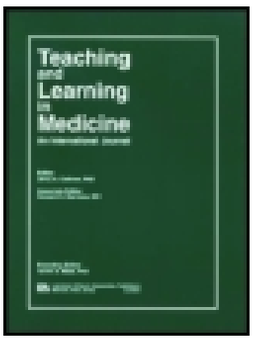

Routledge
Taylor & Francis Group

Teaching and Learning in Medicine
An International Journal

ISSN: 1040-1334 (Print) 1532-8015 (Online) Journal homepage: http://www.tandfonline.com/loi/htlm20

A Phenomenological Study of Italian Students' Responses to Professional Dilemmas: A Cross-Cultural Comparison

Fabrizio Consorti, Shiphra Ginsburg, Ming J. Ho, Laura Potasso & Emanuele Toscano

To cite this article: Fabrizio Consorti, Shiphra Ginsburg, Ming J. Ho, Laura Potasso & Emanuele Toscano (2018): A Phenomenological Study of Italian Students' Responses to Professional Dilemmas: A Cross-Cultural Comparison, Teaching and Learning in Medicine, DOI: 10.1080/10401334.2018.1478731

To link to this article: https://doi.org/10.1080/10401334.2018.1478731

TEACHING AND LEARNING IN MEDICINE
https://doi.org/10.1080/10401334.2018.1478731

Routledge
Taylor & Francis Group

GROUNDWORK

A Phenomenological Study of Italian Students' Responses to Professional Dilemmas: A Cross-Cultural Comparison

Fabrizio Consorti[a], Shiphra Ginsburg[b], Ming J. Ho[c], Laura Potasso[d], and Emanuele Toscano[e]

[a]Department of Surgical Sciences, University Sapienza of Rome, Rome, Italy; [b]Department of Medicine and Scientist, Wilson Centre for Research in Education and Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada; [c]Department of Medical Education & Bioethics, National Taiwan University, Taipei, Taiwan; [d]Department of Medicine II, University Hospital Freiburg, Freiburg, Germany; [e]Department Technologies, Communication and Society – TECOS, University G. Marconi, Rome, Italy

ABSTRACT

Phenomenon: Medical professionalism is a complex construct, based in social and cultural influences, yet little research has been done to show how culture influences the behaviors and attitudes of medical students. We presented Italian students with the same professional dilemmas used in a previous Canadian and Taiwanese cross-cultural study to look for similarities and differences and detect elements of Italian culture that influenced how students responded to dilemmas. The aim was to provide medical educators with some insights into students' behavioral strategies and feelings when faced with a professional dilemma. *Approach*: Using Giorgi's method, we performed a phenomenological analysis of 15 interviews of Italian medical students who responded to standardized video scenarios representing professional dilemmas. These videos were used in Canada and Taiwan and were translated into Italian. All students were from the same degree course, at Year 6, and were recruited on a voluntary basis at the beginning of the Internal Medicine course. Interview transcripts were anonymized before analysis. *Findings*: Scenarios were perceived as realistic and easy to envision in Italy. Four themes emerged: establishing priority among principles, using tactics to escape the dilemma, defending the self, and defending the relationships. When compared with previous studies, we noted that Italian students did not mention the principles of reporting inappropriate behavior, seeking excellence, or following senior trainees' advice. *Insights*: This is the first cross-cultural study of professionalism that involves a Mediterranean country and the observed differences could be interpreted as expressions of Italian cultural traits: distrust toward authority and a cooperative rather than competitive attitude. These findings have practical implications for educators to design and run curricula of professionalism with culturally appropriate topics. They highlight the need for more cross-cultural research.

KEYWORDS
Professional identity; cross-culture; ethical decision; video

Introduction

The global discussion on medical professionalism remains lively, with much research devoted to defining professionalism and to the process of developing professionalism in future doctors.[1–4] More recently there has been an acknowledgment of the importance that cultural context has on the development of professionalism.[5] Nevertheless, a gap of knowledge still exists about the specific culturally related aspects of professionalism. The goal of this cross-cultural study is to provide a description of elements of developing professionalism in Italian medical students. Next we discuss key definitions of professionalism and impact of culture on behaviors when faced with professional dilemmas.

Professionalism was historically intended as a set of correct or desirable values and norms as laid out by medical regulatory bodies,[6] but in more recent years it has been considered the expression of a contract between medical doctors and society,[7,8] or also the evolving result of the process of continuous development of professional identity.[9] A good synthesis of the ongoing debate was proposed by Martimianakis et al.,[10] who adopted a social science point of view and identified four classes of explanatory theories for the construct of medical professionalism: as a list of traits and behaviors, as a role played in society, as a social construct, and as means of social control. Last but not least, a concept emerging through these different definitions is that professionalism cannot be viewed as a fixed and delimited construct, but rather

CONTACT Fabrizio Consorti fabrizio.consorti@uniroma1.it @PedagogiaMedica Dip. Scienze Chirurgiche, viale del Policlinico, 00161 Roma, Italy.

as one that has a contextual and dynamic nature,[11] which strongly depends on societal and individual cultural characteristics.[12] An international working group on the assessment of professionalism noted the medical education literature on professionalism in the past 20 years was limited almost exclusively to "Anglo-Saxon" contexts and raised the concern that discussions about professionalism might ignore important elements of the cultural contexts of other countries. Hence the group issued a call to "Examine the concept of professionalism and its assessment across different linguistic and cultural contexts".[13(p362)] Informing curricula of professionalism with culturally appropriate topics may be very important.

The term *culture* has many possible meanings, but in this article we rely on the classical definition by Tylor: "Culture is that complex whole which includes knowledge, beliefs, arts, morals, law, customs, and any other capabilities and habits acquired by a human as a member of society".[14(p1)] Culture is a social construct that has links both with the level of individual personality and with the social system.

An example of the relevance of culture in understanding professionalism is a study in Canada that used standardized video scenarios to unveil medical students' reasoning and motivation in dilemma situations, both during and prior to the clinical years.[15,16] These studies developed and refined a theoretical framework that characterizes students' motivations for action in relation to principles (avowed and unavowed), affect and implications (which could be avowed, unavowed, or disavowed). Principles are defined as "an abstract or idealized concept".[15(p1018)] Avowed principles constitute an ideal or explicit set of concepts about professionalism, whereas unavowed principles are undeclared but widely accepted concepts that actively shape professional behavior. The term *disavowed* refers to underlying motivations for behavior that are officially rejected by the profession, a classic example being concern for self, which is inconsistent with the principle of altruism.

The videos scenarios in the aforementioned Canadian study were successfully used with Taiwanese medical students, which resulted in modifications to the original framework. For example, the Taiwanese study identified additional avowed principles (e.g., work efficiently, call for help, accountability, ethics, altruism, excellence), as well as implications for relationships and a new category of reasoning related to local cultural norms.[17]

The present study intended to replicate these previous studies[15,17] with final-year students in an Italian medical school. Although Italy, like Canada, is classified as a Western country, its normative and cultural setting is rather distinct from English-speaking countries, where much of the most prominent professionalism research has been conducted.[18] According to Geert Hofstede's system of cross-cultural comparison,[19] when compared to Canada and the United States, Italy displays significantly higher scores on the dimensions of "uncertainty avoidance" (i.e., the extent to which the members of a culture feel threatened by ambiguous or unknown situations and have created beliefs and institutions to avoid such scenarios) and "long-term orientation" (i.e., how a society maintains links with the past while dealing with the challenges of the present and future), but scored lower on "indulgence" (i.e., the extent to which people try to control their desires and impulses).[20]

Our overall goal was to provide medical educators with important insights into students' behavioral strategies and feelings when faced with a professional dilemma, especially those that may be contextually and culturally determined.[11,12] A first specific objective was to explore how Italian medical students would respond to professional dilemmas that were developed in Canada and to compare their responses with those of Canadian and Taiwanese medical students as just described. A second objective was to determine whether we could detect elements of Italian culture that might influence how Italian students responded to the dilemmas.

Methods

Setting

The Italian medical curriculum lasts 6 years and is divided into three segments: basic learning, preclinical, and clinical. The students who participated in this study were not exposed to any formal curriculum on professionalism, but their learning has included reflections on their first clinical experiences (Year 3), bioethics and code of conduct (Years 2 and 6), and social sciences and medicine (Year 4). In Italy, medical curricula are moving from a teacher- and subject-centered approach to an integrated student-centered approach.[21] However, a formal clerkship with long rotations is still rarely offered, and senior students are entrusted with limited responsibilities in the clinical setting. Moreover, residents are not allowed to act as clinical supervisors for students, so faculty members and clinicians serve as students' only official supervisors during their clinical internship. Students usually

Table 1. Summary of video scenarios.

Scenario	Description
Scenario 1:	A patient asks a clerk for the results of a chest X-ray. The results show a large tumor in the patient's lung, but the consultant has told the clerk not to inform the patient because it is someone else's duty. When the patient asks the clerk about her condition, the clerk finds herself in a dilemma.
Scenario 2:	At the end of a Friday shift, a clerk is invited to go out for a drink with the residents. However, there are still things that need to be taken care of in the ward.
Scenario 3:	A clerk is invited to watch an interesting bone marrow procedure in the emergency department but is about to go visit to a chronic patient with dementia who will, as always, spend a lot of time asking her the same questions.
Scenario 4:	A group of clerks at an infertility clinic are persuaded by the professor to examine a patient's genitals without his explicit permission. The patient and the students are visibly uncomfortable with this situation.
Scenario 5:	A clerk is allowed to perform her first thoracentesis under the supervision of a senior resident. The patient does not know that this is the student's first time performing the procedure. In front of the patient, the nurse asks the student how many thoracenteses she has performed.

refer to all supervisors as "professors," even when they are not faculty members.

Intervention

We used the five video scenarios developed by Ginsburg,[15] which are based on real events reported by medical students at three North American universities.[22] A summary of the professionalism dilemmas faced by students in the videos is outlined in Table 1. Each scenario depicts a clinical clerk (final-year medical student) facing a professional dilemma and fades out at the moment when the student is required to act (i.e., to say or do something in response to the dilemma). The methodological premise is that students are prone to identify with the student in the video and will be able to respond to a dilemma scenario in "real time," avoiding the possible bias of rationalization that tends to occur in reflective and written exercises.[23] Subtitles for the five videos were translated into Italian and back-translated into English to check for accuracy. We conducted individual interviews, each lasting about one hour. The videos were shown to each student in the same order as in the original experiment, and each video was followed by a semistructured interview. The questions for each video were as follows: If you were the student in the video, what would you do next? Why? What should you not do? Why? Are there alternative actions? Is the scenario likely to happen in Italy? Further comments were allowed at the end of the interview; the interviewers asked, "Would you like to add any more comments?" These questions were the same as in previous Canadian and Taiwanese studies.

Qualitative approach

In the Canadian and Taiwanese studies,[15,17] constructivist grounded theory was used to develop and refine a theoretical model from empirical data. In the current study, we felt that a different methodology for data analysis could widen our perspective on students' reactions. Because the results of these previous studies suggested that students' experiences in dealing with professional dilemmas could be very rich in meaning, we felt that a phenomenological approach would be suitable.[24] Phenomenology is not meant to produce a theory but to serve as a descriptive tool of the perceptions of students, as expressed by their words, to suggest possible interpretations of the meaning, structure, and essence of the lived experiences of medical students.

Sampling strategy

The research project was introduced to Year 6 students during one of the first meetings of the Internal Medicine class during the first term. Twenty of 60 total students agreed to join the study, on a voluntary basis. Reward or credits were not granted. Interviews were stopped after 15 students because our emerging analysis indicated that we had sufficient rich information to answer the study questions.[25]

Data collection

The research project was conducted with 15 (eight women, seven men) medical students from the Faculty of Medicine and Dentistry at Sapienza University of Rome. They were all 25 years old, Italians, and born in a family of Italian origin. We asked for ethical approval from the Faculty's Committee for Medical Education, which judged the study exempt according to Italian law, as data were anonymized.

The data set consisted of the transcripts of the 15 participants' responses to the videos—230 pages of transcribed text and more than 1,200 coded units of meaning. A unit of meaning is a part of text (a sentence, a series of sentences) that expresses an idea or a perception of the participants. A unit could be coded under more than one subtheme, but most of this double coding was solved during the iterative discussions in the analysis phase. The text of the transcript was very rich in lexicon, often with long

sentences, allowing for full use of the phenomenological analysis.

Data analysis

The interviews were audiotaped and transcribed, and the transcripts were analyzed using Giorgi's descriptive phenomenological method.[26]

The first step in this method is reading the full transcripts more than once, to get the "sense of the whole." The second step is the identification of the units of meaning expressed by the students. The third and the fourth steps are the interpretation of the units with respect to the specific purpose of the study (i.e., Which is the perception the student is expressing in this unit?) and to tie the essential, nonredundant themes together into a synthetic descriptive statement.

The interviews, transcription, and first analysis of data were performed by two researchers (LP and ET) trained in qualitative research methods. Neither of these researchers were known by the students who participated in the study. NVivo 10 software was used to facilitate coding and to organize codes and themes. To enhance trustworthiness, results were iteratively discussed with the first author. MH and SG contributed to the interpretation of the data and to the comparison with the theoretical framework developed in previous studies, through teleconference meetings. All quotations included in this article have been translated into English from the original Italian and are identified by video and student number.

Results

Fifteen students participated in the study. We first report on the applicability of scenarios to the Italian context, following which the four emergent themes are described: establishing a priority among principles, tactics to escape the dilemma, defending the self, and defending the relationships.

Applicability of the scenarios to the italian context

For the most part, Italian students found the Canadian-developed scenarios realistic and easy to envision in Italy. Many of the students had experienced similar situations:

> Yes, it happened. Many patients asked me [for test results]. And I said that we were still waiting for the report and that results would have to be discussed with the professor. (Scenario 1; Student 4)

> Yes, it's very common, especially at the handover at the end of the shift, when you look at your watch instead of taking care of what is still to be done. (Scenario 2; Student 8)

Nevertheless, a student noted that it is not common for a 6th-year student in Italy to have such direct responsibility in patient care: "It's the main situation of the video that is not authentic. It's unlikely that there would be a patient under my responsibility" (Scenario 3; Student 5).

Emergent themes

Establishing a priority among principles

This theme includes the reactions of students who explicitly identified a conflict between two distinct principles when proposing a solution to the professional challenge presented in the video scenario. We chose the term *priority* because students' explicitly mentioned that certain principles were stronger or constituted the first step in solving a dilemma.

For example, in response to Scenario 4, a student prioritized the principle of respect for patients' rights and dignity, responding,

> Well, you need to talk to patients and ask them … I mean … their permission, ask them if all these people can be present. OK, it is true that this is a teaching hospital, but if one does not want you be visited by a female doctor … you can ask. For example, when I was in the gynecology department, there was a Muslim woman and she said she didn't want to be visited by a male doctor. Right … we went out. (Scenario 4; Student 3)

Another student considered students' duty to learn as a prevailing principle, prioritizing it over the duty to care for a patient:

> I'm not yet a resident with a job, an obligation. I think that first of all I have to learn, before I can practice or have real clinical duties … that is, it would be nice to have some duties, but first of all I must learn. (Scenario 3; Student 8)

Despite the high number of units coded as priority, it was not possible to infer a hierarchy of subthemes among principles because students felt different principles should be prioritized in similar situations. On the contrary, in some cases, the same student provided contradictory responses about the prioritization of certain principles. One student responded that, in Scenario 3, she would prioritize the rights of the patient and chose to forgo observation of an interesting procedure because "It's up to me. It's a sense of duty and it's clear that I must go [to the patient]" (Scenario 3; Student 5). However, the same student

prioritized the duty to learn in response to Scenario 4, in which a patient is visibly uncomfortable about having multiple students examine his genitals: "I'd say to the patient that this is a teaching hospital and it is normal that there are students" (Scenario 4; Student 5).

Tactics to escape the dilemma

A second theme that emerged was focused on the strategies or tactics that students might use to escape a dilemma. When faced with professional dilemmas, students sought to find a way to escape or avoid responsibility for tackling the dilemma directly, for example, by sharing or by deferring the burden of decision making. Overall, tactics could be considered the application of a root principle expressed as "if the problem overcomes you, try to escape it!" We identified three groups of tactics used by students: attempting to seek help or share the responsibility, assuming that the solution of the dilemma depended on contextual information not contained in the video, or being stumped and unable to give an answer.

Seeking help or sharing the responsibility

One frequent behavior described in students' responses was to seek help or to share the responsibility. For example, one student avoided dealing directly with the dilemma of missing a social outing with the residents or delaying the discharge of a patient (Scenario 2), by stating,

> I would have asked another person to help me to calculate the dosage of insulin … because my idea of a doctor is that someone alone cannot do anything. Advice from someone else is needed, an exchange of opinions, teamwork. (Scenario 2; Student 3)

Assuming that more information would help solve the dilemma

Another tactic was to achieve two goals by balancing between two possible solutions or to state that the solution depended on contextual information not included in the video. These units usually began with "It depends …". One student could not envision how he would to respond to a situation where a professor was behaving unprofessionally without knowing the professor's characteristics (e.g., authoritative, understanding, etc.):

> It depends on the professor, the way you think he would react, because what you think and do would imply … in the end it's as if you were turning against him. … Actually … it always depends on the relationship with him. … It always depends on how much he is a "professor" [the student stresses with the voice the role] … but yes, he should be noted that one: he does not use gloves and two: it is wrong … [So] I would make a face as if to say, but I would not tell him … that is, I would put on my gloves, without being surly. … (Scenario 4; Student 10).

In another interview the student was not able to prioritize between the duty to learn and the duty to care for the patient, trying instead to adhere to both principles by swinging between them.

> It depends … mmm … first I'd go to the Emergency for 5 minutes to watch the marrow and, if it takes a long time, then I'd anyway go back to my patient. … It depends on my professor: if he is open-minded, I'd explain him the situation and I could ask him to let me to go to the Emergency, then after I looked at the procedure, return to my patient and do the same things I should have done. (Scenario 3; Student 5)

Being stumped

Finally, we observed students who appeared to be stumped, as they were uncertain or hesitant to propose any response to a dilemma. In these cases, the tactic was to avoid the task. In response to the scenario where a patient has not been informed about a lung tumor, one student said, "Honestly, I don't know what I'd have done. I don't think I should keep it hidden, but I don't think I could manage the situation" (Scenario 1; Student 2).

Students defend the self

This theme refers to explanations focused on students' own emotional reactions, personal characteristics, and related implications. These units usually expressed a pathway of action in which the student's decision does not depend on principles or tactics but is a means of defending oneself, avoiding emotional overload, or affirming their personality.

In the interview about the situation of the patient not informed about her cancer, a student said,

> The patient would panic … absolutely panic. I think, I'd panic with him because … I do not know if I did the right thing or the wrong thing, so I'd panic and … the professor would be angry with me because I did not do what he said, I would probably answer that he did not do what he had to do … so it would be a mess! But in the end the fault is not mine, he sent me there, but I would feel guilty all the same … unfairly guilty, seen from the outside, but in fact I would feel really guilty in any case, because one day she will come to know, and if … I meet her again and say "yes, I told you a lie" and … I'd really feel like [expletive]. (Scenario 1, Student 7)

Students defend their relationships

The last theme comprised reactions motivated by the expected effect of the decision on relationships with oneself or others. One example is conflict avoidance:

> There is no use in making a scene with colleagues, because probably they would not change their idea. It would be unbelievable, like a film scene, if they repent and help me to do the dosages after they already put on their coat. In any case, to allow relationships to deteriorate in a working environment is never good, because in the end it damages patients. A department in which there are disagreements among colleagues is neither good for the doctors who work there nor for the patients, and surely there would also be repercussions on them. (Scenario 4; Student 12)

Another is active cooperation:

> Even if I'm not indispensable, if in my daily routine the others expect me to be there and to do some tasks as usual, not being available could cause a difficulty, an unforeseen difficulty. This could cause an inconvenience to the people expecting me to be there. (Scenario 3; Student 7).

We found only one example of a participant considering reporting what they viewed as unprofessional behavior. Of interest, this involved the nurse in Scenario 5, who asks the medical student if it's her first procedure. Even though the participant (S10) considered "telling on" the nurse, the participant stated that they probably wouldn't report the behavior and felt that their colleagues likely wouldn't either.

Discussion

This study examined final-year Italian medical students' responses and reasoning to video scenarios of professionalism dilemmas. We found that the Canadian-developed video scenarios were applicable to the Italian context and that, using a phenomenological approach, students' responses to the dilemmas could be grouped into four categories: establishing priorities among principles, tactics to escape the dilemma, defense of the self, defense of relationships. In the following sections we focus on the most important findings—the strategies used when faced with professional dilemmas, which attempt to defend oneself and one's relationships, and the elements of Italian culture that may help explain these strategies.

To face or to escape?

There was not one consistent strategy identified in students' responses to dilemma situations, and the process of decision making was often contradictory and context-dependent, consistent with previous studies.[27] This picture is consistent with a model of students' reactions as emerging from a complex system[28] and in relation to the current stage of their professional identity formation.[29]

The students in the current study tended to prioritize the common set of values usually related to medical professionalism and contained in the frameworks proposed by Ginsburg and Ho, such as honesty, fairness, and caring for patients.[17] Students also proposed tactics to escape dilemmas, especially in situations where they expressed uncertainty or the desire for more contextual information. In analyzing written essays about professional dilemmas encountered by students on an internal medicine rotation, Lingard[23] observed that dissociation served as a rhetorical strategy in dealing with uncertainty, facilitating noninvolvement in professional situations. A further study by Ginsburg et al. confirmed the dominance of dissociation as a reasoning strategy in conflicting professional situations.[30] In Taiwan, Ho also found that medical students sought to disengage or observe when faced with local culture-related dilemmas.[31] Our study highlights the relevance of these findings to the Italian context, where students sought to protect their still-fragile professional images by avoiding, rather than addressing, professionally challenging situations. This has important implications for the incorporation of uncertainty management in curriculum development.[32,33]

On the contrary, we did not observe instances of the principles of reporting inappropriate behavior, seeking excellence, or following senior trainees' advice, as reported by Ginsburg and Ho.[17] These differences might be explained, at least in part, by Italian culture.

Our participants were quite critical of unprofessional behavior, demonstrating both their knowledge and acknowledgment of the profession's ethical principles as expressed by regulatory bodies[6] and by the Italian Code of Conduct.[34] Yet the students never mentioned the possibility of reporting inappropriate or unprofessional behavior. Rather, they spoke about directly questioning the person responsible for such behavior. Reporting is usually directed to the authorities, but Italians tend to be suspicious of entering into relationships with authority. This has been called the "paradox of Italy,"[35] and it remains a dominant feature of Italian society, leading both to acknowledgment of authority and a reluctance to trust authority. Reporting is often perceived in a negative light—that is, "telling on" someone.

Likewise, the term *excellence* or related concepts did not explicitly appear in students' responses, even

if they frequently spoke about doing their best. In fact, Italian society is usually described as cooperative rather than competitive.[36] The pursuit of excellence, in a competitive sense, therefore, may not have been perceived as a motivation in students' responses to dilemmas. Rather, students intend to do their best to help others.

In the Taiwanese study that used the Canadian video dilemmas, Ho et al. identified an additional subtheme of "following senior trainees' advice."[17] This subtheme was not identified in the Italian context, likely due to the previously mentioned features of the learning environment in Italy, in which students are supervised by professors rather than residents. Also unlike Ho et al.'s study,[17] we did not observe any explicit mention of local culture in students' responses. Ho et al.'s addition of "culture" to the original framework of analysis might have been influenced by the translation of the English-language videos into Chinese, such that the English-speaking Caucasian actors featured in the videos triggered a degree of discordance for the Taiwanese students' watching the Mandarin version of these videos. This may have caused Taiwanese students to make cultural comparisons that were less noticeable to Italian students, who are more familiar with American medical television shows and could have found the context of the videos less unusual. American medical dramas (e.g., *House*, *Grey's Anatomy*, *ER*, *Scrubs*) are in fact popular in Italy.[37,38]

Defense of self and of relationships

Some of the topics we already discussed, like the cooperative attitude and the reluctance to report, have also obvious relevance to the themes of relationships. Moreover, the strong emphasis on emotions, empathy, and advocacy we observed in the participants' reactions of students may reflect the Italian emotional temper.

Lamiani et al.[39] found that Italian students perceived a hidden curriculum that still conveys a paternalistic model of physician–patient relationships. This is in contrast with the ongoing change in organizational culture in medicine, which asks for more focus on teamwork and patient-centeredness.[40] In addition, there has been an increased focus on the issue of burnout in Italy[41] and internationally.[42] This may be another reason why our students were often hesitant when faced with a dilemma and why they looked for a solution that prioritized personal and social well-being, a sense of inclusion and protection.

Limitations

Some limitations should be considered when interpreting our findings. Some of the observed differences, as well as the two instances in which students partially disagreed with the question "Is the scenario likely to happen in Italy?" could be explained by the curricular differences. As mentioned, a formal clerkship is not yet offered in Italy, and Italian students have not usually experienced long rotations in a ward setting, although they do have an opportunity for obtaining clinical experience through shorter periods of attendance or electives. The main difference is the lived experience of autonomy, which makes Canadian students not fully comparable to the Italian students in this regard. Nevertheless, Italian students showed most of the expected reactions as described in previous studies, and the few notable observed differences could be easily attributed to cultural characteristics, as we discussed. Given the definition of culture we adopted, this curricular difference itself is a cultural artifact. Italian high school and university are still strongly imprinted by the reform of Giovanni Gentile, the idealistic philosopher who was Minister of Education in 1923.[43] The concept of the dominance of spirit and knowledge over experience is still deeply rooted in the Italian educational system.

As in all qualitative studies, our results are idiographic and not intended to be generalized. The participants composed a small, self-selected group of students, all from the same class, all from Rome. Italy has a very diverse cultural, economical, and social background between the north and the south of the country, and our findings should be interpreted as an indication that important culturally driven elements exist.

Students might have offered responses that they expected to be correct based on earlier teachings. This concern, however, does not seem to have been a serious limitation, as we observed both "unavowed" and "disavowed" principles in students' responses, which indicates that answers did not always match the expected or "desirable" responses.

As stated in the previous studies in Canada and Taiwan, the video scenario study design allows us to learn only what students say they would do, not what they would do in practice.[15,17] Further studies involving direct observation of students in a clinical setting or the use of simulated patients could help us to identify any discrepancies between theory and practice.

Practical implications

Our findings suggest that many elements of developing professionalism in medical students are common across different cultural environments. We also confirmed that there are some elements that appear to be

culturally driven. The increasing diversity at medical institutions across Europe and the world makes addressing culture and context even more important for medical educators. To our knowledge, this is the first cross-cultural study of professionalism that involves a Mediterranean country. Our findings have practical implications for educators and may be useful in the design of educational activities and in the provision of feedback from supervisors to students when dilemmas are encountered in clinical practice. For example, more cross-cultural research is needed at a local level, to inform curricula of professionalism with culturally appropriate topics, beyond the common core set of professional values that are, mainly derived from medical literature of English-speaking countries.[44–46] The reluctance to report and a cooperative rather than competitive attitude can be the objects both of further research and of tailored educational activities. Finally, the theme of tactics should serve as a reminder to our community of the need to support the ability of students to manage uncertainty and context dependency, a critical skill in the rapidly evolving, contemporary process of healthcare in Western societies.

Competing interests

All authors declare no competing interest.

ORCID

Fabrizio Consorti http://orcid.org/0000-0001-7096-4428

References

1. Egener B, McDonald W, Rosof B, Gullen D. Perspective: organizational professionalism: relevant competencies and behaviors. *Acad Med*. 2012;87(5):668–674.
2. Lebovits A. Maintaining professionalism in today's business environment: ethical challenges for the pain medicine specialist. *Pain Med*. 2012;13(9):1152–1161.
3. Ly CL, Chun MB. Welcome to cultural competency: surgery's efforts to acknowledge diversity in residency training. *J Surg Educ*. 2013;70(2):284–290.
4. Li H, Ding N, Zhang Y, Liu Y, Wen D. Assessing medical professionalism: a systematic review of instruments and their measurement properties. *PLoS One*. 2017;12(5):e0177321.
5. Ho MJ. Culturally sensitive medical professionalism. *Acad Med*. 2013;88(7):1014.
6. Working Party of the Royal College of Physicians. Doctors in society. Medical professionalism in a changing world. *Clin Med*. 2005;5(6Suppl1):S5–S40.
7. Cruess SR, Cruess RL. Professionalism: a contract between medicine and society. *CMAJ*. 2000;162(5):668–669.
8. Cruess SR, Cruess RL. Professionalism and Medicine's Social Contract with Society. *Virtual Mentor*. 2004;6(4). doi:10.1001/virtualmentor.2004.6.4.msoc1-0404.
9. Cruess RL, Cruess SR, Steinert Y. Amending Miller's pyramid to include professional identity formation. *Acad Med*. 2016;91(2):180–185.
10. Martimianakis MA, Maniate JM, Hodges BD. Sociological interpretations of professionalism. *Med Educ*. 2009;43(9):829–837.
11. Baird J, Vanstone M. Professionalism's contextual nature: a call for compassionate, constructive responses. *Med Educ*. 2017; 51(7):678–679.
12. Cruess SR, Cruess RL, Steinert Y. Teaching professionalism across cultural and national borders: lessons learned from an AMEE workshop. *Med Teach*. 2010;32(5):371–374.
13. Hodges BD, Ginsburg S, Cruess R, et al. Assessment of professionalism: recommendations from the Ottawa 2010 Conference. *Med Teach*. 2011;33(5):354–363.
14. Tylor EB. *Primitive Culture. Researches into Development of Mythology, Philosophy, Religion, Language, Art and Customs*, Murray J, eds. London: Brentano's; 1871.
15. Ginsburg S, Regehr G, Lingard L. The disavowed curriculum: understanding student's reasoning in professionally challenging situations. *J Gen Intern Med*. 2003;18(12):1015–1022.
16. Ginsburg S, Lingard L. 'Is that normal?' Pre-clerkship students' approaches to professional dilemmas. *Med Educ*. 2011; 45(4):362–371.
17. Ho MJ, Lin CW, Chiu YT, Lingard L, Ginsburg S. A cross-cultural study of students' approaches to professional dilemmas: sticks or ripples. *Med Educ*. 2012;46(3):245–256.
18. Doja A, Horsley T, Sampson M. Productivity in medical education research: an examination of countries of origin. *BMC Med Educ*. 2014;14(1):243
19. Hofstede G, Hofstede GJ, Minkov M. *Cultures and Organizations: Software of the Mind*. 3rd ed. New York, NY: McGraw-Hill; 2010.
20. Hofstede Centre. 2018. http://geerthofstede.com. Accessed January 15, 2018.
21. Snelgrove H, Familiari G, Gallo P, et al. The challenge of reform: 10 years of curricula change in Italian medical schools. *Med Teach*. 2009;31(12):1047–1055.
22. Ginsburg S, Regehr G, Stern D, Lingard L. The anatomy of the professional lapse: bridging the gap between traditional frameworks and students' perceptions. *Acad Med*. 2002;77(6):516–522.
23. Lingard L, Garwood K, Szauter K, Stern D. The rhetoric of rationalization: how students grapple with professional dilemmas. *Acad Med*. 2001;76(10 Suppl):S45–S47.
24. Hycner R. Some guidelines for the phenomenological analysis of interview data. *Hum Stud*. 1985;8(3):279–303.
25. Saunders B, Sim J, Kingstone T. Saturation in qualitative research: exploring its conceptualization and operationalization. *Qual Quant*. 2018;52(4):1893–1907.
26. Giorgi A. *Psychology as a Human Science: A Phenomenologically Based Approach*. New York, NY: Harper and Row; 1970.

27. Ginsburg S, Bernabeo E, Ross KM, Holmboe ES. It depends: results of a qualitative study investigating how practicing internists approach professional dilemmas. *Academic Medicine*. 2012;87(12):1685–1693.
28. Mennin S. Self-organisation, integration and curriculum in the complex world of medical education. *Med Educ*. 2010;44(1):20–30.
29. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. A schematic representation of the professional identity formation and socialization of medical students and residents: a guide for medical educators. *Acad Med*. 2015;90(6):718–725.
30. Ginsburg S, Regehr G, Lingard L. To be and not to be: the paradox of the emerging professional stance. *Med Educ*. 2003;37(4):350–357.
31. Ho MJ, Gosselin K, Chandratilake M, Monrouxe LV, Rees CE. Taiwanese medical students' narratives of intercultural professionalism dilemmas: exploring tensions between Western medicine and Taiwanese culture. *Adv in Health Sci Educ*. 2017;22(2):429–445.
32. Ledford CJ, Seehusen DA, Chessman AW, Shokar NK. How we teach U.S. medical students to negotiate uncertainty in clinical care: a CERA study. *Fam Med*. 2015;47(1):31–36.
33. Nevalainen M, Kuikka L, Sjoberg L, Eriksson J, Pitkala K. Tolerance uncertainty and fears of making mistakes among fifth-year medical students. *Family Medicine* 2012;44:240–246.
34. FNOMCEO: Codice di Deontologia medica. 2018. http://www.fnomceo.it/fnomceo/showVoceMenu.2puntOT?id=5 Accessed January 15, 2018.
35. Sabetti F. *Search for Good Government: Understanding the Paradox of Italian Democracy*. Montreal, Canada: McGill- Queens University Press; 2000.
36. Fukuyama F. *Trust: The Social Virtues and the Creation of Prosperity*. New York, NY: Simon & Schuster; 1995.
37. Bottega F. *La Relazione "Rappresentata" Fra Medico e Paziente. Analisi Del Medical Drama House M.D*. Bologna, Italy: Faculty of Philosophy of the University of Bologna; 2010.
38. Jain P, Slater MD. Provider portrayals and patient-provider communication in drama and reality medical entertainment television shows. *J Health Commun*. 2013;18(6):703–722.
39. Lamiani G, Leone D, Meyer EC, Moja EA. How Italian students learn to become physicians: a qualitative study of the hidden curriculum. *Med Teach*. 2011;33(12):989–996.
40. Vicarelli GM, Pavolini E. Dynamics between doctors and managers in the Italian national health care system. *Sociol Health Illn*. 2017;39(8):1381–1397.
41. Galletta M, Portoghese I, D'Aloja E, et al. Relationship between job burnout, psychosocial factors and health care-associated infections in critical care units. *Intensive Crit Care Nurs*. 2016;34:59–66.
42. Rothenberger DA. Physician burnout and well-being: a systematic review and framework for action. *Dis Colon Rectum*. 2017;60(6):567–576.
43. Vertecchi B, Agrusti G. L'involuzione idealista [The idealistic involution]. In: *Laboratorio di valutazione*. Bari, Italy: Laterza Ed.; 2008:6–8.
44. Al-Rumayyan A, Van Mook WNKA, Magzoub ME, et al. Medical professionalism frameworks across non-Western cultures: a narrative overview. *Med Teach*. 2017;39(sup1):S8–S14.
45. Helmich E, Cristancho S, Diachun L, Lingard L. How would you call this in English?': being reflective about translations in international, cross-cultural qualitative research. *Perspect Med Educ*. 2017;6(2):127–132.
46. Helmich E, Yeh HM, Kalet A, Al-Eraky M. Becoming a doctor in different cultures: toward a cross-cultural approach to supporting professional identity formation in medicine. *Acad Med*. 2017;92(1):58–62.