**Appendices**

Appendix A. SEBA Methodology

**Theoretical lens**

Krishna's Systematic Evidence-Based Approach (SEBA) is adopted to guide this systematic scoping review (SSR) (henceforth SSR in SEBA) (1-8). SEBA is composed of six stages- 1) Systematic Approach, 2) Split Approach, 3) Jigsaw Perspective, 4) Funnelling Process 5) Analysis of data and non-data driven literature, and 6) Discussion Synthesis (Figure 1). SEBA systematically map available data, structure the extraction of key characteristics of CEP education and its effects, synthesise and summarise actionable and applicable information across a diverse range of study formats and identify gaps in knowledge in current concepts. SEBA's constructivist approach (8-13) and relativist lens (14-17) acknowledges development of CEP competencies are individualised sociocultural constructs informed by the user's narratives, clinical competencies, contextual and environmental considerations.

**Expert advice**

An expert team consisting of a medical librarian from the Yong Loo Lin School of Medicine (YLLSoM) at the National University of Singapore (NUS), and local educational experts and clinicians at the National Cancer Centre Singapore (NCCS), the Palliative Care Unit, and the Institute of Population Health at the University of Liverpool, YLLSoM and Duke-NUS Medical School, ensured that the SEBA methodology was employed in a consistent manner within accepted practices.

**Reflexivity**

Personal reflexivity

Recognising that the research team are informed by their interests, narratives, clinical and research insights and contextual considerations, membership to the research and expert teams were made up of experienced physician-tutors, psychologists, methodologists, and educational scholars. Six members of these teams hold masters degrees in medical education, two hold masters degrees in ethics, two hold masters degrees in clinical research and two hold masters degrees in public health. Most of the expert and research team were experienced in quantitative research however five members of the team are experienced in qualitative methods. Six of the research and expert teams have published articles in peer-reviewed journals using the SEBA methodology. One member of the expert team is an experienced researcher at the Palliative Care Institute Liverpool and another is a member of the Health Data Science Department at the University of Liverpool. Both researchers from the University of Liverpool have

been collaborating with the research team on a number of studies pertaining to portfolio use, death and dying, moral distress, PIF and mentoring and are part of the team expanding the use of the SEBA methodology in medical education and palliative care.

Three senior members of the team are working on various projects on medical education and three others have already published articles in peer-reviewed journals in medical education. Six members of the research team were members of the PMI and have published SEBA guided reviews on mentoring, dignity and medical education. To ensure input from all members of the team, synchronous and asynchronous in-person and online meetings and Sandelowski and Barroso (18)'s approach to 'negotiated consensual validation' was used to reach consensus on the issues discussed.

Methodological reflexivity

Adopting a structured constructivist approach, we sought to build a holistic concept of current models of portfolios within medical education acknowledging however that we were limited by manpower and time constraints. We included articles featured in grey and bibliographic databases within the dates set in our selection criteria. Much of these theories required deeper consideration and discussions and we documented our discussions and decisions.

Iterative process

To ensure transparency and accountability, the expert team was involved in all stages of SEBA as part of the iterative process.

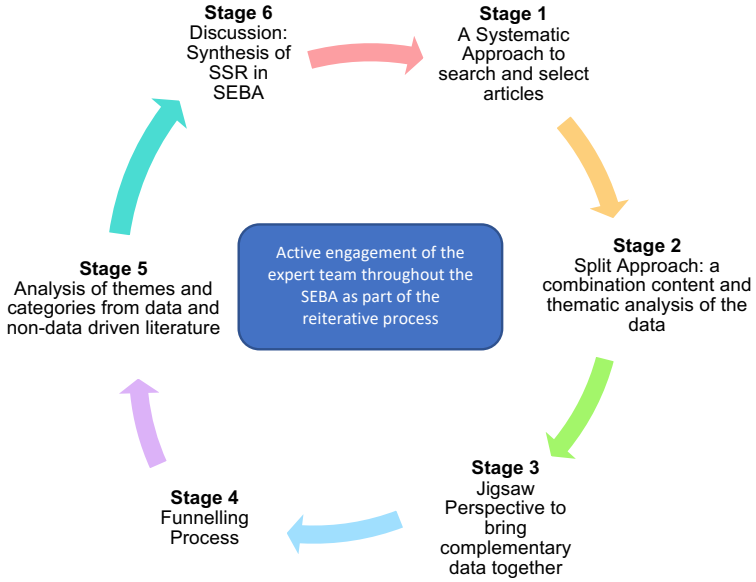


*Figure 1. The SEBA Process*

**Stage 1 of SEBA: Systematic Approach**

The SEBA methodology begins with the research and expert teams agreeing upon the research questions, the search terms and the databases to be scrutinised. In this case the research and expert team determined the primary research question: "*What is known about CEP portfolios?"*. The secondary research questions were "*what role do CEP portfolios have in teaching and assessing CEP development?"*.

**Inclusion criteria**

A PICOs (Population, Intervention, Comparison, Outcome, Study design) format was adopted to guide the research process (Table 1). There was no comparison group.

Table 1. *PICOS Inclusion and Exclusion Criteria*

| PICOS | Inclusion criteria | Exclusion criteria |
|---|---|---|
| **Population** | • Undergraduate and postgraduate medical students<br>• Qualified medical doctors, physician or resident; medical officer, registrar, house officer, attending, consultant | • Allied health specialties such as Pharmacy, Dietetics, Chiropractic, Midwifery, Podiatry, Speech Therapy, Occupational and Physiotherapy<br>• Non-medical specialties such as Clinical and Translational Science, Alternative and Traditional Medicine, Veterinary, Dentistry |
| **Intervention** | • portfolios in undergraduate and postgraduate medical education for teaching and assessment of Communication, Ethics and Professionalism<br><br>Criteria of a portfolio: | Other documentation methods or learning tools that are:<br>• Not longitudinal or single timepoint<br>• Does not include personal intellectual engagement with the content and associated learning (for instance, curriculum vitae, logbooks |

| PICOS | Inclusion criteria | Exclusion criteria |
|---|---|---|
| | • longitudinal (more than a single timepoint) assessment data<br>• candidate's personal engagement with portfolio content and associated learning<br>• Interventions meeting the above criteria were included regardless of whether they were referred to as portfolios<br><br>All types of portfolios were included in the study:<br>• For instance: electronic & non-electronic; formative & summative or combined; clinical & non-clinical<br>• Portfolios with input from students and/or residents and/or doctors, and/or input from faculty members and other individuals<br>• Portfolios with different structures: extent by which the structure has been prescribed and/or left to individual discretion | and the use of personal digital assistants) |
| **Comparison/ Context** | NA | NA |
| **Outcome** | Papers that measured the following outcomes were included:<br>• Effectiveness of the use of portfolios to assess and teach Communication, Ethics and Professionalism<br>• Impact of the use of portfolios on medical students (both undergraduate and postgraduate)<br>• Impact of the use of portfolios on the faculty | NA |
| **Study design** | • Articles in English or translated to English<br>• Articles published from 1st January 2000 to 31st December 2020<br>• Databases: PsycINFO, EMBASE, PubMed, ERIC, Scopus, Google Scholar<br>• All study designs including:<br>• Mixed methods research, meta-analyses, systematic reviews, randomised controlled trials, cohort studies, case-control studies, cross-sectional studies, descriptive papers, grey literature, opinions, letters, commentaries and editorials | NA |

Three members of the research team carried out independent ancestry searches of seven leading journals in medical education (Academic Medicine, Medical Education, Medical Teacher, Advances Health Sciences Education, BMC Medical Education, Teaching and Learning in Medicine and Perspectives on Medical Education) accessed through the NUS library portal. In keeping with Pham, Rajic (19)'s recommendations, the searches were restricted to articles published between 1st January 2000 and 31st December 2020 to accommodate to existing manpower and time constraints. Quantitative, mixed and qualitative research methodologies meeting the inclusion criteria were included.

Table 2. *Search Strategy for PubMed, Embase, PsycINFO, ERIC, Scopus, and Google Scholar databases.*

| | | **Mesh Terms** | **tiab** |
|---|---|---|---|
| | | (1 OR 2 OR 3) AND 4 | |
| **Population** | Medical Students OR Doctors | [1] "Physicians"[MeSH] OR "Students, Medical"[MeSH] OR "Clinical Clerkship"[MeSH] OR "Medicine"[Mesh] OR "Education, Medical"[Mesh] OR "Clinical Competence"[Mesh] | [2] Physician[tiab] OR Physicians[tiab] OR resident[tiab] OR residents[tiab] OR residency[tiab] OR residencies[tiab] OR practice[tiab] OR practitioner[tiab] OR practitioners[tiab] OR doctor[tiab] OR doctors[tiab] OR houseman[tiab] OR housemanship[tiab] OR housemen[tiab] OR medical[tiab] OR clinical[tiab] OR pre-clinical[tiab] OR preclinical[tiab] OR clinician*[tiab] OR surgery[tiab] OR surgical[tiab] OR surgeon*[tiab] OR clerkship*[tiab] OR specialist*[tiab] |
| | | | [3] ("Educational Measurement/methods"[Mesh] OR "Educational Measurement/standards"[Mesh] OR "Documentation/methods"[Mesh] OR "Benchmarking*"[MeSH] OR "Competency-based education/standards*"[MeSH] OR "Records*"[MeSH]) AND (medical[tiab] OR clinical[tiab] OR pre-clinical[tiab] OR preclinical[tiab] OR clinician*[tiab] OR surgery[tiab] OR surgical[tiab] OR surgeon*[tiab] OR clerkship*[tiab] OR specialist*[tiab]) |
| **Intervention** | Portfolios | | [4] Portfolio[tiab] OR portfolios[tiab] OR e-portfolio[tiab] OR e-portfolios[tiab] OR "curriculum vitae"[tiab] OR "personal statement"[tiab] OR "personal statements"[tiab] |

Members of the research team carried out independent searches of databases. To facilitate this approach, the search process saw experienced senior researchers well-versed in carrying out systematic reviews and systematic scoping reviews each meet with a team of two to three medical students to guide them database searches. This approach was to enhance training of new researchers and to ensure that at least two teams were independently reviewing each database. Each team met regularly and discussed their findings. After a search of the first 100 articles in a particular database, the medical students and the senior researcher compared their findings at an online meeting.

Subsequently, the teams met at specific time points, often after reviewing a predetermined number of included articles to discuss their concerns, exchange opinions and advance their understanding of the research process and the area of study. Sandelowski and Barroso (18)'s 'negotiated consensual validation' was used to achieve consensus on the final list of titles to be reviewed. The teams repeated this process, independently studying all the

full text articles on the final list of titles, creating their own lists of articles to be included and discussing their findings at weekly online research meetings over the first 4 months of the project. Consensus on the final list of articles to be analysed was achieved following at least three online meetings when discrepancies were reviewed and discussed by each member of the research team.

As this was a training process for many of the participants who were medical students participating in the Palliative Medicine Initiative, senior mentors and peer-mentors were frequently involved in guiding and discussing individual findings over and above the online meetings especially at the start of each stage of the research process. Interrater reliability was not evaluated.

**Stage 2 of SEBA: Split Approach**

Krishna's 'Split Approach' (18-23) was employed to enhance the reliability of the data analyses. This saw three groups of researchers independently analysing the included articles.

The first team summarised and tabulated the included full-text articles in keeping with recommendations drawn from Wong, Greenhalgh (24)'s RAMESES publication standards: meta-narrative reviews and Popay, Roberts (25)'s "Guidance on the conduct of narrative synthesis in systematic reviews". The tabulated summaries served to ensure that key aspects of included articles were not lost.

Concurrently, the second team analysed the included articles using Braun and Clarke (26)'s approach to thematic analysis. In Phase 1, the research team carried out independent reviews, 'actively' reading the included articles to find meaning and patterns in the data. In Phase 2, 'codes' were constructed from the 'surface' meaning and collated into a code book to code and analyse the rest of the articles using an iterative step-by-step process. As new codes emerged, these were associated with previous codes and concepts. In Phase 3, the categories were organised into themes that best depict the data. An inductive approach allowed themes to be "defined from the raw data without any predetermined classification" (27). In Phase 4, the themes were refined to best represent the whole data set and discussed. In Phase 5, the research team discussed the results of their independent analysis online and at reviewer meetings. 'Negotiated consensual validation' was used to determine a final list of themes approach and ensure the final themes.

A third team of researchers employed Hsieh and Shannon (28)'s approach to directed content analysis to analyse the included articles. Analysis using the directed content analysis approach involved "identifying and operationalizing a priori coding categories". The categories employed in the content analysis for undergraduate communications were Rider et al. (29) 's *"A model for communication skills assessment across the undergraduate curriculum",* Goldie (30)'s *"Review of ethics curricula in undergraduate medical education"*, Duffy et al. (31)'s *"Assessing Competence in Communication and Interpersonal Skills: The Kalamazoo II Report"* and Hong et al. (32)'s *"Postgraduate Ethics Training Programs: A Systematic Scoping Review"*. Tay et al. (33)'s *"Assessing Professionalism in Medicine - A Scoping Review of Assessment Tools from 1990 to 2018"* was employed for codes for professionalism and David (34)'s article *"AMEE Medical Education Guide No. 24: Portfolios as a method of student assessment"* was then used to contextualise their use in portfolios. Any data not captured by these codes were assigned a new code.

By using directed content analysis, this "Split Approach" sought to address shortcomings int thematic analysis. This was done by ironing out disparities in data and increases the validity of the identified themes (35). It also limits inherent biases and condenses the interpretations of terminology used by each team's members. Consistency with existing literature is further offered by directed content analysis, by using existing data to identify codes and categories. The codes were used systematically and objectively, strengthening the validity and reliability of a positivist approach (35, 36). The transparency of this approach is enforced by clearly defined categories, together with references throughout the analytical process.

**Stage 3 of SEBA: Jigsaw Perspective**

The themes and categories identified in the Split Approach were viewed as pieces of a jigsaw puzzle where overlapping/complementary pieces were combined to create a bigger piece of the puzzle referred to as themes/categories. This process was guided by Phases 4 to 6 of France, Uny (37)'s adaptation of Noblit, Hare (38)'s seven phases of meta-ethnography. As per Phase 4, the themes and the categories identified in the Split Approach are grouped together according to their focus. These groupings of categories and themes were then contextualised through the review of the articles from which they were drawn from. Reciprocal translation was used to determine if the themes and categories could be used interchangeably. This allowed the themes and categories to be combined to form themes/categories.

France, Uny's adaptation:
Phase 1: Getting started, deciding on the focus of the synthesis.
Phase 2: Deciding what is relevant to the initial interest.
Phase 3: Reading the Studies.
Phase 4: Determining how the studies are related.
Phase 5: Translating the studies into one another.
Phase 6: Synthesising the translations.
Phase 7: Expressing the synthesis.

Codes derived from thematic analysis (TA): indications, characteristics and strengths and limitations

Codes derived from directed content analysis (DCA): indication for portfolio, portfolio content, portfolio design and strengths and limitations

Overlaps between indications and strengths and limitations allowed the combination of these categories and themes creating two themes/categories called indications and strengths and limitations. Careful review of the categories- portfolio content and portfolio design were subsets of the theme characteristics. For a more accurate presentation, the overlaps were conflated and presented together with the TA codes indicated under the DCA code. (Refer to Domain 4 table)

| **Themes Identified** | **Categories Identified** | **Domains Created** |
|---|---|---|

| | | |
|---|---|---|
| Indications | indications | Indications |
| characteristics | content | Characteristics |
| | Portfolio design | |
| Strengths and limitations | Strengths and limitations | Dignity-conserving Measures |

**Stage 4 of SEBA: Funnelling Process**

The Funnelling Process employs Phases 3 to 5 of France, Uny's adaptation to juxtapose the themes/categories with key messages identified in the tabulated summaries to create domains. These domains form the basis for 'the line of argument' in Stage 6 of SEBA.

**Domain 2. Relationship between Dignity, WTHD and Assisted Dying**

| Subdomains | Codes |
|---|---|
| **Increasing WTHD** | ▪ Loss of dignity (39-81)<br>▪ Fear of loss of dignity (42, 44, 52, 59, 82, 83)<br>▪ Loss of autonomy (39, 40, 42, 45, 47, 50-53, 55, 59, 62, 65, 69, 70, 73, 74, 77, 79, 81, 82, 84-88)<br>▪ Fear of loss of autonomy (42, 54, 70, 89) |
| **Decreasing WTHD/protective factors** | ▪ Addressing of dignity related issues improves health-related quality of life (46)<br>▪ Improving dignity reduces desire for euthanasia (50) |
| **Effect of assisted dying on dignity** | ▪ Reclamation/preservation of dignity (45, 49, 58, 90-95)<br>▪ Lack of assisted dying interferes with dignity (50, 76, 96)<br>▪ Reclamation/preservation of autonomy (43, 45, 49, 51, 52, 67, 73, 74, 77, 85, 88, 92, 94, 97-100)<br>▪ Lack of assisted dying interferes with autonomy (49, 96)<br>▪ Violation of autonomy (100) |

**Domain 3. Stakeholder Perspectives on Dignity**

| Subdomains | Codes | |
|---|---|---|
| **Patient Perspectives** | **Positive Aspects**<br>▪ Respect for humanity (67)<br>▪ Right to die (99)<br>▪ Unaffected by fear of death (48)<br>▪ Good death (67, 73, 99, 101-103)<br>- Maintaining control of their death (67, 73, 99, 101-103)<br>- Ending suffering (67, 73)<br>▪ Perceived futility (73, 74)<br>▪ General support (73, 98)<br>▪ Wanting the option for themselves (98) | **Negative Aspects**<br>▪ Religious concerns (67, 73, 102)<br>▪ Ethical concerns (62, 67, 73)<br>- Inability to ascertain patient consent (62, 67)<br>- Equating to murder/suicide (67)<br>▪ Change in ideologies (50)<br>▪ Deterioration of patient-doctor relationship (58, 62, 74, 101)<br>- Loss of faith in palliative/hospice care (62, 101)<br>- Feeling of abandonment when WTHD is turned down (74)<br>- Poor communications (58)<br>▪ Against legislation (73) |
| **Healthcare Provider Perspectives** | **Positive Aspects**<br>▪ Good death for patients (42, 47, 49, 50, 54, 56, 57, 61, 69, 70, 82, 87, 101, 103)<br>- Fulfilling patients' desire for control (47, 50, 56, 61, 82, 87, 101, 104)<br>- Ending suffering (42, 54, 57, 61, 69, 70, 103)<br>- Not requiring a long life (49)<br>▪ Feeling helpless (68)<br>▪ Non-abandonment of patients (90)<br>▪ Reducing patients' family burden (90)<br>▪ Avoiding unlawful hastening death (50)<br>▪ General support (40, 47, 62, 68-70, 75, 82, 90, 101, 103-105)<br>▪ Disregarding the need for alternatives (i.e. palliative care) (50) | **Negative Aspects**<br>▪ Religious concerns (106)<br>▪ Disrespecting patients' autonomy by not entertaining their wishes (104, 107)<br>▪ Emotional/moral distress (49, 50, 69, 91, 101, 108-113)<br>- Guilt (91, 112)<br>- Opposing medical principles (49, 69, 101, 108, 110, 111)<br>- Grief, avoidance after carrying out WTHD (113)<br>- Turning doctors into killers (111)<br>▪ No right to die (90)<br>▪ Unable to ascertain if patient's disease is incurable (109)<br>▪ Change in perceptions after disease (82)<br>▪ WTHD should not involve family members (113)<br>▪ "Slippery slope" (110)<br>▪ Societal pressure (55, 74)<br>▪ Disapproval of WTHD (62, 69, 75, 82, 101, 107, 113-115)<br>- Disagreement with the law (115)<br>- Reluctance to carry out WTHD (75, 101)<br>▪ Proposing alternatives (57, 62, 63, 90, 105, 111)<br>- Improving quality of life of dying patients (62, 111)<br>- Better palliative care (63, 90, 105)<br>- Healing (57)<br>▪ Death as an unknown (57) |

| | | |
|---|---|---|
| | | ▪ Disapproval of 'tired of living' as a reason for WTHD (57) |
| **Lawmaker Perspectives** | ▪ Belief in a right to die (76)<br>▪ Avoiding unlawful hastening death (96)<br>▪ Government's duty to consider patients' WTHD (74)<br>▪ Approval of WTHD (76, 100) | ▪ "Slippery slope" (98, 114)<br>- Risk of abuse (114)<br>▪ Instigating social pressure (on the elderly) (74)<br>▪ Disapproval of WTHD (74, 83, 106, 114) |

**Domain 4. Dignity Conserving Measures**

| Subdomains | Codes |
|---|---|
| **Advantages to Dignity Conserving Measures** | ▪ Palliative services<br>- Palliative care (40, 44, 47, 49, 50, 62, 63, 66, 73, 82, 90, 91, 103, 111, 116-118)<br>- Palliative sedation (47, 49, 91, 119)<br>- Palliative starvation (85, 109)<br>▪ Pain and symptom management<br>- Control of physical pain (58, 66, 75, 104, 107, 108, 119)<br>- Control of psychological symptoms (75, 102, 120)<br>▪ Hospice care (46, 47, 75, 100, 106, 107, 117)<br>▪ Holistic approach (43, 57, 105, 111, 112, 117, 121, 122)<br>▪ Ease of access to information (47, 57, 71, 87, 92, 100, 112, 117)<br>▪ Distributive justice (55)<br>▪ Social support<br>- Religious (75)<br>- Familial (45)<br>- Healthcare providers (47, 57, 58, 71, 87, 112) |
| **Limitations to Dignity Conserving Measures** | ▪ Cannot completely address:<br>- Existential suffering (54)<br>- Pain (50)<br>- Complete loss of mobility (103)<br>- Extreme shortness of breath (103)<br>- Fear of sudden and rapid bleeding (103)<br>- Ongoing stress of losing autonomy and dignity (103)<br>▪ Side effects of pain medication (58) |

**Stage 5 of SEBA: Analysis of data and non-data driven literature**

A novel aspect of the SEBA methodology has been its inclusion of position, perspective, conference, reflective and opinion papers, editorials, commentaries, letters, posters, oral presentations, forum discussions, interviews, blogs, governmental reports, policy statements and surveys from PubMed, Embase, PsycINFO, Cochrane Database of Systematic Reviews, CINAHL, Scopus databases and the Journal of Pain and Symptom Management, BMC Palliative Medicine, Death Studies, and Palliative Medicine. With many current survey and assessment tools not able to capture the intricate connections and personalised nature of wider concepts of dignity, assisted dying, WTHD, personhood and identity, these resources are a rich source of information. These resources also capture wider patient, HCP and lawmaker perspectives and offer information on ethical, existential, and societal considerations often excluded by traditional systematic reviews as evidenced by recent reviews into how physicians and patients deal with death and dying and moral distress (123-130)

The use of non-data driven articles such as position, perspective, conference, reflective and opinion papers, editorials, commentaries, letters, posters, oral presentations, forum discussions, interviews, blogs, governmental reports, policy statements and surveys is consistent with a constructivist approach that includes all forms of data. In addition, use of non-data driven articles is a valuable source of information for subject matter such as concepts of dignity which are notoriously difficult to study and open to sociocultural considerations.

However, with some of these sources neither peer-reviewed nor necessarily evidence-based, they were differentiated from primary research, compiled and thematically analysed. The themes identified from primary data sources and non-evidence based and/or tertiary data sources were then compared to enhance further the accountability and reproducibility.

With the themes from the two groups found to be similar, the expert and research teams were satisfied that their inclusion did not bias the overall data.

**Stage 6 of SEBA: Synthesis of the Discussion**

The Best Evidence Medical Education (BEME) Collaboration Guide (131) and the Structured approach to the Reporting In healthcare education of Evidence Synthesis (STORIES) (132) were used to guide the discussion.

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