STROBE Statement—checklist of items that should be included in reports of observational studies

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|  | Item No. | Recommendation | Page No. | Relevant text from manuscript |
| **Title and abstract** | 1 | (*a*) Indicate the study’s design with a commonly used term in the title or the abstract |  1 |  The erosion of ambiguity tolerance and sustainment of perfectionism in undergraduate Medical training: Results from multiple samplings of a single cohort. |
| (*b*) Provide in the abstract an informative and balanced summary of what was done and what was found |  2-3 | This was a multiple sampling of a single cohort at the start and end of clerkship. Sampling was accomplished through an anonymous online survey which used validated scales of tolerance of ambiguity (TOA) and perfectionism. We found that TOA decreased while perfectionism remained stable.  |
| Introduction |  |
| Background/rationale | 2 | Explain the scientific background and rationale for the investigation being reported |  3 | We are not aware of any studies investing how perfectionism changes with clinical training and experience and its relationship with TOA. Given that clerkship is the first time medical students are exposed to a clinical setting in a full time setting we sought to study medical students in this phase of their training.  |
| Objectives | 3 | State specific objectives, including any prespecified hypotheses |  3-5 | This study was guided by three research questions: 1) To what extent does relationship exist between TOA and perfectionism for medical students in their first year of clerkship? 2)How does clerkship modify these factors and/or their relationship? 3) Do these factors relate to a student’s specialty choice?  |
| Methods |  |
| Study design | 4 | Present key elements of study design early in the paper | 5 | Medical students at the start and end of their clerkship year were sampled through an anonymous survey assessing TOA and perfectionism.  |
| Setting | 5 | Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection |  5 | All medical students in their clerkship year at our local institution from August 27th, 2018 to August 9th, 2019 were invited to participate in an anonymous survey assessing tolerance of ambiguity and perfectionism. |
| Participants | 6 | *Cohort study*—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up | 5 | The survey was distributed to eligible applicants through the school’s undergraduate medical education (UME) office with responses being anonymous to comply with UME policies. This was a repeated single cohort pre and post-study. The survey was distributed at 2 times points: the start of the first rotation (pre-clerkship) and again at the start of the last rotation (post-clerkship). At each distribution, students who had not completed the survey received a 2-week reminder. |
| Variables | 7 | Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable | 5 | This has been explained in variable point 6 above. |
| Data sources/ measurement | 8\* | For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group | 6 | 2 validated scales were used. Tolerance of Ambiguity in Medical Students and Doctors (TAMSAD) and The Big Three perfectionism scale-short form (BTPS-SF) |
| Bias | 9 | Describe any efforts to address potential sources of bias |  5 | This was an anonymous survey |
| Study size | 10 | Explain how the study size was arrived at |  5  | The entire cohort was studied |

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| Quantitative variables | 11 | Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why |  5-6  | Gender, age, and items from TAMSAD and BTPS-SF were analysedThe relationship between TOA and perfectionism with specialty choice was assessed by grouping the top 3 specialties. This was done because of the lower than anticipated response rate, but also because family medicine, internal, and emergency medicine can be classified as primary care specialties. Family medicine, internal, and emergency were grouped and then compared to other remaining specialties. |
| Statistical methods | 12 | (*a*) Describe all statistical methods, including those used to control for confounding |  6 | The data was analysed using t-tests of the two time points |
| (*b*) Describe any methods used to examine subgroups and interactions | na |  |
| (*c*) Explain how missing data were addressed | na | Participants were required to complete all questions in the survey |
| (*d*) *Cohort study*—If applicable, explain how loss to follow-up was addressed | na | Data was not matched |
| (*e*) Describe any sensitivity analyses | na |  |
| Results |
| Participants | 13\* | (a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed | 6-7 | 51in the pre clerkship study and 62 in the post. 174 eligible students |
| (b) Give reasons for non-participation at each stage | 5 | This study was optional. Students were invited to participate, but were not obligated |
| (c) Consider use of a flow diagram | na |  |
| Descriptive data | 14\* | (a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders | 6-7 |  |
| (b) Indicate number of participants with missing data for each variable of interest | n/a |  |
| (c) *Cohort study*—Summarise follow-up time (eg, average and total amount) | n/a | There was a fixed time point. Study terminated august 9th 2019.  |
| Outcome data | 15\* | *Cohort study*—Report numbers of outcome events or summary measures over time | *6-8* | The outcome studied was the level of TOA and perfectionism in students before and after clerkship.  |
| Main results | 16 | (*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included | 15-17 | Tables 2-5 |
| (*b*) Report category boundaries when continuous variables were categorized | na | These were discreet variables |
| (*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period | na | This was not relevant.  |

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| Other analyses | 17 | Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses |  na |  |
| Discussion |
| Key results | 18 | Summarise key results with reference to study objectives |  8 | clinical exposure showed a decrease in the tolerance of ambiguity (TOA) while perfectionism was relatively stable |
| Limitations | 19 | Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias |  9 | We have a limitation section |
| Interpretation | 20 | Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence |  10 | We discuss the limitation in the interpretation of the data |
| Generalisability | 21 | Discuss the generalisability (external validity) of the study results |  9 | We discuss the generalizability of our data in the context of the anxiety cycle |
| Other information |   |
| Funding | 22 | Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based | 12 | We have declared our funding here. |

\*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

**Note:** An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.