HPCSA
Health Professions Council of South Africa

Issue 01/09/2024

DIETETICS & NUTRITION NEWS

Newsletter of Professional Board for Dietetics and Nutrition

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CHAIRPERSON'S MESSAGE

My fellow practitioners, we are now well into 2024, and I trust that all practitioners continue to make great strides to ensure their professional growth and the highest standards of evidence-based ethical practice.

As at July 2024, **92%** of the Dietetics and Nutrition Board (DNB) practitioners had paid their annual fees. This is indeed encouraging to the Board since all activities of the DNB are funded solely by the practitioners' fees, enabling the DNB to continue with all its planned activities for the 2024/25 financial year. Please also be aware that as of this year, the HPCSA is also moving to have practitioners who have not paid their annual fees removed from the Register in October 2024.

As at June 2024, CPD compliance for the DNB was **56.1%**. The DNB in its newsletters and e-Bulletins, have over the last three years attempted to highlight the importance of CPD compliance. In terms of the Regulations, practitioners that are not CPD compliant may also be removed from the Register. The HPCSA is now taking definite action to implement this CPD compliance in terms of the Regulations possibly in the next financial year i.e. with effect from **01 April 2025**. All practitioners are also encouraged maintain their CPD compliance. You can access your current CPD status on **https://hpcsaonline.custhelp.com/**

In the last newsletter, I indicated that the DNB had finally promulgated the Scope of profession for Dietitians on 23rd February 2024. After the promulgation, the DNB noted some minor administrative errors in the Regulations and requested the legal services to correct the Regulations. As a result, you will be aware that the latest **Scope of Profession for Dietitians** has been published on **21st June 2024**, wherein all errors have been corrected.

As the current Board term of office is nearing its end (with about 12 months remaining of the current term), I want to encourage you to give some thought to whom you wish to nominate to be the members of the Dietetics and Nutrition Board for the next term (2025-2030). The HPCSA will shortly publish calls for nominations, so please do begin the conversations with your colleagues about whom you think will best represent you and will take forward the issues related to these professions for you, on the next Professional Board.

With best wishes,
Lenore Spies

Chairperson of the Professional Board for Dietetics and Nutrition

THE SCOPE OF PROFESSION VERSUS THE SCOPE OF PRACTICE

DID YOU KNOW?

There is a difference between the Scope of Profession and the Scope of Practice.

The Scope of Practice supplements the Scope of Profession.

The scope of profession is defined in terms of Section 33 of the Health Profession Act, 56 of 1974 for all professions registrable with the Health Professions Council of South Africa (HPCSA).

Scope of profession defines the duties of a qualified practitioner in the specific field.

The scope of practice is defined in terms of Ethical rule 21 of the HPCSA, which states that: "A practitioner shall perform, except in an **emergency**, only a professional act - (a) for which he or she is **adequately educated, trained** and **sufficiently experienced**; and (b) under proper conditions and in appropriate surroundings."

Scope of practice guides the practitioner to work within the boundaries of their scope of work.

Emergency: Provision of healthcare services should always be conducted within the limits of their practice and according to their education and/or training, experience and competency under proper conditions and in appropriate surroundings. If unable to do so, refer the patient to a colleague or an institution where the required care can be provided. Provide emergency interventions when required: In an emergency, where there is threat to life or limb (including a perceived threat) and where no appropriately trained healthcare professional is available, then the practitioner must intervene to the best of their ability.

Appropriately educated and trained: To qualify as appropriately educated and trained, the individual practitioner must have successfully completed a training programme approved and accredited by the relevant Professional Board for registration purposes with the following requirements also met:

- The training entity/institution/hospital needs to be accredited by the Professional Board for training in that particular profession or discipline and for that particular competency.
- The trainee must have completed a duration of undergraduate and/or postgraduate training as laid down by the Professional Board.
- The trainee must have been evaluated and certified as having met the requirements of the training programme by an entity accredited by the Professional Board (e.g. Colleges of Medicine, Universities).
- Short courses can only be recognised as enhancing or maintaining skills within the field of practice and category of registration in which the practitioner had already been credentialed and registered by the Professional Board.
- Practice should be within the scope of the practitioner's profession as laid down by the Professional Boardand is judged by the standards and norms considered reasonable for the circumstances under which the intervention took place.

Sufficiently experienced:

- Initial training under supervision as defined in clause above, by an entity accredited by the Professional Board for such purposes.
- Certification of successful completion of such training.
- With any intervention, proficiency must be demonstrable, taking into account and judged by the standards and norms considered reasonable for the circumstances under which the intervention took place.
- The introduction of new interventions within the practitioners' scope of profession is only permissible if the practitioner has undergone further appropriate training as approved by the Professional Board.

Work under proper conditions and surroundings: All interventions must take place under appropriate conditions and surroundings. These are subject to judgement by the Professional Board as to what is considered reasonable for the circumstances, surroundings and conditions, under which the intervention took place. No practitioner may embark upon an intervention unless he/she feels that it is in the patient's interest, and other than in a life or limb threatening emergency, that it is safe to do so. The practitioner will be judged on what requirements are reasonably needed to best ensure a patient's dignity, integrity and safety.

Attached to this article is the following.

The Scope of Profession for Nutritionist, click the link below to view.
https://www.hpcsa.co.za/Content/upload/professional_boards/dnb/regulations/Regulations_defining_the_scope_of_the_professions_of_Nutritionists.pdf

The Scope of Profession for Dietitians, click the link below to view:
https://www.hpcsa.co.za/Content/upload/professional_boards/dnb/guidelines/SCOPE_OF_PRACTICE_FOR_DIETITIANS_2024.pdf

The Scope of Practice for Dietitians, click the link below to view.
https://www.hpcsa.co.za/Content/upload/professional_boards/dnb/guidelines/DT_SCOPE_OF_PRACTICE_updated_JANUARY_2024.pdf

RECOMMENDING, PRESCRIBING AND DISPENSING NUTRITION SUPPLEMENTS

1.THE HANDLING OF NUTRITION SUPPLEMENTS BY DIETITIANS (PUBLIC VERSUS PRIVATE SECTOR)

Dietitians conduct several nutrition interventions as part of the Nutrition Care Plan. These include nutrition education, nutrition counselling, food and nutrient delivery as well as co-ordination of care. The implementation of the food and nutrient delivery intervention differs depending on whether the dietitian works for the public or private sector in South Africa.

1.1 Dietitians working in the South African public sector.

In the public settings, dietitians are responsible for ordering, prescribing and issuing the supplements that are either on the government tender or purchased off tender using a quotation system. This is done as part of their food and nutrient delivery interventions. The nutrition supplements are often bought by dietitians or managers of nutrition programmes according to the state tender. They are then kept in designated areas which include pharmacies, tube feed rooms, supplements store-rooms or supplement cabinets in the wards and in dietitians' offices. The route and rate of administration or quantity to be given are written in the patient's files. In many facilities, a protocol is also written for nursing staff to issue the feeds after office hours, during public holidays and when dietitians are not available. Outpatients receive the amounts of supplements from dietitians based on the nutrition supplementation guidelines and calculated disease specific nutrition requirements. The amounts are reviewed or renewed during each patient follow up consultation.

1.2 Dietitians working in private practice in South Africa.

Dietitians who work in private practice record supplements recommended or ordered and rate of administration or amounts to be issued on the patients' medical records under prescriptions or in medicines charts and these are issued by the hospital pharmacy for the sole use of the patient. The payment of these supplements is subject to the members medical aid scheme rules and the hospital policies. Patients who are seen in the private rooms receive counselling and options of available supplements that they can purchase if needed. Most private practising dietitians do not keep or sell nutrition supplements directly to their patients.

Most nutrition supplements are not scheduled drugs and can be sold at supermarkets or obtained over the counter at pharmacies. The following HPCSA rules should guide dietitians regarding issuing, recommending and sale of nutrition supplements to their patients.

2.HPCSA ETHICAL RULES

The following ethical rules guide practitioners (including dietitians) on the sale of medicine and medical devices:

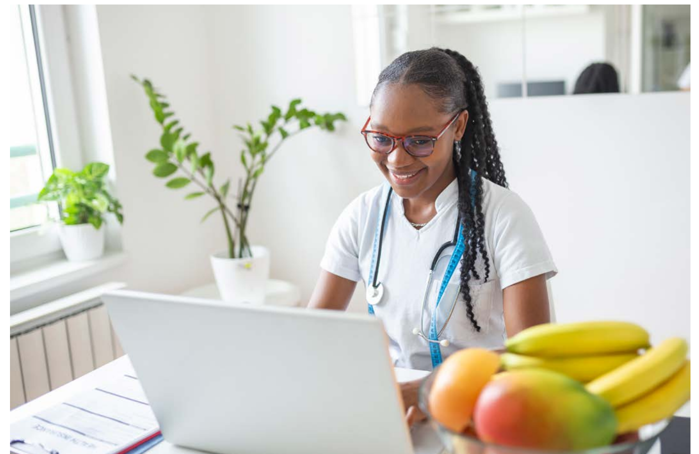
2.1 Ethics booklet 2: Preferential use or prescription Rule 23.

(1) A practitioner shall not participate in the manufacturing for commercial purposes, or in the sale, **advertising or promotion** of any medicine or medical device or in any other activity that amounts to selling medicine or medical devices **to the public or keeping an open shop or pharmacy.**

2) A practitioner shall not engage in or **advocate the preferential use or prescription of any medicine or medical device** which, save for the valuable consideration he or she may derive from such preferential use or prescription, **would not be clinically appropriate or the most cost-effective option.**

(5) A practitioner **may prescribe or supply medicine or a medical device to a patient: Provided that such practitioner has ascertained the diagnosis of the patient concerned** through a personal examination of the patient or by virtue of a report by another practitioner under whose treatment the patient is or has been and such medicine or medical device is clinically indicated, taking into account the diagnosis and the individual prognosis of the patient, and **affords the best possible care at a cost-effective rate** compared to other available medicines or medical devices and the **patient is informed of such other available medicines or medical devices,**

The key messages from HPCSA Ethics Rule 23 is that there should be no open shop (i.e. Dietitians should no sell supplements from their practices to clients who just walk in to buy, but should only issue supplements to patients who have been assessed and found to be in need of nutrition supplements), there should be no preferential use of a particular supplement, the supplement should only be recommended when it is indicated for the condition, and patients should be informed of other available supplements (alternatives).



2.2 Ethics booklet 11: Guidelines on over-servicing, perverse incentives and related matters;

The following sections from Booklet 11 are important guides for dietitians in terms of the provision and supply of nutrition supplements:

- Definition of terms:

"Promote" means any action taken by a person or body or allowed to be taken by such person or body to further or to encourage the preferential use of any health establishment or orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance or health related product or health related service or to further or to encourage the preferential sale of any such product or service for the purpose of financial gain or other valuable consideration: **This definition does, however, not prohibit the practice of those professions where, in terms of their scopes of practice, it is appropriate to sell such product or service at market related prices.**

- Sub section 3.4

"Healthcare practitioners shall not **engage in or advocate the preferential use** of any health establishment or medical device or health related service or prescribe any orthodox medicine, complementary medicine, veterinary medicine or scheduled substance, if any financial gain or other valuable consideration is derived from such preferential usage or prescription or the advocacy of **preferential usage by the healthcare professional".**

The key message according to booklet 11, any products sold by a practitioner should be at market related price and there should be no preferential use of a product.

3.TRENDS IN THE USE OF NUTRITION SUPPLEMENTS

3.1 The market for nutrition supplements and customer knowledge on the use of vitamin and mineral supplements

Research conducted by Truter and Steenkamp (2016) found that in 2013, a total of 164 233 vitamin products were dispensed by 327 community pharmacies (also known as retail pharmacies) to 84 807 patients at a cost of ZAR7 689 306.34. About 45% of the vitamins issued were unscheduled products and 33% of the dispensed items were vitamin B complex.

The use of supplements by customers is not always guided by health practitioners as customers do not normally seek professional advice prior to purchasing vitamin products (Owens, 2014). It is not always possible to evaluate amount of unscheduled over the counter supplements used by patients therefore monitoring the amount dispensed by the pharmacists can give some indication of supplements use.

It is therefore important for dietitians to utilise all potential opportunities to educate patients on responsible supplementation, monitor supplementation pattens, implement appropriate awareness campaigns and work with pharmacies to establish referral systems (Truter & Steenkamp, 2016).

3.2 The use and recommendation of nutrition supplements by dietitians

A study conducted in the USA among 300 private practising dietitians found that 97% of dietitians recommend supplements to their patients for a variety of reasons including bone health, to fulfil nutrition gaps and for overall health and wellness (Dickson, et al, 2012).

Dietitians were interested in continuing education on the regulation of the use of dietary supplements, drug nutrient interactions as well as sports nutrition supplements (Dickson, et al, 2012)

3.3 Regulations regarding the use of nutrition supplements

There are different international regulations guiding the use of supplements. It is important to take note of the definitions in order to determine what is in the scope of the profession.

Dispensing – Issuing of any scheduled product (Schedule 1-9) is considered dispensing. Issuing of unscheduled products (schedule 0) is not considered dispensing.

Prescribing – Providing a written or oral order to dispensing authority to issue a particular product (Cohen, 2016)

Recommending – According to the Ontario, recommendation of any supplement that is not scheduled is not considered prescription but recommendation.

Sell - means sell by wholesale or retail and includes import, offer, advertise, keep, expose, transmit, consign, convey or deliver for sale or authorise, direct or allow a sale or prepare or possess for purposes of sale, and barter or exchange or supply or dispose of to any person whether for a consideration or otherwise; and ‘sale’ and ‘sold’ have corresponding meanings. (SAHPRA, 2017)

Therapeutic Use in the case of health supplements - means “maintaining, complementing, or assisting the innate healing power or physical or mental state”. SAHPRA, 2022

Even when there are no restrictions to recommending nutrition supplements, dietitians must still act within their scope of practice and within their own knowledge, skill and judgement when making the recommendations (Cohen,2016).

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SOCIAL MEDIA GIVES FREEDOM
BUT THAT COMES WITH RESPONSIBILITY

Social media is seen as a crucial and essential component of communication in the world of the professional these days and no educational programme can be complete if it does not include training on how to use social media (Apdillah et al., 2022). The multiple possibilities, reduction in time and the ease with which it can be used are but some of the reasons why it is an essential element of communication. As a result, there is also a multitude of popular and research articles on the topic (Solar-Costa et al., 2021). However, good use of social media is still a problem and causes much hesitation and sometimes misuse, especially in a professional environment.

Self-awareness and recognition of one's moral responsibility is essential in communication through social media. It may seem so easy to quickly post on your blog or load a photo on Instagram, but ethics in social media is, as with any other method of communication more difficult to negotiate. Ethics in communication is based on a good understanding of grammar, early education about manners and learning to understand from a young age to limit curiosity about the privacy of others (Apdillah et al., 2022). If we follow these rules, most ethical "potholes" will be evaded. However, there are still so many examples of bad grammar, impolite ways of communication, the violation of privacy and many other problems seen on social media. Any professional institution should therefore have rules to assist their workers to communicate properly. Most poorly designed social media messages may do no damage other than reflecting poorly on the individual user, but some can be very damaging to the organisation and profession.

The term "netiquette" is already used for decades to describe good etiquette in social media. Netiquette was formed by merging the words network and etiquette and is described by Scheuermann and Taylor (1997) as "the conventions of politeness recognised" for the use of the internet and it includes common standards of etiquette. There are many guidelines written, but most of these include that one should first think before you write, use proper grammar, do not only use lower case letters, avoid using abbreviations but be concise. For formal communication avoid emojis 😍 and know the audience.

Examples of these guidelines include the "ten commandments" of Rinaldi (1996), *inter alia* that one should not use a computer to harm others or interfere with their work or copy software for which you have not paid. One should not use others' work without recognition or authorisation. One should also show consideration and respect. Brakeman (1995) also gave "ten commandments" that include, in addition to those of Rinaldi (1996), that one should not forget that the person on the other side is a human being, electronic communication should be brief and written with consideration so that one can be proud of one's messages. It is also important to be careful with humour and sarcasm.

Even though it is already used for a long time, netiquette as a field of study is still in its initial phase. There are not many research articles on the topic. One reason is that it is a complex field as it is difficult to define ethics for a context that changes almost daily. Nevertheless, it is an important field if we want to improve society and ensure professional behaviour (Soler-Costa, 2021).

Booklet 16: Guidelines for good practice in the healthcare professions; Ethical guidelines on social media, is a guideline compiled by the HPCSA that is a welcome tool for the dietitian and nutritionist to maintain high ethical and professional standards when negotiating social media. The intent of these guidelines is to recognise the relationship of trust between patients and healthcare practitioners and to help healthcare practitioners to understand their obligations when using social media. These guidelines are also part of the standards of professional conduct against which a complaint of professional misconduct can be evaluated.

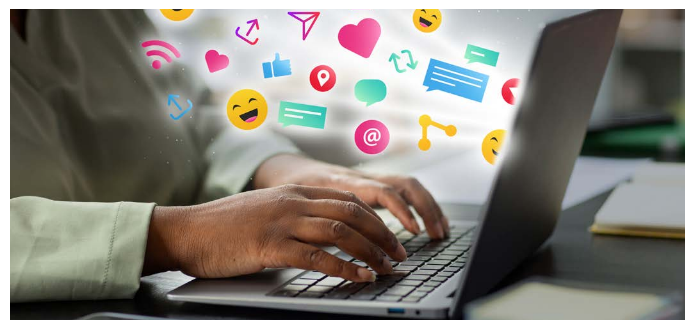
In the section on the obligations of the healthcare professional in relation to social media, it is clear that all other responsibilities and ethical norms apply also to social media. Through social media it is so quick to post messages, but one should not forget to carefully read through the message before it is posted to prevent unintended transgressions. One of the specific aspects that is highlighted in the section is the electronic storage and transmission of patient information which is discussed in more detail in Booklet 10.

Some important aspects that can be highlighted are the following:

Sharing information of patients on social media

Although one may share confidential information with other members of a patient's healthcare team and even some other individuals, the patient's consent (or the consent of the parents if the patient is under twelve years of age) is required. Even though it is allowed, the person who sends the information should make sure that the receiver understands the importance of keeping the information confidential and it should be shared with respect to the rights of the patient. You may think that the patient may not see it if you refer to her as "the old witch", but a printed version of the email may be on the desk of the next partner in the team where the patient may see it.

If information is used for matters other than the treatment of the patient, such as diagnosis or training, consent is also necessary and the sender must make sure that the patient cannot be identified from the information provided.



Interaction with patients on social media

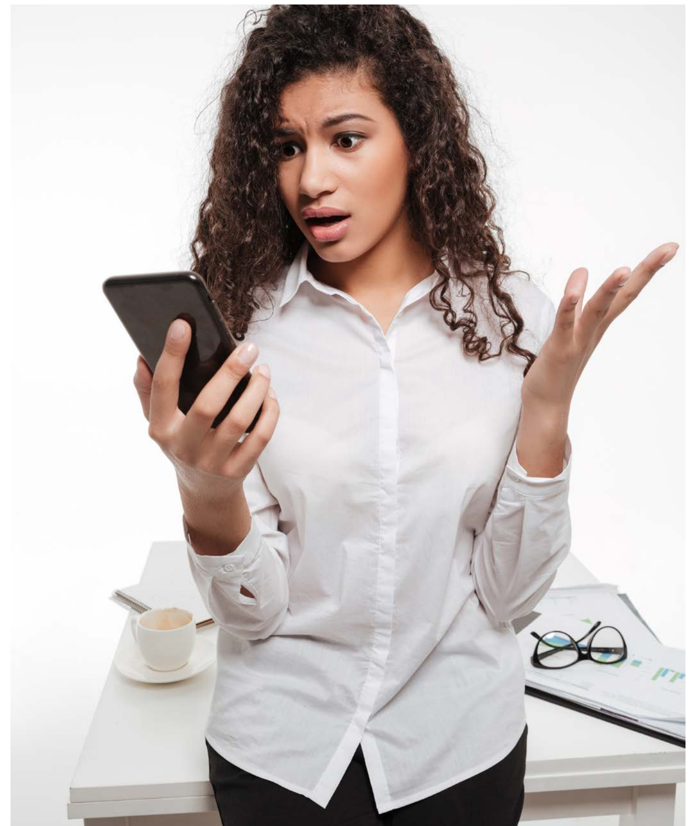
Under the practitioner-patient relationship, the golden rule of not interacting with patients through social media is mentioned due to the fact that it is more difficult to maintain strictly professional relationships and that may lead to other ethical dilemmas if these relationships are damaged. Even in the healthcare practitioner's private life, it is important to remember that patients may read the practitioner's social media posts, and they may start to make comments about "your cute dog". Therefore, restrict access, to make it easier to maintain appropriate professional boundaries - anonymity is never guaranteed on social media.

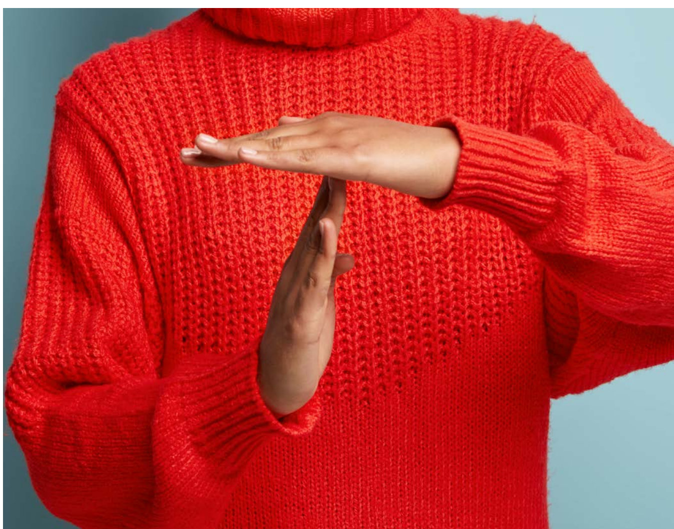
During COIVD-19 the practice of using social media as treatment platform may have been necessary, but the guidelines of booklet 16 make it clear that such consultations should only be done in exceptional cases such as an emergency or life-threatening situation.

Inappropriate use of social media can damage the profession

It is not only the individual healthcare professional that is influenced by his or her social media postings, it could have much wider repercussions if incorrect or damaging content is posted. One should remember that information on social media is easily accessible, also for people for whom it was not intended. In addition, employers these days can use the social media of an applicant for a post to get more information about the applicant.

Of course, health practitioners may participate in debates on health matters, however
one should make sure that information that you provide is evidence based and copyright should still be protected. If one disagrees with colleagues or feel that a colleague's post on social media is inappropriate, it should be managed discreetly, for example not as an open debate in social media.
Good advice that is given in this section is that health practitioners should include disclaimers in their social media profiles, indicating that their views are their own and not that of their institution or the profession.





Conflict of interest

These days it is easy to advertise online and it is also easy to become a media influencer. This may lead to conflict of interest as the healthcare practitioner cannot be separated from his or her workplace and it can cause much damage if not executed responsibly. One must always comply with the HPCSA rules, especially Booklet 2 (Ethical and professional rules) and Booklet 11 that guides, inter alia, on incentives and related matters.

The information in Booklet 16 concludes with the advice to err on the side of caution. Rather get more information or advice when you are not sure.

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WHAT HAPPENS AFTER A COMPLAINT IS LODGED?

SCREENING AND CATEGORISATION

The complaint goes through a screening process to establish if the practitioner is registered with HPCSA and whether the complainant has provided comprehensive details relating to the allegations.

After screening, a process of perusal, analysis and categorisation takes place. The complaint is registered against the name of the practitioner and referred for either mediation or preliminary investigation depending on the transgression.

MEDIATION

The complaint goes through a screening process to establish if the practitioner is registered with HPCSA and whether the complainant has provided comprehensive details relating to the allegations.

After screening, a process of perusal, analysis and categorisation takes place. The complaint is registered against the name of the practitioner and referred for either mediation or preliminary investigation depending on the transgression.

PRELIMINARY INVESTIGATION

A notice together with the complaint is sent to the practitioner to respond to the allegations. The written response must be received within 40 working days. The investigator will table the complaint, any further information and the written response to the Preliminary Committee of Inquiry for consideration. If the practitioner fails to provide the written response, the matter will be tabled before the committee and the committee will be informed of the failure to respond. In some cases, an onsite investigation will be conducted prior to sending the notice to establish facts.

PRELIMINARY INQUIRY

The Preliminary Committee of Inquiry will consider the matter and decide whether there is evidence of unprofessional conduct or not. In a case where there is evidence of unprofessional conduct, the committee will decide whether the transgression is minor or serious. If a transgression is minor, the committee will impose a penalty as prescribed and if serious the matter will be referred for an inquiry to be held. In a case where there is no evidence of unprofessional conduct, the committee will note and accept the explanation and the matter will be closed

EXECUTION OF PENALTIES IMPOSED BY THE COMMITTEE

In cases where a penalty has been imposed, a notice of charges will be sent to the practitioner to either accept or reject the charges. The response must be received within 14 days upon receipt of the notice of charges.

If the practitioner accepts the charges and payment made in a case of a fine the matter will be finalised and closed. If the practitioner rejects the charges or fails to respond within 14 days, the matter will be referred for an inquiry to be held.

1. CONTRIBUTING FACTORS TO DELAYS IN MANAGING COMPLAINTS

FAILURE TO RESPOND TO NOTIFICATION RELATING TO ALLEGATIONS OF UNPROFESSIONAL CONDUCT

In terms of Regulation 4(1) of regulations relating to conduct of inquiries into alleged unprofessional conduct under the Health Professions Act of 1974, the practitioner must provide response to the allegations of unprofessional conduct within 40 working days. Council has observed that most practitioners are failing to respond to Council regarding allegations of unprofessional conduct within the stipulated time. This contributes to delays in management of complaints by Council.

Practitioners are advised that failure to respond will constitute contempt of Council and a penalty may be imposed.

FAILURE TO UPDATE CONTACT DETAILS

In terms of Section 18(3) of the Health Professions Act, 56 of 1974, every registered person who changes his or her contact details shall in writing notify the Registrar within 30 days.

Council has also observed that some of the reasons provided by the practitioner for not responding to Council within 40 working days is that their contact details has changed however, the same was not communicated to Council. Practitioners are advised that failure to comply with the updating of the contact details will constitute an offence to the provision of the Act.

Practitioners are reminded to respond to any correspondence from Council within the stipulated time and update their contact details in line with the Act.

CEU Activity 1

You can obtain 2 CEUs ethics credits for reading the article. Please submit your answer sheet to **Annelie.Gresse@mandela.ac.za**. by due date as indicated.

CPD Accreditation No: DT/A01/2024/0010

Reference:

Reference: Dart, J., McCall, L., Ash, S. & Rees, C. 2022. Conceptualising professionalism in dietetics: an Australasian qualitative study. Journal of the Academy of Nutrition and Dietetics, 122(11): 2087-2096. Available: DOI: **10.1016/j.jand.2022.02.010**

(Free article)

RESEARCH

Research Paper

Conceptualizing Professionalism in Dietetics: An Australasian Qualitative Study

Janeane Dart*; Louise McCall, PhD; Susan Ash, PhD; Charlotte Rees, PhD

ARTICLE INFORMATION

Article history:
Submitted 15 June 2021
Accepted 16 February 2022

Keywords:
professionalism
dietetics
education
qualitative research
healthcare

Supplementary materials:
Tables 1 and 3 and Figure 1 are available at www.jandonline.org

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https://doi.org/10.1016/j.jand.2022.02.010

*Advanced Accredited Practicing Dietitian (Australia).

ABSTRACT

Background Professionalism is a vital aspect of health care and multidisciplinary teamwork. Although there is substantive professionalism literature in medicine and an expanding health care professions literature, there is a significant gap in understanding professionalism in dietetics. There are very few research papers in the dietetics literature on this issue compared with other health professions. Given the multidisciplinary nature of health care, it is important to understand what professionalism means within each profession to develop shared understandings across health care teams.

Objective The study aim was to explore how dietetics professionalism is conceptualized by dietetic practitioners/preceptors, faculty, and new graduates.

Design A constructionist exploratory qualitative interview study was conducted.

Participants/setting One hundred participants (dietetics graduates, faculty, and practitioners/preceptors), associated with 17 universities across Australia and New Zealand and from diverse geographical and work settings, participated in 27 group and 24 individual interviews from March 2018 to June 2019.

Statistical analyses performed Thematic framework analysis was used to examine participants' understandings of professionalism.

Results Twenty-three dimensions of dietetics professionalism were identified, with the most common being communication and including four novel dimensions of professionalism (generational, emotion management, cultural capability, and advocacy) not previously described in other professions. Professionalism as emotion management and generational adds new insights to the professionalism literature, expanding understandings of this vital aspect of health care. Although high levels of consistency in professionalism understandings existed across the three stakeholder groups, some interesting differences were found. The profession of dietetics shares similarities with other professions in the ways professionalism is conceptualized.

Conclusions Using these dimensions of professionalism as a framework for teaching and learning about professionalism will help in clarifying expectations and expand shared understandings about professionalism for dietitians, other health professions, and across multidisciplinary teams.
J Acad Nutr Diet. 2022;122(11):2087-2096.

HEALTH CARE PROFESSIONALISM IS CENTRAL TO safe and effective health care and ensures the public of quality health care.[1] Modern healthcare requires integrated care from multidisciplinary teams working across multiple cultures, contexts, and settings. This multidisciplinary backdrop means that healthcare professionals should have some shared understandings of what professionalism means.[2] Although health care professions have commonalities, with considerable overlap in many core areas of professionalism, each profession is influenced by its own unique histories, cultures and norms, roles and services, legal and ethical frameworks, competency and accreditation standards, and educational approaches.[1,3,4] Such diversity therefore reinforces the need for explicit understandings of professionalism within each profession. Although the medical professionalism literature is extensive and the healthcare professionalism literature is growing, scant research exists about professionalism from the perspective of dietitians.[5]

Professionalism has been conceptualized in diverse ways, even within the same healthcare discipline.[1,6-12] Conceptual divides also exist, influenced by the theoretical positioning and backgrounds of researchers investigating professionalism and the rationale underpinning their desires to understand professionalism better.[9,13] It is clear from the large body of existing literature in this area that professionalism is a socially constructed phenomenon that is complex; multidimensional; and changes across time, places, cultures, and

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people.[1,4,8,14,15] The notion of professionalism being dynamic is therefore key to understanding professionalism.[13] Whereas professionalism is a constantly mediated contract between the profession and society, it needs to be explicit so that it can be taught and learned.[4] Indeed, it is not something that occurs "by chance alone and cannot be absorbed passively."[16] From an educational perspective, therefore, professionalism should not be a vague notion, but something that can be understood and operationalized.[10] There are benefits to developing shared understandings within and across professions to support multidisciplinary teamwork and optimizing health outcomes.[2] Although the medical professionalism literature is substantive, there is growing literature exploring conceptualizations of professionalism within other health professions, including dentistry,[17] physiotherapy,[18] occupational therapy,[19] pharmacy,[20] podiatry,[3] and paramedics.[3]

A dearth of scholarly work exists within dietetics on professionalism.[5] As a modern health care discipline, dietetics has been established for just over a century and is therefore considered a young profession alongside some other allied health professions.[3,21] Dietitians are experts in food and nutrition, working across the health care continuum from population to individual approaches in various settings, including private dietetic practices, community health centers, multidisciplinary health practices, public and private hospitals, aged care, rehabilitation, and fitness centers.[22] In addition to providing direct client care, dietitians also work across a range of government and nongovernment organizations, contributing to public health policy, food standards, research, and education.[23] Until recently, professionalism in dietetics has been articulated via competency standards developed by professional associations and regulatory bodies.[5] A systematic literature review published in 2019 proposed the first definition and conceptual model of professionalism for dietetics integrating results from seven empirical studies, and drawing on national and international competency standards.[5] Identified in this review were four major themes conceptualizing professionalism for/by dietitians: personal attributes, interpersonal communication, approach to practice, and commitment to lifelong learning. In addition, 30 descriptors related to the themes were included.[5]

Dietetics students, faculty, and practitioners/preceptors are all expected to exemplify professionalism through adhering to professional codes and norms, without consensus or discussion of what professionalism means and how it is practiced. Professionalism is acknowledged as one of the most difficult competency areas to assess in dietetics.[24] There are limited evidence-based approaches to facilitate understanding and guide teaching and learning of professionalism in dietetics education.[5,18] Those responsible for teaching and assessing dietetics professionalism have, to date, depended largely on the broader medical and health care literature described above. What is still lacking is a comprehensive study exploring how professionalism is understood in the dietetics profession and how this relates to other health care professions.

To address this gap, and to extend existing research,[1,11,25] this study aims to explore how multiple dietetics stakeholders (dietetics practitioners/preceptors, faculty, and graduates) across Australia and New Zealand conceptualize professionalism. More specifically, we aimed to answer two research questions: What are dietitians' understandings of professionalism? and, How do professionalism understandings differ across participant groups?

RESEARCH SNAPSHOT

Research Question: What are dietitians' understandings of professionalism and how do professionalism understandings differ across participant groups?

Key Findings: In this constructionist exploratory qualitative study using interviews with 100 participants (dietetics practitioners/preceptors, faculty, and new graduates) across Australia and New Zealand, 23 dimensions of professionalism were identified. Communication was the most dominant conceptualization of professionalism. Four new dimensions of professionalism unique to dietetics were identified, including generational, emotion management, cultural capability, and advocacy. The findings clarify dietetics professionalism expectations and provide a framework for teaching and assessing professionalism.>

MATERIALS AND METHODS

Study Design

We employed constructionist qualitative inquiry using group and individual interviews.[26,27] The research sits within an interpretive approach, which acknowledges that multiple interpretations of reality exist and that meaning and understanding are socially constructed.[28] All participants involved in this research contributed unique perspectives in their conceptualizations of professionalism relevant to their multiplicity of experiences, contexts, and settings. This current work represents one part of a larger study exploring teaching and learning professionalism in the education of dietitians in Australia and New Zealand.

Sampling and Recruitment

We drew on the concept of information power to guide our sampling approach.[29] Information power is a model applied in planning and evaluating adequacy of sample size in qualitative studies.[29] Information power considers the study aim, sample specificity, quality of dialogue, the analysis strategy and use (or not) of established theory.[29] We aimed for maximum variation sampling,[30] with participants with diverse experiences and perspectives recruited across Australia and New Zealand. After receiving ethics approval from the Monash University Human Research Ethics committee (approval 0431), we invited faculty members responsible for teaching, by contacting via email the respective heads of department of all accredited dietetic education programs in Australia and New Zealand (n = 18 total; 15 in Australia 15 and 3 in New Zealand). We invited practitioners/preceptors (practicing dietitians who are responsible for supervision and/or teaching of students in the work setting) through established university placement networks, snowballing, and advertisement via an Australia-New Zealand Dietetic Educator Community of Practice. Finally, we invited dietetics graduates at the completion of their degrees through a flyer on their respective program electronic bulletin boards.

Data Collection

We collected data from March 2018 to June 2019. We completed in-depth semistructured individual and group interviews (2 to 6 participants) to explore participants' understandings and experiences of teaching, learning, and assessing professionalism. At the time of receiving written consent, participants opted for an individual or group interview and completed a personal details questionnaire. Within the personal details questionnaire, participants self-selected age and gender and cultural/ethnic identities, and included details of their work/study experiences. Group interviews were homogenous to avoid hierarchies as much as possible (eg, dietetics graduates only). The majority of data collection occurred using Zoom technology or teleconference due to geographic distance. We offered the opportunity for face-to-face or Zoom interviews to local participants. All interviews were audio recorded. We had two participants who volunteered for the study but did not participate after initial expression of interest and one participant withdrew for personal reasons. The first author conducted all study interviews. After a general icebreaker, the interviewer drew on the first question from the interview guide, asking all participants: "What are your understandings of professionalism for dietetics" (the focus of this current work). The question was prefaced with there being no right or wrong or expected answers because we were interested in their unique perspectives. Although participants' professionalism understandings were mostly provided in response to this direct question, participants also provided perspectives and understandings of professionalism as part of their narratives collected throughout the rest of the interviews. All participants were encouraged to participate equally and share their responses to the question. After exhausting participants' professionalism narratives, we concluded the interviews.

Study data collection finished when we perceived the sample had sufficient information power according to the five elements outlined by Malterud and colleagues.[29] Our sample of 100 participants across 17 Australia and New Zealand universities and 51 interviews (24 individual and 27 group interviews) was therefore sufficient.

Researcher Characteristics and Reflexivity

We had not worked together before as a research team, so we engaged early on in a team reflexivity activity.[31] This was important to explore our work and research experiences and our epistemological standpoints. We have clinical and/or educational backgrounds in three health disciplines (dietetics, nursing, and health psychology) and have broad career and research experiences, which provided diverse perspectives throughout our team-based analysis. Although a range of qualitative research experience exists across our team (from novice to expert), we share similar personal social constructionist epistemologies. Whereas two authors (J.D. and S.A.) identify as insider researchers in the context of dietetics, two authors (L.M. and C.R.) identify as dietetics outsiders.[32]

Data Analysis

All interviews were transcribed verbatim by professional transcribers with one author (J.D.) checking transcriptions through listening to the audios, editing and verifying, and de-identifying and anonymizing the transcripts. We then employed a team-based approach to framework analysis to analyse the data.[33] In step one, we familiarized ourselves with data by reading and listening to a subset of diverse transcripts. In step two, identifying a thematic framework, we came together to negotiate our individual interpretations of the data. We took an abductive approach, working simultaneously deductively and inductively with data.[34] For example, one author (C.R.) considered the data primarily deductively in relation to previous research, including an established professionalism understandings coding framework.[1] However, the other authors (J.D., S.A., L.M.), unfamiliar with this coding framework, approached step two inductively based on the data, but were also influenced deductively by our rich understanding of dietetics, including our previous systematic review.[5] An abductive approach enabled iterative, team-based development of a new coding framework, which drew on previous work but also included various new codes relevant to the novel dietetics context. Two authors (J.D. and L.M.) further refined the framework and all four of us agreed on the final coding framework (Figure 1, available at www.jandonline.org). In step three, indexing, one author (J.D.) employed the coding framework to code all data using NVivo 12.[35] The same author (J.D.) simultaneously coded the transcripts while listening to the data, attuning to cues not always apparent in transcripts. During this coding, we met as a research team four times to discuss and clarify points of ambiguity between the coding framework and data. Step four, charting, involved one author (J.D.) interrogating patterns in the data using NVivo, such as exploring the presence of professionalism dimensions across the interviews to identify which were more dominant (eg, those most dominant were present in more than 50% of the interviews, whereas those least dominant were present in less than one-quarter of the interviews). This interrogation also enabled the comparing and contrasting of professionalism conceptualizations across the three participant groups, in discussion as a team over several meetings. In the final step, mapping and interpretation, we interpreted the findings in light of the literature, through an iterative process of writing the results and preparing the manuscript.

RESULTS

Participant Characteristics

In terms of the total sample, the majority were women (n = 96), had English as a first language (n = 92), and ranged in age from 21 to 63 years (median = 38 years, interquartile range = 29 to 46 years). Participants came from 17 of 18 Australia and New Zealand universities with accredited dietetics programs, five of which were 4-year undergraduate, 11 were 2-year postgraduate, and one university with both. Participants came from a range of geographical (six Australian states and territories and New Zealand) and workplace settings and contexts, including universities, acute and subacute hospitals (adult and pediatric, public and private, regional and metropolitan), rehabilitation, mental health services, and community and public health and food industry (Table 1). Interviews ranged from 18 to 116 minutes (Table 1), with an average interview length of 50 minutes. Twenty-one of the interviews were conducted via Zoom, 19 by telephone, and 11 were face-to-face (Table 1). From the 51 interviews

Figure 2. Dimensions of dietetic professionalism identified from qualitative semistructured individual (n = 24) and group (n = 27) interviews with 100 participants (dietetic faculty [n = 51], practitioners/preceptors [n = 27], and new graduates [n = 21]).

conducted, 42 hours and 52 minutes of data were collected: 18 hours and 18 minutes from faculty, 13 hours and 7 minutes from practitioners/preceptors, and 11 hours and 27 minutes from graduates.

Conceptualizing Professionalism

Participants in our study had varied responses when asked to articulate their professionalism understandings. Although many provided prompt and clear responses, others found it difficult, either pausing or hesitating, or commenting that it was "really hard," or "almost impossible." Some participants struggled to define the concept as "it can mean so many things," is "so complex" and has "so many layers to it." Others appeared to acknowledge professionalism as "dynamic," and requiring flexibility in its interpretation; for example, it is "not a shopping list of facts." In the next section, we outline the range of professionalism dimensions identified across our whole dataset (Research Question 1), whereas in the subsequent section we explore the differences in conceptualizations between the three participant groups (Research Question 2)

What Are Dietitians' Understandings of Professionalism? (Research Question 1)

Dimensions of Professionalism. Twenty-three professionalism dimensions were identified across the entire dataset (Figure 2). We have included all the dimensions in this work because it is important to illustrate the breadth of our findings regarding how professionalism is conceptualized in dietetics. However, we describe only the 15 more dominant dimensions; that is, those present in more than one-quarter of the interviews. We present them next in descending order of dominance across the dataset, including illustrative participant quotes. The remaining eight dimensions (present in less than one-quarter of the interviews) (see Figure 2) are described in Table 2, along with illustrative participant quotes provided by faculty members (FAC), practitioners/preceptors (PR), or graduates (GR) (the participant's unique participation number follows the role identifier). Although we present each dimension below separately, the dimensions often overlap.

Professionalism as Communication. Included in this, the most dominant dimension, were numerous elements of professional communication: Professionalism is so important …how we communicate with other people "… *determines how effective and how successful you'll be*" (FAC43). Communication included: respectful communication; adaptability in verbal and nonverbal communication style, tone, and language in response to different cues and contexts; communicating with broad-ranging stakeholders including health care professionals, patients and families, and foodservice staff and communicating via social media. Giving, receiving, and responding to feedback and listening within work/learning environments were also described.

Professionalism as Presentation. How dietitians present themselves to others (including their attire) was reported as fundamental. A person dressing and looking appropriate (including following dress code rules or standards) was described as being both valued and expected, although participants acknowledged that standards varied across contexts. For example, in community settings, a more relaxed dress code was considered professional. Participants described conflicts within the profession about presentation expectations including being an acceptable weight or "thin," as well as narrow views of acceptable professional attire: "*I think that we have a very narrow view of what a dietitian should look like… even if you take the weight away… you'll get, occasionally, the sort of hippie dietitian and everyone will comment on that…*" (FAC5)

Professionalism as Competence. Being able to do the job competently, and at the appropriate level was another dominant dimension. More specifically, this was articulated as dietitians working within their scope of practice: "*Knowing*

Table 2. Descriptions of less-dominant dimensions of dietetics professionalism from interviews with 100 dietetic faculty, practitioners/preceptors, and new graduates exploring understandings of professionalism, and including illustrative participant quotes

Dimension	Description
Professionalism as behavior	Professionalism was also defined as appropriate behavior and conduct at the individual level in particular contexts and having an understanding that what you do "has an impact on people and processes around you." *"… my understanding of professionalism is, uh, your personal conduct... and how it, uh, how it enables you to, to further your work goals essentially." (PR72)*[a]
Professionalism as knowledge	Professionalism as knowledge included things like expertise, "mastery of knowledge," using an evidence base and a commitment to updating knowledge. *"… being a professional dietitian it is around um, using the evidence that we have and not just um, going along with the latest sort of fad that comes out." (FAC77)*[b]
Professionalism as person centeredness	Here, professionalism was recognized as putting patients' (or clients') needs and perspectives at the center of one's approach to practice and management. *"… having the clinician, um, really engaged in what the family's needs are at that point in time but also, um, uh, what the family's priorities are… so what I define as someone being professional… is whether they've got that at their, at their core of their practice." (PR68)*
Professionalism as hierarchy	Participants' talk included an understanding of professionalism as hierarchy within the health care system broadly in relation to other members of the health care team representing other professions, and within the dietetics profession itself. *"… there is hierarchy [laughs] in the hospital system, so knowing how to approach… knowing how to communicate upwards and sideways or downwards [laughs]." (PR67)*
Professionalism as internalized self	The idea that professionalism is something that is internal to the individual such as one's values, was illustrated by some participants' talk. Furthermore, participants highlighted that one's own cultural beliefs and values may limit the ability to "take on" (internalize) a professional self and identity until fully qualified and certified to do so. *"It's not something you can see, necessarily. It's, um, like, so, it's like thought—not thought processes, but, um, it kind of seems like an intrinsic thing that you have or you don't. And it's got to do with other things like how you were brought up, what your culture is…" (PR57)*
Professionalism as nutrition advocacy	Professionalism was conceptualized by some participants as advocacy for the dietetics profession, including empowering and building capacity to improve nutrition and health outcomes. *"The ability I guess to promote the profession as well, probably advocate the profession probably falls under that professionalism banner." (FAC32)*
Professionalism as phronesis	Some participants conceptualized professionalism as practical wisdom, which in our data was the ability to negotiate real-world complexities by applying different combinations of one's knowledge, skills and abilities to particular situations. *"Students need to start stepping up to that because, at the end of their degree, that's where they will be, they will be a professional… They will need to um use their knowledge and skills that they've learnt in one aspect and apply them to an ever-changing context." (FAC41)*
Professionalism as service provision	Some participants identified the idea of professionalism as offering one's dietetic knowledge and skills as a service to society. *"Um, the other part of…professionalism is that, in dietetics… it's also about service to others. Um, so it's um, providing something which will enhance or protect people's health with regards to nutrition." (PR59)*

[a]PR = preceptors (respective participant number).
[b]FAC = faculty participants (respective participant number).

how important your job scope is, especially in dietetics, where you're dealing with something so personal to people" (GR14). This dimension also included using evidence-based practice wherever possible, practicing safely, having appropriate technical expertise and skills required to fulfil their roles, seeking clarification and guidance when needed, and referring on when required. Participants also described such competence as being effective and efficient, being able to manage complexity and uncertainty, and engaging in problem solving and critical thinking.

Professionalism as Respect. Respect was defined as respect for self, for patients/clients, their families, for supervisors, faculty, peers, colleagues, the health care team, and for: "*anyone you come in[to] contact with... no matter who they are... respect is a huge component of professionalism*" (PR63). Professionalism also included respect for time (eg, of colleagues), for learning and working environments and organizational rules, for continuity of care and for the profession more broadly.

Professionalism as Individual Attributes. Professionalism was described as comprising dietitians' personal qualities and behaviors. Specific qualities included honesty, punctuality, integrity, initiative, empathy, compassion, and being well mannered. Other qualities included being reflective, confident (but humble), being ethical, nonjudgmental, enthusiastic, caring, reliable, fair, and polite but assertive. Participants also talked about the personality–professionalism interplay: "*I feel like your personality has a lot of play in terms of your professionalism*" (GR15), with some suggesting that dietitians needed to 'curb' (and thus modify) their personalities.

Professionalism as Role Models. Participants expressed valuing diverse role models such as peers, faculty, supervisors, and other members of the health care team. However, participants also talked about role modeling "imperfection" such as uncertainty, making mistakes and managing professionalism lapses as key elements: "*Just trying to model that professionalism is also about learning... and that when we don't know it's actually extremely professional to state that you actually don't know the answer to something but you'll endeavor to find out*" (PR68).

Professionalism as Generational. Professionalism as generational related to different understandings and expectations of professionalism existing inter-generationally, which could lead to intergenerational conflict. Participants also perceived that professionalism was an evolving concept: "*... we've got notions of professionalism that are drawn from our own experiences... but workplaces are changing... In a new entrepreneurial kind of environment... what does professionalism mean there? ... our expectations of what is professional might need to shift*" (FAC6).

Professionalism as Teamwork. Professionalism as teamwork included developing and maintaining collaborative working relationships: "*being professional... respecting, allowing others to speak and have a perspective about uh the system and working collaboratively with people around recommendations*" (FAC29). Such teamwork was described as involving dietitian peers, clients and their families, other health professionals, and stakeholders outside health care systems such as local government and nongovernment organisations.

Professionalism as Contextual. Participants suggested that professionalism varied across different contexts, thereby requiring adaptability and flexibility in understandings and enactment: "*... the one thing that stands out to me... is just how... professionalism or how professional someone is can vary across different settings... the standard of professionalism is different, everywhere you go*" (GR16). Some of the contextual variations discussed included different practice areas (eg, clinical versus community or public versus private), as well as local variations within those areas, cultural and geographical variations (eg, remote/regional/metropolitan settings or country settings), and between the university learning environment vs the health care workplace.

Professionalism as Rules. Professionalism was conceptualized by participants as both informal and formal rules laid down by organizational settings, regulatory bodies, and society. For example, participants talked about abiding by the rules, codes of conduct, policies and procedures, and practicing ethically: "*Our code of conduct that we have to follow, it kind of dictates our professionalism and where the boundaries are for our organization*" (PR53). Participants' uncertainties of the rules around social media and maintaining professionalism was also evident.

Professionalism as Emotion Management. Emotion management included the importance of empathy when working and learning with others, and at an individual level having insight and self-awareness, and incorporating self-care, self-regulation, resilience, and reflexivity into learning and/or working practices: "*... What is a professional dietitian? It's a dietitian that's reflexive, a dietitian that can actually reflect on what's happened and what's gone on and change[d] their behavior so they don't keep repeating... it comes back to having this very deep understanding of your own self and what switches you on, what switches you off, where you come from, why you behave that way in certain situations*" (FAC6). Participants described this as what was expected of students, peers, and colleagues, rather than about clients.

Professionalism as Segregation (Boundaries). Professionalism as segregation was articulated as a boundary between one's personal and professional lives. For example, boundaries related to finding the balance between personal privacy vs disclosure: "*I feel like someone who is professional... potentially keep[s] their personal life and professional life separate... or know when it's acceptable to you know, to cross between the two*" (PR50). Boundaries were described across many relationships, including clinicians–colleagues, students–faculty, practitioners/preceptors–students, and students–patients. Participants acknowledged that maintaining boundaries could be challenging to navigate and could vary across contexts and people. Social media was especially presenting new challenges in terms of managing boundaries.

Professionalism as Responsibility/Accountability. Professionalism as responsibility/accountability included taking responsibility for one's own choices/actions and corresponding outcomes with colleagues, patients, and team members: "*A key component of professionalism is actually being accountable for what you do and being accountable for your mistakes. And then how you actually manage um that mistake*" (PR68). Participants also talked about responsibility/accountability in more general terms; for example, acting in ways consistent with public expectations for dietitians.

Professionalism as Development. Participants suggested conceptualizations of professionalism as a developmental process from dietetic student through to practitioner, without a finite end point to being professional. This included a commitment to lifelong learning: "*... you need to keep building your professional skills in order to maintain your professionalism*" (FAC14).

Professionalism as Cultural Capability. This was described as practicing with cultural sensitivity with students, clients, and colleagues from culturally diverse backgrounds and in Indigenous health contexts: "*... cultural differences around what's like professional and what's not... we need to be open... not everyone has that same base kind of understanding of what's okay and what's not*" (FAC17). Cultural safety was thought essential in learning and working across cultural differences. Participants acknowledged the challenges of navigating cultural nuances and differences.

How Do Conceptualizations of Professionalism Differ across Participant Groups? (Research Question 2)

High levels of consistency existed across the three participant groups (graduates, faculty, and practitioners/preceptors) in terms of their professionalism understandings. For example, we found evidence of nearly all dimensions in all three participant groups (Table 3 available at www.jandonline.org), although describing professionalism as "service provision" was absent from the graduates' and "phronesis" was absent from graduates' and practitioners/preceptors' data.

There were some interesting variations in the dominance of some professionalism dimensions across the participant groups (Table 3 available at www.jandoline.org). University-based faculty understandings of professionalism appeared to differ from graduates and practitioners/preceptors in four ways. Although we found professionalism as rules, responsibility/accountability, and development to be more dominant in faculty data, professionalism as hierarchy seemed less dominant in faculty data. Practitioners/preceptors' understandings of professionalism seemed to vary from graduates and faculty in two ways. Whereas professionalism as segregation (boundaries) appeared more dominant in practitioner/preceptor data, professionalism as contextual seemed less dominant in practitioner/preceptor data. Graduates' understandings of professionalism seemed to vary from those of educators (faculty and practitioners/preceptors) in two ways: professionalism as generational and emotion management appeared less dominant in graduates' data.

DISCUSSION

To our knowledge, this is one of the largest qualitative studies exploring conceptualizations of professionalism using an interpretive approach across all health professions. Furthermore, this is one of only few studies simultaneously comparing graduates' conceptualizations of professionalism with those of faculty and practitioners/preceptors.[10,17-19,36] Similar to other studies, some participants found professionalism difficult to define.[11,25] This study is the first to identify new dimensions of professionalism as generational, emotion management, cultural capability, and advocacy and therefore extends existing understandings of professionalism in health care.

Summary of Key Findings in Light of Existing Literature

We identified 23 dimensions of dietetics professionalism, finding both similarities and differences with existing research.[1,5,11] The most dominant dimension of dietetics professionalism in our study was communication. Although communication has been previously considered an element of professionalism,[37] our finding is distinct from the previous research of Monrouxe and colleagues[1,11,25] where "being a good communicator" was included as part of another dimension (ie, individual attributes) rather than being a distinct dimension. The dominance of communication as a dimension of dietetics professionalism perhaps stems from communication being the key tool of the dietetics trade; for example, counseling in the individual nutrition management of medical conditions, facilitating community nutrition education programs, and written communications—policy development, menus, and nutrition resources.[38] A more challenging area in terms of conceptualizing professionalism was communicating via social media and the associated blurred boundaries about what is acceptable or professional. This is a challenge not distinct to dietetics, with an emphasis more recently exploring educational interventions to support health care students and their e-professionalism.[39-41]

Four dimensions of dietetics professionalism identified in our study have not been previously identified across other health care professions such as medicine, nursing, dentistry, physiotherapy, and pharmacy.[1,11,12] These were professionalism as generational, emotion management, cultural capability, and nutrition advocacy. Emotion management and cultural capability have been previously identified as elements of professionalism within the dietetics systematic review providing further evidence of their importance in dietetics professionalism.[5]

Emotion management, as we defined it, has not been mentioned previously outside of dietetics in terms of professionalism conceptualizations. We use the term *emotion management* because of a lack of consensus in defining (and a problematizing of) the term *emotional intelligence* in the literature.[42,43] Although exploring emotions and developing skills in regulating emotions are recognized as important elements of teaching and learning professionalism, there is currently little empirical evidence in this space.[43,44] Self-reflection, and peer review of self, have also been previously acknowledged as critical components of professionalism,[13] yet our study is the first to acknowledge emotion as a way of conceptualizing professionalism.

Professionalism as cultural capability was also a new dimension adding to the broader professionalism literature but also found previously in a systematic review.[5] That professionalism is culture-sensitive, and understandings vary across cultural contexts, is clearly established in the literature,[1,14,15,25,45] but cultural capability, conceptualized, and articulated as a professionalism dimension in this study is new. This may reflect dietitians' work adapting interactions to different cultures and focusing on food and eating practices, which are tied very closely to cultural expression.[46,47] Furthermore, demonstrating cultural competency is an element of competency standards for dietitians in Australia and New Zealand and could also account for this novel finding.[38,48]

The remaining two novel dimensions—generational and nutrition advocacy have not been reported in the existing health care professions literature as ways of conceptualizing professionalism. Professionalism as generational may be unique to our study because previous research has tended to focus on student conceptualizations, rather than involving multigenerational participants, including recent graduates, as well as experienced faculty and practitioners/preceptors. Indeed, although present in all three groups' data, professionalism as generational was most prominent in faculty data in our study. Although generational archetypes and generational othering are not new to the health care education literature, with "every generation complaining about the next,"[49,50] conceptualizing professionalism as generational is novel. Finally, professionalism as nutrition advocacy probably reflects the education of dietitians with dietitians at the point of entry into the profession in Australian and New Zealand, being equipped to work in public health nutrition roles involving advocacy; that is, capacity building, empowering, and collaborating.[38,48]

Although we identified new dimensions in comparison with existing literature[1,5,25] our findings also revealed interesting absences compared with the literature. For example, compared with the work of Monrouxe and colleagues,[1,11,25] we did not find any evidence in our participants' data of three dimensions: special (belonging to a privileged self-regulated group), stasis (having a full set of responsibilities from the beginning), and integration (where one cannot completely segregate personal and professional lives). This may partly reflect the less established professional identity of dietetics compared with some other health care professions. For example, although limited dietetics literature exists exploring professional identity,[51,52] the findings from one study with senior dietetic students, illustrates them as having simplistic and naïve views of the profession during their education.[52] Finally, our study showed no evidence of mentoring and leadership in participants' conceptualizations of professionalism, contrary to our previous dietetic systematic review.[5] This perhaps illustrates that contemporary Australia and New Zealand graduates/students, faculty, and practitioners/preceptors do not conceptualize professionalism as mentoring and leadership.

Although high levels of consistency existed in participants' understandings of dietetics professionalism across the three stakeholder groups, we found some interesting differences. Faculty and educators spoke more about professionalism as development, rules, and responsibility/accountability than practitioners/preceptors and graduates and less about hierarchy. Faculty's developmental focus and connection to rules and responsibility/accountability possibly relates to their educational roles in teaching and assessing learners' professionalism. That hierarchy was less dominant in faculty data may relate to their distance from hierarchical hospital and health care environments.[53,54] For practitioners/preceptors, professionalism as boundaries seemed more common, probably reflecting inherent health care workplace tensions about how much to disclose vs keep private. Further, professionalism as contextual seemed less common in practitioners/preceptors' data than graduates and educators. Perhaps this was because practitioners/preceptors work within one context only, whereas students are learning across a range of contexts and educators are teaching and developing curricula to support learning across contexts. Graduates focused less on generational dimensions of professionalism compared with faculty and practitioners/preceptors, probably reflecting their novice status. Furthermore, graduates talked less about professionalism as emotion management, which may relate to their uncertainty about the role of emotion and the relationship to professionalism rather than an absence of needing to manage emotions.

Methodological Strengths and Limitations

A key strength of this qualitative study is that it explores conceptualizations of professionalism from a diverse sample of stakeholders across 17 Australian and New Zealand universities. The diversity of the sample, including novice through to senior faculty and practitioners/preceptors, adds richness to our dataset. We are satisfied that our study sample of 100 participants has sufficient information power.[28] Indeed, our study aim was focused; we employed established theory, and enjoyed high-quality interviewer-participant dialogue. However, our sample specificity was broad, including three stakeholder groups and from wide-ranging Australian and New Zealand sites. Finally, the rigorous and reflexive team-based approach that we employed in our analysis of data further adds to the strength of this study. However, although we present a comprehensive synthesis of dietetics professionalism dimensions, we acknowledge that our study has limitations, and that these are situated within time and place. Our study is located in one continent only; however, with similar standards of dietitian training, education, and accreditation to the United States, Canada, and the United Kingdom, the findings are likely have both transferability and variations across continents. Understandings of professionalism will vary for all dietitians, across cultural and work contexts and settings. Our participants were predominantly women with English as a first language and were of Oceanian/European descent, so the findings may be less transferable to men and culturally and linguistically diverse dietitians, although our sample was representative of the profession's demographic characteristics. We therefore recommend further research on professionalism across a more culturally diverse sample of dietitians, and how it evolves across time. Moreover, we collected a smaller amount of data from graduates, meaning that the absence of certain dimensions in this smallest subsample may be due to the amount of data rather than an absence of that conceptualization by graduates. Further data collection is therefore needed with new graduates. Finally,

although we included three stakeholder groups, we have not involved patients or the public. Further research should explore their important perspectives on dietetics professionalism.

CONCLUSIONS

Viewing professionalism through an interpretive lens may be challenging for a discipline traditionally educated in the scientific paradigm and steeped in a history of positivism more comfortable with facts supported by statistics. Moving beyond focusing on professionalism as a list of acceptable and unacceptable behaviors creates room for flexibility and tolerance amid the complex social worlds that dietitians learn and work within. The dimensions presented are considered as frameworks—to extend understandings of professionalism these need to be anchored in local, cultural, and diverse professional contexts. This study is key for the profession, helping to clarify professionalism expectations across university and workplace environments, and providing a framework for teaching and assessing professionalism.

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STATEMENT OF POTENTIAL CONFLICT OF INTEREST

No potential conflict of interest was reported by the authors.

FUNDING/SUPPORT

Supported by the Faculty Learning and Teaching Small Research Grant 2018 and an Australian Government Research Training Program Scholarship.

ACKNOWLEDGEMENTS

The authors than Associate Professor Claire Palermo for her guidance and perspective on the final manuscript and to Kat Orgallo for her assistance with the graphic design of Figure 2.

AUTHOR CONTRIBUTIONS

All authors conceptualized the design of the study. J. Dart completed the recruitment and data collection and drafted the manuscript. All authors contributed to the data analysis and interpretation of data. C. Rees, L. McCall, and S. Ash reviewed the manuscript critically and edited multiple iterations. All authors approved the final version.

Table 1. Interview details and demographic characteristics of 100 dietetic graduates, faculty, and practitioners/preceptors participating in semistructured interviews exploring understandings of dietetics professionalism

	Participant Group		
Characteristic	Graduates (n = 22)	Faculty (n = 51)	Practitioners/Preceptors (n=27)
	←n→		
Interviews			
Individual	11	6	7
Group	4	14	9
Mode of interview			
Zoom	3	12	6
Telephone	9	3	7
Face-to-face	3	5	3
	←*mean (range)*→		
Interview duration (min)	46 (18-116)	55 (39-77)	49 (29-70)
	←n→		
Gender			
Female	21	49	26
Male	1	2	1
	←*mean (range)*→		
Age (y)	27 (21-43)	43 (29-63)	37 (25-59)
	←n→		
First language			
English	19	46	27
Other	3	5	0
Identification as Aboriginal and/or Torres Strait Islander	1	0	0
Other cultural and ethnic identification[a]			
Oceanian	17	37	18
European	3	17	9
Asian	3	3	0
Sub Saharan African	0	0	2
Geographic diversity of participants			
Australian	20	45	25
Australian Capital Territory	1	1	0
New South Wales	5	8	10
Queensland	6	12	2
South Australia	0	2	1
Victoria	8	18	11
Western Australia	0	4	1
New Zealand	2	6	2

(*continued on next page*)

Table 1. Interview details and demographic characteristics of 100 dietetic graduates, faculty, and practitioners/preceptors participating in semistructured interviews exploring understandings of dietetics professionalism (*continued*)

	Participant Group		
Characteristic	**Graduates (n = 22)**	**Faculty (n = 51)**	**Practitioners/Preceptors (n=27)**
University / workplace diversity of participants interviewed (n)	From 9 of 18 universities in Australia and New Zealand with accredited dietetics programs (14 undergraduate, 8 postgraduate students); 19 domestic and 3 international	17 of 18 universities in Australia and New Zealand with accredited dietetics programs	Public/private hospitals (adult and pediatric), subacute, foodservice, community and public health nutrition and the private sector; 18 metropolitan/urban, 8 regional and 1 rural

[a]This classification comes from the Australian Bureau of Statistics, Australian Standard of Cultural and Ethnic Groups (2019).[34]

Table 3. Dimensions of dietetics professionalism across participant groups (from semistructured interviews with dietetic faculty, practitioners/preceptors, and new graduates, n = 100)[a]

Graduates (15 interviews) (n = 22)	Faculty (20 interviews) (n = 51)	Practitioners/preceptors (16 interviews) (n = 27)
Competence	**Communication**	**Communication**
Presentation	**Presentation**	**Presentation**
Respect	**Competence**	**Competence**
Role models	**Individual attributes**	**Individual attributes**
Communication	**Respect**	**Segregation (boundaries)**
Contextual	**Generational**	**Respect**
Individual attributes	**Emotion management**	**Generational**
Team playing	**Contextual**	**Team playing**
Rules	**Responsibility and accountability**	**Role models**
Cultural capability	**rules**	**Emotion management**
Hierarchy	**Development**	Rules
Development	**Team playing**	Responsibility and accountability
Patient centeredness	Role models	Contextual
Segregation (boundaries)	Segregation (boundaries)	Development
Generational	Behavior	Cultural capability
Internalized self	Knowledge	Hierarchy
Responsibility and accountability	Cultural capability	Patient centeredness
Behavior	Internalized self	Nutrition advocacy
Knowledge	Patient centeredness	Knowledge
Emotion management	Nutrition advocacy	Behavior
Nutrition advocacy	Phronesis	Internalized self
Service provision	Hierarchy	Service provision
Phronesis	Service provision	Phronesis
Integration	Integration	Integration
Special	Special	Special
Stasis	Stasis	Stasis

[a]In Table 3, dimensions of professionalism are listed in descending order of dominance (ie, presence across the interviews) for each participant group; bold text indicates dimensions that are present in more than half of the interviews for each participant group. Dimensions are merged within a box when they are present in the same number of interviews. Dimensions presented with a strikethrough are not present in the talk of that participant group.

Dimensions of Dietetic Professionalism Coding Framework
1. **Professionalism as presentation**
This subtheme relates to the aspect of professionalism that suggests professionalism is about "looking the part," specifically the aesthetics of presentation. This might be due to factors such as: wearing the "correct" dress code for the work/placement setting, covering up skin art, and being an "appropriate" weight.
2. **Professionalism as competence**
This subtheme is about being competent at what you do at the appropriate level at any one time, practicing safely and effectively. Competency includes an evidence-based approach, being rational and informed and having the technical expertise and skills required to fulfill your role. It also relates to working within scope of practice—knowing your limits, seeking clarification and guidance, and referring on when those limits are stretched. It relates to specific and diverse elements of competent practice such as workload and time management, problem solving and critical thinking, and being able to manage in complexity and uncertainty.
3. **Professionalism as individual attributes**
This subtheme relates to the aspect of professionalism that is often considered "natural" and "common-sense" and the underlying tenets of professionalism at the individual level. For dietetics, this is described as many things, including honesty, punctuality, humility, politeness, insight, caring, compassion, reflection, being reliable, self-motivated, organized (well-prepared), nonjudgmental, having a sense of humor, trustworthiness, being a reliable nutrition expert, "pulling your weight," and being proactive (initiative) and having appropriate personal conduct and attitudes.
4. **Professionalism as role models**
This subtheme relates to the aspect of professionalism, that identifies role modeling professionalism. This may include a dietetic practitioner or academic being a role model to dietetics students, dietetics students being role models to one another, other members of the health care team being role models and students acting as role models to their seniors.
5. **Professionalism as teamwork**
This subtheme relates to the idea that professionalism is about how the person interacts with others in the workplace/learning environment for example, group working situations at university, interacting and working with the health care team and establishing work relationships that add value to work/practice (eg, developing relationships with non−health-care colleagues on placements, maintaining placement relationships for education capacity). This subtheme relates to working in partnership/collaboratively with others, and establishing and maintaining effective working/learning relationships.
6. **Professionalism as contextual**
This subtheme is about how environment can influence how you behave and your approach to learning/practice. This relates to varying expectations across different domains of learning and practice in dietetics, different educators/supervisors and requires flexibility and adaptability. Professionalism is nuanced—it is "gray," "murky," and variable across contexts.
(continued on next page)

Figure 1. Dimensions of Dietetic Professionalism Coding Framework,[a] applied to qualitative interview (individual and group) data of 100 dietetic faculty, preceptors, and new graduates.

Dimensions of Dietetic Professionalism Coding Framework
7. **Professionalism as rules**
This subtheme relates to the aspect of professionalism, governed by abiding to rules and regulations, policies and procedures. These rules and regulations may be those of dietetic associations, workplaces, and/or universities. This can relate to academic integrity and conduct in the university context. This also relates to maintaining and upholding confidentiality. There might also be rules such as ethics that may or may not be different to one's personal ethical code. It also encompasses society's expectations of the profession.
8. **Professionalism as segregation (boundaries)**
This subtheme relates to knowing how to set boundaries around yourself as a person and yourself as a professional (so, not being a friend to the patient and maintaining professional boundaries with colleagues, peers, and patients). It also relates to the notion that one can separate one's personal life and personal views from one's professional life. This includes aspects such as not letting personal opinions and judgments cloud treatment/behavior with a patient.
9. **Professionalism as development**
This subtheme relates to the aspect of evolving and developing professionalism from dietetics student through to practitioner and a lack of a finite end point to being professional. For some this is seen as beginning in childhood and the morals, values, and beliefs developed early on and extended into adulthood. Some students begin at university and "they just get it/ have it." Intrinsic to this is the notion that professionalism can be taught but that it is more difficult to teach if a person did not learn such things early on in life. Practitioners, academics, and students acknowledge that maturity (not necessarily related to age), life experiences including work experiences and upbringing influence starting points for students. Students see themselves developing into professionals, developing their skills and knowledge and behavior for future practice. Part of this development relates to students not being fully formed and calling themselves "just" or "only" a student, whereas others see it as legitimate recognition that they are at certain stages of development and that they shouldn't be taking on certain responsibilities. This subtheme also relates to a commitment to lifelong learning—continuous personal and professional development.
10. **Professionalism as knowledge**
This subtheme relates to the idea that professionalism is knowledge-based and equates with aspects such as how well you do your job and how expert you are in your work. It relates to the technical expertise required to do the job. There is an element of quality of work and this includes keeping up to date with knowledge, and using an evidence-based approach to practice.
11. **Professionalism as patient (person) centeredness**
This subtheme relates to aspects of professionalism, that suggest that, the patient/client/person needs to be at the center of a dietetics student or practitioner's concerns and approach to practice. This subtheme also expands to include family, and significant/important others in the care and management of a patient/client/person, encompassing a holistic approach. Ensuring the patient/client/person perspective and his or her continuum of care is at the forefront of a student dietitian's/ practitioner's mind and approach to management. This subtheme also includes advocacy for the client/person to support optimal care and management.
(continued on next page)

Figure 1. *(continued)* Dimensions of Dietetic Professionalism Coding Framework,[a] applied to qualitative interview (individual and group) data of 100 dietetic faculty, preceptors, and new graduates.

Dimensions of Dietetic Professionalism Coding Framework
12. **Professionalism as hierarchy**
This subtheme relates to the idea that professionalism is about having a sense of your place in the hierarchy of dietetics and health care. It relates to privileging and hierarchies within the dietetics profession, other health care professions, and the health care system more generally.
13. **Professionalism as internalized self**
This subtheme relates to the idea that professionalism is something that is internal to the individual. This may link with feelings of discomfort when one feels as if he or she is being "unprofessional" or when seeing others being "unprofessional." This subtheme also has cultural applications. Acknowledging one's cultural underpinning may limit the ability to "take on" (internalize) a professional self and identity until fully qualified/certified to do so.
14. **Professionalism as phronesis**
This subtheme relates to the idea of professionalism as practical wisdom: the ability to negotiate real-world complexities by applying different combinations of one's knowledge, skills, and abilities to particular situations.
15. **Professionalism as service provision**
This subtheme relates to the idea of professionalism as offering one's dietetics knowledge and skills as a service to society.
16. **Professionalism as communication**[b]
This subtheme relates to the idea that professionalism in dietetics is expressed in many aspects of communication required within dietetic practice—listening to one another, the ability to seek, provide, and respond to constructive feedback, seeking clarification/guidance, being assertive, transparency and openness, adapting language and approaches, education (students, clients, and clinicians), and body language. This also relates to more advanced aspects of communication, including conflict resolution (transformation), navigating uncertainty, and complexity in the learning/workplace environment and finding the balance between disclosure and privacy.
17. **Professionalism as respect**[b]
This subtheme relates to professionalism being expressed in practice as respect: respect for self, and respect for others and interactions with patients, coworkers, peers, colleagues, and supervisors as well as respecting clients as "experts of their own life." This also extends to public respect and expectations for the dietetics profession.
18. **Professionalism as generational**[b]
This subtheme relates to the dynamic nature of professionalism in terms of its changes across time. This can present across varying expectations of professionalism across generations in workplaces and learning situations. It also includes acknowledging generational differences when learning and developing professionalism.
(continued on next page)

Figure 1. *(continued)* Dimensions of Dietetic Professionalism Coding Framework,[a] applied to qualitative interview (individual and group) data of 100 dietetic faculty, preceptors, and new graduates.

Dimensions of Dietetic Professionalism Coding Framework
19. **Professionalism as emotion management**[b]
This subtheme relates to the idea of professionalism in dietetics as emotional management—of self and others and encompassing self-awareness and insight, empathy, resilience, and self-regulation. This can be an approach to practice and working with clients, stakeholders, peers, and colleagues as well as the approach taken with self, practicing with reflexivity and self-awareness, and insight. This also encompasses self-care and management of ones' own health and well-being, including stress management, and physical and mental health. A comprehensive understanding of self supports approaches to dietetic practice.
20. **Professionalism as responsibility and accountability**[b]
This subtheme relates to responsibility and accountability within the work role for decisions, mistakes and how they are managed, and the work undertaken. It also includes responsibility for one's own choices, actions, and corresponding outcomes. This also links to responsibility to act in ways expected by the public.
21. **Professionalism as cultural capability**[b]
This subtheme includes the flexibility, cultural capability, cultural safety, and sensitivity of practitioners and students to practice effectively amongst cultural diversity, with diverse peers, colleagues, clients, and stakeholders as well as diverse communities and nutrition-related contexts to improve nutrition and health outcomes.
22. **Professionalism as behavior**[b]
This subtheme relates to professionalism as behavior and conduct at the individual level and the interplay between the interactional and organizational contexts.
23. **Professionalism as nutrition advocacy**[b]
This subtheme relates to professionalism being enacted as empowerment and capacity building beyond individual consultations and patient management. This may include advocacy for enhanced foodservice systems to support improved nutrition outcomes or broader community/population capacity building approaches to improve nutrition and health outcomes.
The framework is used and adapted with the authors' permission. [a]This coding framework is drawn from previous health care professionalism research by Monrouxe and colleagues[1,11,25] and is adapted for dietetics data. [b]Identification of additional (new) dietetics professionalism dimensions.

Figure 1. *(continued)* Dimensions of Dietetic Professionalism Coding Framework,[a] applied to qualitative interview (individual and group) data of 100 dietetic faculty, preceptors, and new graduates.

ACTIVITY 1 - QUESTIONS

1. A systematic review that was published in ……... was the first document to propose a definition and conceptual model of professionalism for dietetics. The results of seven empirical studies were integrated. It drew on national and international competency standards.
   a. 1996
   b. 1998
   c. 2008
   d. 2019

2. Modern healthcare requires………… from multidisciplinary teams
   a. integrated care*
   b. diverse ways of treatment
   c. cone simple approach
   d. more inputs to ensure co-operation

3. Although healthcare professions have commonalities, with considerable overlap in many core areas of professionalism, each profession is influenced by its own unique histories……………., roles and services, legal and ethical frameworks, competency and accreditation standards, and educational approaches
   a. settings
   b. experts
   c. cultures and norms
   d. definitions and philosophies

4. Professionalism is taught and learned and therefore it needs to be
   a. explicit
   b. easily understandable
   c. universal
   d. adapted to the educational approach

5. Professionalism should be something that can be
   a. understood.
   b. theoretical and philosophical.
   c. operationalised.
   d. grounded in experiences.
   e. a and c.

6. Professionalism is acknowledged as one of the most difficult ………. areas to assess in dietetics.
   a. knowledge
   b. practice
   c. competency
   d. communication

7. What is still lacking is a comprehensive study exploring how professionalism is understood in the dietetics profession and how this relates to
   a. communication
   b. behaviour
   c. the knowledge base of dietetics
   d. other healthcare professions.

8. During this qualitative study. …….. professionalism dimensions were identified across the entire dataset.
   a. 6
   b. 12
   c. 17
   d. 23

9. Respect was defined as "respect for self, for patients/clients, their families, for supervisors, faculty, peers, colleagues, the healthcare team, and for: "anyone you come in[to] contact with, no matter who they are… Professionalism also included respect for ……..., for learning and working environments and organisational rules, for continuity of care and for the profession more broadly.
   a. behaviour
   b. time
   c. funding
   d. social interaction

10. Professionalism as teamwork is about how the person ………. with others in the workplace/learning environment
    a. interacts
    b. shares jokes
    c. shared emotions
    d. shares data
    e. c and d

11. Using an evidence-based approach, being rational and informed and having the technical expertise and skills required to fulfil your role is known as
    a. professionalism as competence.
    b. professionalism as teamwork.
    c. professionalism as contextual.
    d. professionalism as development.

12. Ensuring the patient/client/person perspective and his or her continuum of care is at the forefront of a student dietitian's/practitioner's mind and approach to management is known as
    a. professionalism as nutrition advocacy.
    b. professionalism as patient/person centeredness.
    c. professionalism as responsibility and accountability.
    d. professionalism as service provision.

13. Working in partnership/collaboratively with others, and establishing and maintaining effective working/learning relationships is known as
    a. professionalism as hierarchy.
    b. professionalism as respect.
    c. professionalism as teamwork.
    d. professionalism as role models.

14. Advocacy for enhanced foodservice systems to support improved nutrition outcomes or broader community/population capacity building approaches to improve nutrition and health outcomes is known as
    a. professionalism as nutrition advocacy.
    b. professionalism as behaviour.
    c. professionalism as patient centeredness.
    d. professionalism as responsibility and accountability.

15. Sensitivity of practitioners and students to practice effectively amongst diverse peers, colleagues, clients, and stakeholders as well as diverse communities and nutrition-related contexts to improve nutrition and health outcomes is known as
    a. professionalism as segregation.
    b. professionalism as phronesis.
    c. professionalism as generational.
    d. professionalism as cultural capability.

HOW TO EARN YOUR CEUs

1. Complete your personal details below.
2. Read the article: **Dart, J., McCall, L., Ash, S. & Rees, C. 2022. Conceptualizing professionalism in dietetics: an Australasian qualitative study. Journal of the Academy of Nutrition and Dietetics, 122(11): 2087-2096. Available:** DOI: **10.1016/j.jand.2022.02.010** (Free article); and answer the questions
3. Indicate the answers to the questions by marking an "x" in the appropriate block at the end.
4. **You will earn 2 CEUs (Level 1 - Ethics) if you answer 70% or more of the questions correctly. A score of less than 70% will unfortunately not earn you any CEUs.**
5. Make a photocopy for your own records in case your answers do not reach us.
6. Scan and email or post your answers to: Annelie.Gresse@mandela.ac.za

Please note: The answers should not reach us later ***than 31st October 2024*.**
Answer sheets received after this date will not be processed.

ANSWER SHEET ACTIVITY 1

HPCSA Number: ……………………………………………………………………………………………
(NT or DT with 7 digits)

Initials: ……………………………………………………………………………………………………

Surname as registered with the HPCSA: ………………………………………………………………

Contact number: ……………………………………………………………………………………………

E-mail address: ……………………………………………………………………………………………

PLEASE ANSWER ALL THE QUESTIONS AND MARK THE APPROPRIATE BLOCK WITH AN "X "

1. A ☐ B ☐ C ☐ D ☐
2. A ☐ B ☐ C ☐ D ☐
3. A ☐ B ☐ C ☐ D ☐
4. A ☐ B ☐ C ☐ D ☐
5. A ☐ B ☐ C ☐ D ☐ E ☐
6. A ☐ B ☐ C ☐ D ☐
7. A ☐ B ☐ C ☐ D ☐
8. A ☐ B ☐ C ☐ D ☐
9. A ☐ B ☐ C ☐ D ☐
10. A ☐ B ☐ C ☐ D ☐ E ☐
11. A ☐ B ☐ C ☐ D ☐
12. A ☐ B ☐ C ☐ D ☐
13. A ☐ B ☐ C ☐ D ☐
14. A ☐ B ☐ C ☐ D ☐
15. A ☐ B ☐ C ☐ D ☐

CEU Activity 2

You can obtain 2 CEUs ethics credits for reading the article Please submit your answer sheet to **Annelie.Gresse@mandela.ac.za**. by due date as indicated.

CPD Accreditation No: : DT/A01/2024/00141

Reference:

Health Professions Council of South Africa, Developed by the human rights, ethics and professional practice committee Pretoria, 2019.Ethical Guidelines on Social Media. HPCSA booklet 16. Available:

https://www.hpcsa.co.za/Uploads/professional_practice/ethics/Booklet_16_Ethical_Guidelines_on_Social_Media.pd

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

GUIDELINES FOR GOOD PRACTICE

IN THE HEALTH CARE PROFESSIONS

ETHICAL GUIDELINES ON SOCIAL MEDIA

EDITED BY THE HUMAN RIGHTS, ETHICS AND PROFESSIONAL PRACTICE

BOOKLET 16

2019

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THE INTENT OF PROFESSIONAL GUIDELINES

Practicing as a health care professional is based upon a relationship of mutual trust between patients and health care practitioners. The term "profession" means "a dedication, promise or commitment publicly made".[1] To be a good health care practitioner, requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one's fellow human beings and society. In essence, the practice of health care professions is a moral enterprise. The HPCSA presents the following ethical guidelines to guide and direct the practice of health care practitioners. These guidelines form an integral part of the standards of professional conduct against which a complaint of professional misconduct will be evaluated.

[Note: The term "health care practitioner" in these guidelines refers to persons registered as such with the HPCSA].

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TABLE OF CONTENTS

[1] Pellegrino, ED. Medical professionalism: Can it, should it survive? *J Am Board Fam Pract* 2000; **13**(2):147-149 (quotation on p. 148).

The Health Professions Council of South Africa wishes to thank the following persons for their contributions towards the compiling of these guidelines:

- Dr N Tsotsi for the first draft, and Ms Nerissa Naidoo and Prof DJ McQuoid-Mason for the second and third drafts.
- Prof A Dhai for reviewing the first and third drafts.
- The Committee for Human Rights, Ethics and Professional Practice of the Health Professions Council of South Africa for initiating and advising the review process: Dr S Balton (Chairperson), Prof D J. McQuoid-Mason, Dr N Tsotsi, Prof B Pillay, Prof N Gwele, Prof N Mekwa, Prof S Hanekom.
- Adv Mathibeli as the legal advisor, Ms N Manciya as Committee coordinator and Mr N Sipeka as the Council secretariat.

1 ABOUT THESE GUIDELINES

The guideline was developed to help health practitioners understand their obligations when using social media. The guideline applies to all health practitioners registered with the Health Professions Council of South Africa.

2 INTRODUCTION

2.1 The use of social medial is expanding rapidly as individuals and organisations are embracing user-generated content through social networks, internet forums and personal blogs.

2.2 Irrespective of whether online content is accessible to the public at large or is limited to specific health practitioners, there is a need to maintain high professional and ethical standards in using social media.

2.3 Health professionals need to be aware that there are potential risks involved in the sharing of information via social media, even if the consequences are unintended.

2.4 The General Ethical and Professional Rules of Conduct set out in Booklet 2: Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act, 1974 as published under Government Notice R7171 in *Government Gazette* 29079 of 4 August 2006 and as amended.

3 DEFINITION OF SOCIAL MEDIA

3.1 Social media describes the online tools and electronic platforms that people use to share content such as opinions, information, photos, videos and audio.

3.2 Social media includes social networks (e.g. Facebook, Twitter, WhatsApp and LinkedIn), content-sharing platforms (e.g. YouTube and Instagram), personal and professional blogs (including email, SMS, electronic journals as well as those published anonymously), internet discussion forums, and the comment sections of websites.

4 CONTEXT IN RELATION TO HPCSA

4.1 A key objective of the HPCSA and its Professional Boards is to guide the profession and protect the public.

4.2 Health practitioners may find social media beneficial as it allows them to keep updated on the latest healthcare developments through reputable user-generated content, build a professional support network as well as communicate and share health-related information with the public and other health practitioners.

4.3 These guidelines must be read in conjunction with the other HPCSA Ethical Guidelines Booklets and other applicable publications.

5 OBLIGATIONS IN RELATION TO SOCIAL MEDIA

5.1 Just as with all aspects of professional behaviour, health practitioners should be aware of their obligations under the HPCSA Ethical and Professional Rules, the Professional Board's scope of practice and other relevant legislation, such as the Promotion of Access to Justice Act 3 of 2000, the Protection of Personal Information Act 4 of 2013, and the common law.

5.2 There are ethical obligations and responsibilities imposed on health practitioners regarding their relationships with their patients and each other, such as those set out in Booklet 1 *General Ethical Guidelines for Health Car e Professionals* and Booklet 5 *Confidentiality: Prot ecting an d Providing Information*.

5.3 Obligations relating to the electronic storage and transmission of patient and client data for professional purposes are found in Booklet 10 *General Ethical Guidelines for Good Practice in Telemedicine*.

6 PATIENT CONFIDENTIALITY AND PRIVACY

6.1 All patients are entitled to privacy and confidentiality, which is enshrined under the human right to privacy in the South African Constitution and the National Health Act.

6.2 Disclosure of a patient's information may only be in accordance with a court order, patients consent and in terms of the law.

6.2.1 Health practitioners can share confidential information with other members of the health care team involved in the patient's care and with individuals who have the patient's consent.

6.2.2 Health practitioners can also share information if it is justified in the public interest, or if failure to do so will result in harm to the patient.

6.3 Health practitioners must obtain the written consent of the patient before publishing information (e.g. case histories and photographs) about them in media to which the public has access, whether or not the health care practitioner believes the patient can be identified by the data.

6.4 If the patient is a minor under the age of 12 years old, the health care practitioner will require the written consent of the patient's parent or guardian and assent of the minor.

6.5 Health practitioners sharing information or data for the sake of diagnosis, treatment or education and training through social media must ensure that the recipient of the information is not able to identify the patient from the data disclosed.

6.5.1 Health practitioners must ensure that the recipient of patient information via social media understands that such information is given to them in confidence, which they must respect.

6.6 Disclosure of information on social media must be kept to the minimum necessary in order to protect the rights of patients.

6.7 Health practitioners must be aware that there is always a risk that the information can be disseminated, even in so-called "invisible" groups, (i.e. people you do not know are reading the information or who you did not know could read the information).

6.8 The obligation to keep patient information confidential remains even after the patient dies.

7 THE PRACTITIONER-PATIENT RELATIONSHIP

7.1 Interaction between health practitioners and their patients on social media can blur the boundaries of the professional practitioner-patient relationship.

7.2 Health practitioners are advised not to interact with patients via social media platforms as a failure to maintain strictly professional relationships with patients could result in other ethical dilemmas.

7.3 The Protection of Personal Information Act outlaws the acquisition of data about an individual's health or sex life outside the healthcare setting, and by having access to patients' social media profiles, health care practitioners may find themselves privy to personal patient information that has not been shared in the healthcare setting.

7.4 Health practitioners may choose to share personal information about themselves with their patients during face-to-face consultations, but social media does not offer a similar level of control over the extent and type of content shared.

7.5 If the health practitioner performs a non-medical role in their community, maintaining appropriate professional boundaries may be difficult as they may receive requests on social media from patient's they know in a non-professional capacity. In these instances, health practitioners should consider the circumstances and implications before accepting these requests.

7.6 Should the health practitioner receive an inappropriate message from a patient via social media, they should politely re-establish professional boundaries and explain their reasons for doing so.

7.7 Except in an emergency or life-threatening situation, if a patient is seeking health care advice over social media, the health care practitioner should politely request them to set up an appointment in-person.

7.8 If a patient persists in contacting the health practitioner, the practitioner should keep a log of all contacts and seek advice from the HPCSA.

7.9 Providing health advice over social media to individuals with whom the health practitioner does not have a practitioner-patient relationship is discouraged and should be done with the outmost discretion.

7.10 If health advice is shared online, it must be evidence based , scientifically sound and generic and the recipient must be directed to consult with a health practitioner in person before following through.

7.11 Health practitioners should separate their professional and personal social media accounts to help maintain the appropriate professional boundaries.

8 THE HEALTH PROFESSION'S IMAGE

8.1 If the health care practitioner uses social media in their personal capacity, their online activity may nevertheless bring the profession into disrepute.

8.2 The media routinely monitor online activity to research stories or potential stories. Information posted online may be disseminated, whether intended or not, to a larger audience, and may be taken out of context.

8.3 Content posted on social media may also harm the health practitioner's employability and recruitment, limiting professional development and advancement. Employers often monitor the social media profiles of prospective employees, and are known to turn away applicants based on questionable digital behaviour.

8.4 Social media activities health practitioners should avoid for example include:

8.4.1 Taking photographs during surgery and other forms of care or treatment;
8.4.2 Making unsubstantiated negative comments about individuals or organisations;
8.4.3 Making informal and derogatory comments about patients;
8.4.4 Making comments that can be perceived as racist, sexist, homophobic or otherwise prejudiced, even if meant in jest or as satire.

8.5 Health practitioners may engage fully in debates on health matters, however they must be aware that the laws regarding defamation, hate speech and copyright also extend to content shared via social media.

8.6 Health practitioners must not post their opinions on the probity, skill or professional reputation of their colleagues on social media, lest the public lose faith in the health care profession.

8.7 Online relationships between practitioners of varying levels of training should only be initiated upon consideration of the purpose of the relationship. In the case of senior staff receiving social media requests from students (or vice versa), the purpose might be mentorship, research or career advice. Regardless of intent, the traditional boundaries of the trainee-teacher relationship apply even in interactions via social media. These boundaries also extend to staff and other health practitioners.

8.8 If a colleague makes derogatory or inappropriate comments on social media, health practitioners are advised to bring it to their attention discreetly, and not to engage or respond publicly on the social media platform.

8.9 Health practitioners are advised to include disclaimers in their social media profiles, indicating that the views expressed therein are their own and not those of the health profession or the health establishment they represent. However, this does not absolve the health care practitioner from the above rules.

9 CONFLICTS OF INTEREST

9.1 Social media is also a popular tool for the advertisement and promotion of goods and services, with the growing online market being one of the most emphasised in business practice.

9.2 When using social media, even if via personal or anonymous blogs, health care practitioners must comply with the HPCSA rules on advertising practice, (including not engaging in active or passive touting and canvassing or allowing others to do so on their behalf), and must make sure that they declaring their financial interests in hospitals (see Booklet 2 *Ethical and Professional Rules of the Health Professions Counc il of South Africa* and Booklet 11 *Guidelines on Overservicing, Pe rverse Incentives and Related Matters)*.

9.3 Touting involves drawing attention to one's professional goods or services by offering guarantees or benefits that fall outside one's scope of practice. An example is advertising free WiFi services to patients while waiting for their consultations.

9.4 Canvassing involves the promotion of one's professional goods and services by drawing attention to one's personal qualities, superior knowledge, quality of service, professional guarantees, or best practice. An example of canvassing is a health care practitioner declaring on social media or posting patient reviews that state he or she is 'the best health care practitioner in the country'.

9.5 Health practitioners may not advertise, endorse or encourage the use of any hospital, medicine or health-related product on social media in a manner that unfairly promotes the practice of a particular health practitioner or establishment for the purposes of financial gain or other valuable consideration.

9.6 A failure to follow these guidelines when using social media will undermine public trust in the health profession.

10 PRECAUTIONARY MEASURES WHEN USING SOCIAL MEDIA

11.1 Health practitioners must be aware that, even with a pseudonym, anonymity on social media platforms is never guaranteed. The identity and location of the user can be traced through their linked accounts or IP address.

11.2 If health practitioners use social media in their personal capacity, they are advised to adjust their privacy settings to restrict public access. However, even with advanced security measures and end-to-end encryption, complete privacy on social media cannot be guaranteed. There is always the risk that the content can be shared beyond the scope of the health practitioner's personal network.

11.3 Once content is shared online, it is difficult to remove, and health practitioners must use social media on the understanding that the information they post will remain on the internet permanently.

11.4 Even if a health practitioner deletes a post on a social media site, this does not necessarily mean the content has been removed. Content may be copied or reproduced by other users before it has been deleted, and many websites and internet browsers use cache and cookie systems that inconspicuously store data.

11.5 Health practitioners should avoid using social media when stressed, tired, upset or under the influence of alcohol.

11.6 Health practitioners are advised to err on the side of caution when using social media. If uncertain about whether it is ethically and legally permissible to share particular content via social media, it is best not to do so until advice has been obtained.

12 REFERENCES

12.1 American Medical Association Policy: Professionalism in the Use of Social Media (2012) https://mededu.jmir.org/article/downloadSuppFile/4886/28296.

12.2 British Medical Association: Social media, ethics and professional (2017) https://www.bma.org.uk/advice/employment/ethics/social-media-guidance-for-doctors.

12.3 General Medical Council: Doctors Use of Social Media (2013) https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/doctors-use-of-social-media.

12.4 South African Medical Association: Guidelines for doctors using social media (2015) https://www.samedical.org/files/Guideline%20for%20Drs%20Using%20Social%20Media%20febr015.pdf.

12.5 Grobler C, Dhai A. Social Media in the healthcare context: Ethical challenges and recommendations. *S Afr J BL* 2016; 9(1): 22-25.

12.6 National Department of Health. *National Policy Framework and Strategy on Palliative Care 2017-2022.*

ACTIVITY 2 - QUESTIONS

1. The term used to describe online tools and electronic platforms that people use to share content.
   a. social media
   b. socialising
   c. Twitter
   d. Google

2. Social media is beneficial to health practitioners. It allows them to
   a. build a professional support network.
   b. communicate and share health-related information.
   c. keep updated on the latest healthcare developments.
   d. a and b.
   e. all of the above.

3. Practitioners needs to keep patient information confidential,
   a. even after the death of the patient.
   b. until retiring, then give it to other practitioners.
   c. for 10 years after the patient left the practice.
   d. for 5 years after the death of the patient.

4. If a health practitioner receives an inappropriate message from a patient on social media, they should
   a. politely re-establish professional boundaries and explain their reasoning.
   b. not confront the patient and pretend nothing happened.
   c. make a harassment case, get a case number.
   d. block the patient on social media.
   e. b and d.

5. Health advice shared online
   a. must be scientifically sound and generic.
   b. must be evidence based.
   c. can be your own views.
   d. a and b.
   e. all of the above.

6. Healthcare practitioners should request patients to set up an appointment in-person, except
   a. if they are in a life-threatening situation.
   b. when there is an emergency.
   c. when they live far away.
   d. a and b.
   e. all of the above.

7. If an academic staff member or a practitioner involved in student training, receives a social media request from students, the purpose might be mentorship, research or career advice. Regardless of intent,
   a. you may accept the student’s request and communicate more socially.
   b. you may not accept the student’s request, social media is not the platform for training.
   c. the traditional boundaries of the trainee-teacher relationship apply when using this form of training.
   d. it does not matter; your own personal views will dictate what you do.

8. Touting involves drawing attention to one's professional goods or services by offering …………..that fall outside one's scope of practice.
   a. guarantees
   b. bribes
   c. benefits
   d. b and c
   e. a and c

9. Promoting your professional goods and services by drawing attention to your personal qualities, superior knowledge, quality of service, professional guarantees, or best practice is known as………
   a. canvassing
   b. decorating
   c. embellishing
   d. touting

10. When should health practitioners avoid using social media?
   a. when tired
   b. when upset
   c. when stressed
   d. when under the influence of alcohol
   e. all of the above

11. Health practitioners are advised to adjust their……..to………
   a. privacy settings; restrict public access
   b. privacy settings; facilitate public access
   c. profile; make it user friendly
   d. profile; make them look approachable

12. It is best to not share particular content via social media if you are uncertain about whether
   a. it is ethically and legally permissible to share
   b. viewers will like it or whether it will invite negative debate.
   c. it will benefit you or impact negatively on you.
   d. all of the above.

13. Health practitioners must obtain …………before publishing information (e.g. case histories and photographs) about them in media to which the public has access, whether or not the healthcare practitioner believes the patient can be identified by the data.
   a. oral consent of the patient
   b. written consent of the patient
   c. a sworn statement of approval from the patient
   d. a sworn statement of approval from the patient or descendants (if the patient has passed away)

14. Health practitioners who share information about a patient for the sake of diagnosis, treatment or education and training through social media must ensure that the information is
   a. only accessible by the persons that it is intent to reach.
   b. password protected
   c. not able to identify the patient from the data disclosed.
   d. a and b.

15. If the healthcare practitioner uses social media in their personal capacity,
   a. the profession cannot prescribe to the person what should be on the social media.
   b. their online activity may nevertheless bring the profession into disrepute.
   c. should be scrutinised by a supervisor.
   d. it is personal, and will only be seen by some other persons and therefore their profession is not relevant.

HOW TO EARN YOUR CEUs

1. Complete your personal details below.
2. 2. Read the booklet: **Health Professions Council of South Africa, Developed by the human rights, ethics and professional practice committee Pretoria, 2019.Ethical Guidelines on Social Media. HPCSA booklet 16;** and answer the questions.
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PLEASE ANSWER ALL THE QUESTIONS AND MARK THE APPROPRIATE BLOCK WITH AN “X “

1. A ☐ B ☐ C ☐ D ☐
2. A ☐ B ☐ C ☐ D ☐ E ☐
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14. A ☐ B ☐ C ☐ D ☐
15. A ☐ B ☐ C ☐ D ☐

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