Professional values and behaviours of younger and older general practitioners in Scotland: a cross-sectional survey

Trudy Lynn Foster 1,2, Paul Bowie3

ABSTRACT
Aim Professionalism has been linked with improved patient care and reduced complaints. Our goal was to define what, if any, differences exist in the professional values and behaviours of younger general practitioners (GPs), those aged 34 years and under, compared with their older colleagues, those being aged 55 years and over.

Method An online cross-sectional questionnaire survey of GPs in Scotland was undertaken during 2018 using a modified version of the Nijmegen Professionalism Scale, which comprises 4 domains: professionalism towards patients, towards colleagues, towards society and towards oneself. Descriptive and inferential data analysis was undertaken between responses from both GP groups.

Results 273 responses were obtained. Of these, 106 respondents were classed as either younger GPs (n=55; 51.9%) or older (n=51; 48.1%). The greatest number of differences were found in the Professional Distance subsection of professionalism towards patients. The greatest single disparity in responses was to distinguish between personal and professional interests in negotiations (p<0.0001). Younger GPs also reported they were less likely to bear the consequences of their own actions (p<0.02) and to be more likely to give others the blame or responsibility (p<0.006). Younger GPs report being less skilled in quality management, being less able to signal suboptimal care (p<0.006) and justify indications for making home visits (p<0.001).

Conclusion While there were areas of similarity in relation to collaborating with colleagues, reflection on learning and dealing with emotions, differences were identified in relation to the 5 other subsections. Some differences may be explained by lack of exposure and experience, but this may not account for all the differences reported.

INTRODUCTION
The definition of professionalism in medicine (box 1) is a debated term which has changed over time.1–3 The methods for teaching professionalism have also changed with many institutions developing formal professionalism modules within their curricula.4 However, the informal and hidden curriculum continue to be relevant as medical trainees often learn by watching senior colleagues.4 A good role model may help the junior colleague articulate and discuss values as well as engage in personal and professional development.6 This was probably never more evident than in the one-to-one mentoring relationship between a general practice trainee and their trainer. The development of professionalism depends on homogenous shared values, a situation which no longer exists7 as medicine and society, and the contract between them has changed.8–10 For this paper, the definition of medical professionalism is a set of values, behaviours and relationships that underpin the trust the public has in doctors.

But why is medical professionalism important? Medical professionalism is characteristic of being a ‘good doctor’ and is considered critical to achieving a high-quality patient-centred healthcare service, while poor professionalism is often associated with suboptimal medical care by the public.10 Research has shown that recent high-profile cases of lapses in medical professionalism have damaged the profession’s reputation while on an individual level poor professionalism may increase complaints, litigation, incidents of adverse events and reduce patient and colleague satisfaction.11

Anecdotal stories abound of conflicts between older and new general practitioners (GPs) in relation to what is professional behaviour, particularly in respect of work-life balance and altruism. We set out to shed light on this area and to begin a discussion on the potential implications to future professionalism of the younger generation entering the medical workforce. The aim of this study was to identify what, if any, differences exist between younger and older GPs working in Scotland in terms attitudes and behaviours related to different elements of professionalism.

METHODS
Study design, participants and setting
A cross-sectional online questionnaire survey of younger and older GPs working in Scottish general practices was undertaken. There was no single GP performer list available at the time of this study and while the Information Services Division of NHS Services Scotland (ISD) maintain a list of GP partners, this would have excluded salaried and locum GPs. To reach as wide and diverse a group as possible, multiple strategies were used to disseminate the questionnaire including email circulation through the main primary care organisations in the 14 Scottish NHS territorial boards, postal mailing where email was not permitted, professional networks and social media. It was not possible to determine the ages of GPs to allow only younger and older GPs to be targeted. This circulation strategy was also limited because no follow-up reminders could be sent to non-responders. The online Questback
Box 1 Definitions of medical professionalism

‘Professionalism as an application of virtue to practice’.1

‘Intellectual operation with large individual responsibility’

Derive their raw material from science or learning

Work this material to a practical and definite end

Possess an educationally communicable technique

Self-organise

Increasingly altruistic in motivation’.3

‘Medical professionalism signifies a set of values, behaviors and relationships that underpin the trust the public has in doctors’.8

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survey software system, hosted by NHS Education for Scotland, was used to administer the survey questionnaire.

Data collection

Data were collected using the Nijmegen Professionalism Scale questionnaire which was developed in 2006 to assess professional behaviour in general practice trainees in the Netherlands.12 Although not developed in a UK healthcare setting, unlike other professionalism tools which have been developed in the UK, the Nijmegen Professionalism Scale was developed specifically for general practice. It identified four themes to professionalism related specifically to general practice: professionalism towards the patient, professionalism towards other professionals, professionalism towards the public and professionalism towards oneself. These four areas are broadly similar to the key areas identified by the Ottawa Working Group.10 Each theme in the Nijmegen Professionalism Scale consisted of two sub-sections and there are 84 questions in total using a point Likert scale for responses (1=almost never, 2=sometimes, 3=often, 4=almost always). The stem statement in the Nijmegen Professionalism Scale was modified from ‘The GP trainee’ to ‘I’ for this survey. No other changes were made to the original questions or the form of the questionnaire, but additional questions were added to gather demographic information on respondents including age, gender and professional role. The age brackets used corresponded with those used by ISD and the generational groups (table 1) with six questions generating a difference which did not cross 0, indicating a statistically significant difference between the two groups. Table 2 provides information on the gender profile of respondents.

Professionalism towards the patient

This domain had the greatest number of differences between the generational groups (table 3) with six questions generating a difference which did not cross 0, indicating a statistically significant difference between the two groups. Table 2 provides a summary of responses for the two sub-sections of this domain.

Regarding respecting patient interests both generations responded similarly to ‘Approaches patients with a different frame of reference (eg, religion)’ but in response to ‘Takes sex-specific differences into account’ there was a difference of 30.5%, (95% CI 11.7% to 46.6%, p=0.001). Younger and older GPs also appear to differ on the right of patients to inspect their medical record (28.2% difference, 95% CI 11.6% to 42.8%, p=0.001). In subsection 2, professional distance, there was statistically significant differences in all responses except ‘Takes care not to become too involved in the patient’s emotions’ and ‘Does not give patients false hope’.

Professionalism towards other professionals

Responses from younger and older GPs were very similar for several questions in the collaboration skills subsection of this domain with particular agreement on ‘Ensures structured information transfer with other care providers’ and ‘Makes clear agreements with support personnel’ (table 4).

However, this was not the pattern for the second subsection management skills where the only question generating strong agreement was ‘Ensures coherence in first-line and second-line medical care’. The greatest single variation in responses across the whole survey was in this subsection to “Am able to distinguish between professional and personal interests in negotiations” 40.1% (95% CI 21.4%–55%, p<0.0001) with statistically

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Table 1 Age profile of GPs working in Scotland and survey respondents

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Proportion of GP workforce by age group (n, %)</th>
<th>% of GP works</th>
<th>No of survey respondents by GP age group (n, %)</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 or under</td>
<td>3</td>
<td>0.06</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>25–34</td>
<td>991</td>
<td>20.17</td>
<td>55</td>
<td>20.45</td>
</tr>
<tr>
<td>35–44</td>
<td>1547</td>
<td>31.49</td>
<td>61</td>
<td>22.68</td>
</tr>
<tr>
<td>45–54</td>
<td>1526</td>
<td>31.06</td>
<td>102</td>
<td>37.92</td>
</tr>
<tr>
<td>55–64</td>
<td>799</td>
<td>16.26</td>
<td>48</td>
<td>17.84</td>
</tr>
<tr>
<td>65 and over</td>
<td>47</td>
<td>0.06</td>
<td>3</td>
<td>0.12</td>
</tr>
<tr>
<td>Total</td>
<td>4913</td>
<td>100</td>
<td>269</td>
<td>100</td>
</tr>
</tbody>
</table>

GP, general practitioner.

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Original research

significant differences also noted to “Am able to discuss differences of opinion with a specialist directly” (p=0.04), “Am able to take policy decisions” (p=0.001) and “Am able to conduct job evaluations” (p=0.0004).

**Professionalism towards society**

The subsections for this domain are responsibility and quality management (table 5).

Differences in responses between younger and older GPs were noted in relation to several questions in both subsections namely “Bear the consequences of my own conduct” (p=0.02), “Do not hide behind others (give others the blame or responsibility) (p=0.006)”, ‘Is able to signal suboptimal care within the practice’ (p=0.007) and “Is able to name the tasks to be, or that I would like to be, delegated to an assistant” (p=0.02), with older GPs consistently scoring higher for each question. Older GPs were also more likely to be ‘able to justify indications for making home visits’ than their younger counterparts (32.7, 95% CI 13.9 to 48.3, p=0.001).

**DISCUSSION**

There has been an increase in interest in medical professionalism in recent years with efforts focused on definition, understand and teaching. As professionalism is often learnt as part of the hidden curriculum from mentoring and role models, a consistent difference would further shift an emphasis onto the undergraduate and postgraduate training institutions to bring professionalism into the light of the formal curricula. Focus could be placed explicitly on professionalism and how it translates to modern medical care, particularly following the publication of the realistic medicine trilogy and considering consultation styles enabling shared decision making with the patient.

The purpose of the survey was to identify what, if any, differences existed in professionalism between younger and older GPs working in Scotland. Using a modified Nijmegen Questionnaire comprising four domains of professionalism (towards the patient, towards other professionals, towards society and...
Original research

Table 4  Domain 2: professionalism towards other professionals (comparison of responses between both groups were both groups score=4 on 4-point Likert scale)

<table>
<thead>
<tr>
<th>Question</th>
<th>GPs aged 34 and under (n=55)</th>
<th>GPs aged 55 and over (n=55)</th>
<th>Difference % (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is able to mediate with other care providers in the interests of the patient</td>
<td>33 (60.0)</td>
<td>32 (62.8)</td>
<td>2.8 (−15.3 to 20.6)</td>
<td>0.77</td>
</tr>
<tr>
<td>Consults other care providers with targeted questions</td>
<td>33 (60.0)</td>
<td>21 (42)</td>
<td>18 (−11.1 to 35.3)</td>
<td>0.07</td>
</tr>
<tr>
<td>Complies with multidisciplinary working agreements</td>
<td>35 (63.6)</td>
<td>27 (52.9)</td>
<td>10.7 (−7.8 to 28.3)</td>
<td>0.27</td>
</tr>
<tr>
<td>Ensures structured information transfer with other care providers</td>
<td>32 (59.3)</td>
<td>30 (60.0)</td>
<td>0.7 (−17.6 to 18.9)</td>
<td>0.94</td>
</tr>
<tr>
<td>Deals correctly with targeted questions from other care providers</td>
<td>32 (58.2)</td>
<td>33 (64.7)</td>
<td>6.4 (−11.9 to 24.0)</td>
<td>0.50</td>
</tr>
<tr>
<td>Is able to write a good referral letter with direct questions</td>
<td>34 (61.8)</td>
<td>34 (68.0)</td>
<td>6.2 (−11.9 to 23.5)</td>
<td>0.51</td>
</tr>
<tr>
<td>Is able to motivate support personnel</td>
<td>14 (25.5)</td>
<td>21 (41.2)</td>
<td>15.7 (−2.2 to 32.4)</td>
<td>0.09</td>
</tr>
<tr>
<td>Makes clear agreements with support personnel</td>
<td>20 (36.4)</td>
<td>18 (64.7)</td>
<td>1.1 (−16.8 to 18.7)</td>
<td>0.90</td>
</tr>
<tr>
<td>Listens to the contributions of support personnel</td>
<td>34 (61.8)</td>
<td>33 (64.7)</td>
<td>2.9 (−15.1 to 20.5)</td>
<td>0.76</td>
</tr>
<tr>
<td>Transfers services correctly</td>
<td>25 (45.5)</td>
<td>26 (51.0)</td>
<td>5.5 (−13.1 to 23.6)</td>
<td>0.57</td>
</tr>
<tr>
<td>Discussed bottlenecks in cooperation with others directly</td>
<td>10 (18.2)</td>
<td>11 (22.0)</td>
<td>3.8 (−11.5 to 19.3)</td>
<td>0.62</td>
</tr>
<tr>
<td>Is able to discuss differences of opinion with a specialist directly</td>
<td>9 (16.4)</td>
<td>17 (33.3)</td>
<td>16.9 (0.5 to 32.5)</td>
<td>0.04</td>
</tr>
<tr>
<td>Is able to manage the mutual demarcation of tasks between GP and specialists</td>
<td>8 (14.6)</td>
<td>14 (27.5)</td>
<td>12.9 (−2.7 to 28.1)</td>
<td>0.10</td>
</tr>
<tr>
<td>Ensures coherence in first-line and second-line medical care</td>
<td>13 (23.6)</td>
<td>13 (25.5)</td>
<td>1.9 (−14.2 to 18.2)</td>
<td>0.82</td>
</tr>
<tr>
<td>Is able to distinguish between professional and personal interests in negotiations</td>
<td>20 (36.4)</td>
<td>39 (76.5)</td>
<td>40.1 (21.4 to 55.0)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Is able to deal constructively with conflicts</td>
<td>12 (21.8)</td>
<td>17 (38.3)</td>
<td>16.5 (−0.9 to 32.8)</td>
<td>0.06</td>
</tr>
<tr>
<td>Is able to take policy decisions</td>
<td>7 (13.0)</td>
<td>25 (49.0)</td>
<td>36 (18.5 to 50.8)</td>
<td>0.001</td>
</tr>
<tr>
<td>Is able to conduct job evaluations</td>
<td>6 (11.1)</td>
<td>21 (41.2)</td>
<td>30.1 (13.5 to 44.9)</td>
<td>0.0004</td>
</tr>
</tbody>
</table>

GP, general practitioner.

Towards oneself with eight subsections (respecting patients' interests, maintaining professional distance, collaboration skills, management skills, responsibility, quality management, reflection on learning and dealing with emotions) significant differences in responses were noted in relation to five of the eight subsections. However, several individual questions yielded particularly significant differences between younger and older respondents, with the most striking in response to distinguishing between personal and professional interests in negotiations. Other statistically significant responses were obtained to questions within quality management and respecting patients' interests. However, the domain with the most discordance in responses was maintaining professional distance, with significant differences in four of the six questions. Within the final domain, professionalism

Table 5  Domain 3: professionalism towards society (comparison of responses between both groups were both groups score=4 on 4-point Likert scale)

<table>
<thead>
<tr>
<th>Question</th>
<th>GPs aged 34 and under (n=55)</th>
<th>GPs aged 55 and over (n=55)</th>
<th>Difference % (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bears the consequences of own actions</td>
<td>44 (81.5)</td>
<td>49 (96.1)</td>
<td>14.6 (2.3 to 27.2)</td>
<td>0.02</td>
</tr>
<tr>
<td>Is able to justify deviations from rules and guidelines</td>
<td>40 (72.7)</td>
<td>37 (72.6)</td>
<td>0.1 (−16.5 to 16.9)</td>
<td>0.99</td>
</tr>
<tr>
<td>Keeps promises and agreements</td>
<td>39 (70.9)</td>
<td>41 (82.0)</td>
<td>11.1 (−5.3 to 26.5)</td>
<td>0.18</td>
</tr>
<tr>
<td>Does not hide behind others (give others blame or responsibility)</td>
<td>43 (78.2)</td>
<td>49 (96.1)</td>
<td>17.9 (5.1 to 30.8)</td>
<td>0.006</td>
</tr>
<tr>
<td>Is aware of how own norms regarding disease influence disease management</td>
<td>28 (50.9)</td>
<td>29 (59.2)</td>
<td>8.3 (−10.6 to 26.3)</td>
<td>0.40</td>
</tr>
<tr>
<td>Is aware of the meaning and relative value of scientific evidence in decision making</td>
<td>34 (61.8)</td>
<td>28 (56.0)</td>
<td>5.8 (−12.6 to 23.8)</td>
<td>0.55</td>
</tr>
<tr>
<td>In decision making, weighs scientific evidence against factors related to the patient or circumstances</td>
<td>30 (54.6)</td>
<td>25 (49.0)</td>
<td>5.6 (−13.0 to 23.7)</td>
<td>0.57</td>
</tr>
<tr>
<td>Is able to justify choices made on the basis of scientific evidence</td>
<td>21 (38.2)</td>
<td>16 (31.4)</td>
<td>6.8 (−11.2 to 24.0)</td>
<td>0.47</td>
</tr>
<tr>
<td>Is able to explain own norms and values regarding the application of scientific evidence</td>
<td>22 (40.0)</td>
<td>20 (39.2)</td>
<td>0.8 (−17.3 to 18.8)</td>
<td>0.93</td>
</tr>
<tr>
<td>Is able to signal suboptimal care within the practice</td>
<td>12 (22.2)</td>
<td>24 (47.1)</td>
<td>24.9 (6.7 to 41.1)</td>
<td>0.007</td>
</tr>
<tr>
<td>Is able to work out quality improvement projects</td>
<td>21 (38.2)</td>
<td>23 (45.1)</td>
<td>6.9 (−11.5 to 24.8)</td>
<td>0.47</td>
</tr>
<tr>
<td>Is able to estimate which problems are suitable for a quality improvement project</td>
<td>17 (30.9)</td>
<td>17 (34)</td>
<td>3.1 (−14.4 to 20.6)</td>
<td>0.74</td>
</tr>
<tr>
<td>Is able to name tasks to be, or that would like to be, delegated to an assistant</td>
<td>12 (21.8)</td>
<td>22 (43.1)</td>
<td>21.3 (3.5 to 37.5)</td>
<td>0.02</td>
</tr>
<tr>
<td>Has perceptions about how form can be given to means of contact</td>
<td>14 (25.9)</td>
<td>22 (44)</td>
<td>18.1 (−0.1 to 34.9)</td>
<td>0.05</td>
</tr>
<tr>
<td>Is able to justify indications for making home visits</td>
<td>23 (41.8)</td>
<td>38 (74.5)</td>
<td>32.7 (13.9 to 48.3)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

GP, general practitioner.
Additionally, a further limitation of questionnaire surveys is that responses to questions cannot be verified in terms of their veracity. The inferential statistical analysis lacks complexity and could be improved by, for example, application of univariate and multivariate statistical analysis which may have provided better insights. Although data on gender and years of experience were requested through the survey, these have not been used in the analysis.

The findings of this survey would suggest the two groups have different professional values in relation to their patients. One possible explanation for the observed difference in respect of patients accessing their own medical records is the socioeconomic climate in which younger GPs have learnt their craft. 

Increasing challenges to medical authority from insurance companies could be increasing the tendency towards risk aversion behaviours among younger GPs while the older generation are perhaps insulated by virtue of the longer relationships and the different climate during which they refined their skills postqualification. While the Patients’ Rights (Scotland) Act of 2011(19) states people should be provided with such information as needed to allow participation and that communication should be clearly accessible and understood, the changes made early in 2018 to the Data Protection Act introducing General Data Protection Regulation will have impacts on data collection and patient access to records.

The Nijmegen Professionalism Scale was developed and validated for use in Dutch GP trainees. Use out of this context may impact on its validity and reproducibility. Although data on gender and years of experience were requested through the survey, these have not been used in the analysis.

There are several strengths to this survey:

- The Nijmegen Professionalism Scale is an already validated tool for the assessment of professional values and behaviours, saving time and resources developing and validating a tool for this survey.
- The respondents were from a diverse area covering remote and rural as well as urban areas of practice.
- The percentage of respondents in the younger and older groups very closely resembled the reported national figures for these age groups.
- It is also worth noting the limitations of the study:
  - The Nijmegen Professionalism Scale consists of over 80 questions which may have affected its completion rate.
  - The inferential statistical analysis lacks complexity and could be improved by, for example, application of univariate and multivariate statistical analysis which may have provided better insights.
  - Although data on gender and years of experience were requested through the survey, these have not been used in the analysis.
  - Overall, the response rate is low for both GP groups and so the results cannot be generalised, and caution should be exercised when interpreting the findings.

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Data Protection Regulation\textsuperscript{20} mean any person with capacity can request part or all of their medical record without providing a reason, potentially further eroding medical authority over the records they hold.

Recent years have seen Scotland celebrate its expanding multicultural diversity with campaigns under the ‘One Scotland’ banner.\textsuperscript{21} General practice appears to have embraced the diversity of our population while gender remains an area of difference between the two generations studied. While acknowledging gender differences may seem to be demonstrating bias, it could be argued gender-specific differences exist in the prevalence of many conditions. Therefore, is disregarding gender potentially detrimental to good patient care? Currently, no evidence exists to argue gender differences may seem to be demonstrating bias, it could be less likely to accept responsibility for their actions, in the subsection of reflection younger GPs report they are just as likely to admit their mistakes as older GPs and do not withdraw from the consequences of those mistakes. Clearly, further exploration is required to understand the apparent incongruity.

In summary, while some differences have been demonstrated in responses between younger and older GPs, there is no clear delineation in professionalism which would be expected based on population-based generational studies. What may be inferred is that policy makers should not necessarily consider GPs as one homogenous group when postulating the implications of strategy changes on the profession. Consideration should also be given to the ongoing development of skills, knowledge and ability among newer qualified GPs with a focus on management skills and an understanding of the wider healthcare system. There would still appear to be a positive role for mentoring by more experienced GPs with this regard.

CONCLUSION

Despite its limitations, our small study offers a potentially new perspective on professionalism as it relates to the modern GP in Scotland and may inform how professionalism should be taught to the future generations of GPs. By comparing the values and behaviours deemed professional by newly qualified GPs with those nearing the end of their careers we have been able to demonstrate there is a disparity in several areas, including management skills, maintaining professional distance and quality management.

Several questions remain unanswered, including are these findings the result of a cultural and societal change on an emerging generation in the workforce or are they the result of experience, or lack of, which balances out over time? It may be possible to perform triangulation of the results which will increase the value of the information obtained.\textsuperscript{29} Ideally, repeating the survey in the younger GP group at discrete intervals may help answer the state or trait question and contribute to the longitudinal assessment of professionalism called for by the Ottawa Consensus Group.\textsuperscript{30}

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Competing interests None declared.

Patient consent for publication Not required.

Ethics approval Under UK ‘Governance Arrangements for Research Ethics Committees’, ethical research committee review is not required for service evaluation or research which, for example, seeks to elicit the views, experiences and knowledge
of healthcare professionals (by virtue of their professional role) on a given subject area.

Provenance and peer review  Not commissioned; externally peer reviewed.

Data availability statement  Data are available on reasonable request.

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Original research