our students for them pursuing a career in medicine were multi-factorial. For some, it was for intellectual fulfillment and for others it was for intrinsically derived pleasure (wishing to be an agent of change) or was related to extrinsic factors (affluence, position in society). Still others were inspired by medical professionals in their own families. Our themes were concordant with previous studies where the beliefs of incoming students were recorded and analyzed.[20,14] Some of the themes like humanitarian response, fulfillment and contribution to society were similar to the themes expressed by the medical students of other countries.[20] The interest in acting as agents of change and a commitment to patient satisfaction is seen in the initial stages (novice) of professional lucrativeness. It has been postulated that students who have a strong emotional attachment and patient-centered values in the early stages gradually undergo a phase of emotional detachment as they enter the clinical years.[30] Our study highlights the need to nurture patient-centered values through frequent discussions as students transition through the clinical years.

Other themes that emerged centered around the privileges of being a doctor and financial security (“I can earn even after the age of 65 years”); however, the proportion of students who listed these motivations was low. On clustering the theme of personal experiences, we found that many students in one way or another had an experience (positive or negative) which influenced them to pursue a career in medicine. The ‘critical shadowing’ was either due to the commitment shown by a physician while treating their peers or relatives or due to their early introductory experience in the hospital. We had a prompt which asked them to describe the admirable features in a doctor they had met earlier in their lives. Our aim was to provide a post-positivist view which, even if it gave no meaningful or valuable information, might help the students understand and imbibe healthy professional identity formation. Studies suggest that educational interventions should shift the interpretation of professionalism toward a broader focus of “thinking, acting and feeling like a physician”.[8, 21] This is as per Mezirow’s transformative learning theory, which suggests that students should be helped to become aware of their own assumptions and to understand the context of their belief systems within social structures.[31]

For the question 'what are the desirable traits of a doctor?' our students believed that a good doctor should be competent, high in professional skills, and one who enthusiastically communicates with patients. Some students reported that they had encountered, in the past, physicians who had treated their patients without respect, had exhibited poor communication skills, and had disrespected the opinion of others. On other hand, they also reflected on the virtues of altruism, trust and communication that some physicians had exhibited. Unlike other professions, defining a 'good doctor' is not an easy task. One who always makes the best diagnosis may not be a compassionate doctor and, likewise, one who is gentle, compassionate and honest with the patient may not be efficient or effective

in making medical decisions. Thus, accrediting someone as being a 'good doctor' demands in them a multi-dimensional construct of virtues.

The concept map obtained from the themes generated from the script could be clustered around physician ability, patient-centeredness and professional domains. The primary themes encompassed elements from the competencies expected to be acquired by an Indian medical graduate at the end of training, making the results relevant to the Indian context.[32]. They also tended to be aligned with the concept of '3Cs' (communication, competence and care) that patients seek in a good doctor.[33] In other studies, students endorse other attributes, such as competence and decisive leadership, as important for a good doctor.[14] This variation is understandable in light of an analysis which reports that discourses vary between pre-clinical and clinical students and also between schools.[26] In a study that used a mixed methods approach, it was seen that students valued compassion and communication skills over clinical competence and knowledge.[27] Thus, the constructs of a 'good doctor' and a 'professional doctor' can be perceived as separate.

The undesirable traits of a doctor generated by our students could also be categorized under the same clusters as desirable traits. Our findings somewhat contrasted with those of a study from the West where participants ranked discrimination and contemptuous behavior most frequently, followed closely by dishonesty and corruption.[34] It has been reported that the Western framework of professionalism might not be appropriate in developing countries owing to the myriad socio-cultural contexts.[35] This argument is augmented by the fact that the list of attributes generated by our study is highly comparable to a study from Saudi Arabia conducted among final year students.[36] This finding impels us to reiterate the need for different regions and even different institutions to develop their own list of expected behaviors and generate discussions around them, using them as learning outcomes. Our study demonstrates that this can be done and thus fulfills the three strategies for teaching professionalism, namely sensitization to traits of professionalism, immersion to hypothetical situations, and provision of opportunities to reflect in a conducive environment.[37]

Limitations

This qualitative study is based on self-perceptions of first year medical students and the results must be considered in relation to other factors such as social contingencies which we did not study. The students may not have shared factors that they consider socially undesirable; thus, some responses may have been under-represented in the scripts. These issues might reduce the generalizability of our findings. Since the data was anonymous, we could not verify some individual specialized phrases, and it made us to lose some primary themes. Despite these limitations, especially since there is very little qualitative research in our country on this important issue, our findings still provide valuable insight.

Conclusion

Our results suggest that first year medical students have a fair idea of the kind of behavior that is expected from a good doctor. Students' perceptions of the attributes of a good doctor may be naive and idealistic; however, they can be used as a baseline upon which to build their professionalism. A formal reflection on expectations and perceptions can help hone the concept of professionalism for

new entrants into the profession. The study provides an insight into discourses on professionalism which are generated by students and are meaningful to them. The teaching of professionalism could incorporate such formal reflective activities highlighting the complexities of medical practice, and allowing students and educators to openly articulate and explore any tensions between what is taught and what is experienced by them as they progress through the profession. Longitudinal studies are needed to follow up change in perceptions among medical students as they progress. Because professionalism is a dynamic construct, medical educators should reaffirm cultural context-specific definitions of professionalism for development of curricula.

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Acknowledgments: to the management of Pondicherry Institute of Medical Sciences, and to the faculty, non-academic staff, and students of the department of Anatomy, without the help of whom this endeavour wouldn't have been accomplished.