Professional Responsibilities in Medical Education: General Consultation Survey Report

Introduction

The College of Physicians and Surgeons of Ontario (CPSO) is currently reviewing its *Professional Responsibilities in Undergraduate Medical Education* and *Professional Responsibilities in Postgraduate Medical Education* policies. These policies have been combined into a new draft *Professional Responsibilities in Medical Education* policy and a new companion *Advice to the Profession: Professional Responsibilities in Medical Education* document has been developed.

As part of this review process, an external consultation was undertaken from September to November 2020. Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including all Ontario physicians. In addition, a general invitation to provide feedback was posted on CPSO's website and social media platforms.

Feedback was collected via email, an online discussion forum, and an online survey.

This report summarizes only the stakeholder feedback that was received through the online survey.

Caveats

Participation in this survey was voluntary. As such, no attempt has been made to ensure that the sample of participants is representative of any sub-population.

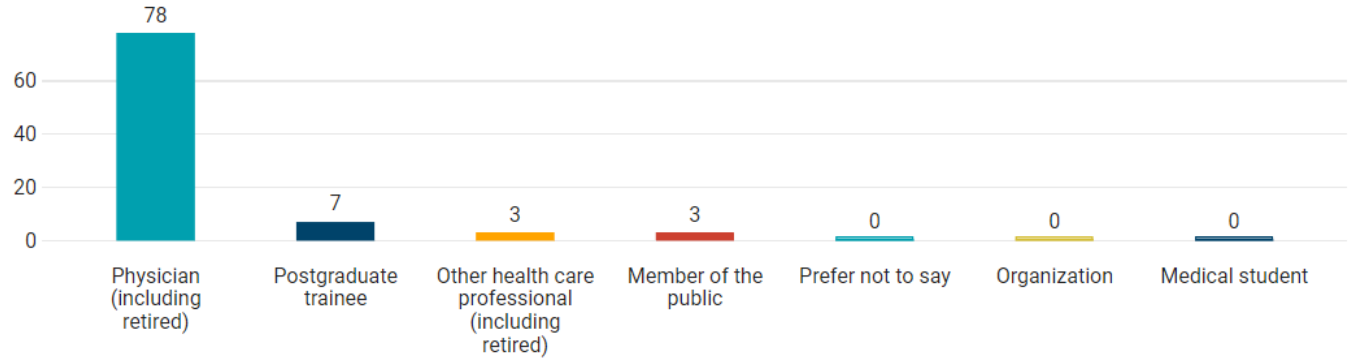
In the interest of space, stakeholder feedback to open-ended questions has been summarized to capture key themes and ideas.

Who we heard from

A total of 91 surveys were received in response to this consultation.

The vast majority of respondents were from Ontario (98%) and were physicians (94%).

Respondent Demographics:

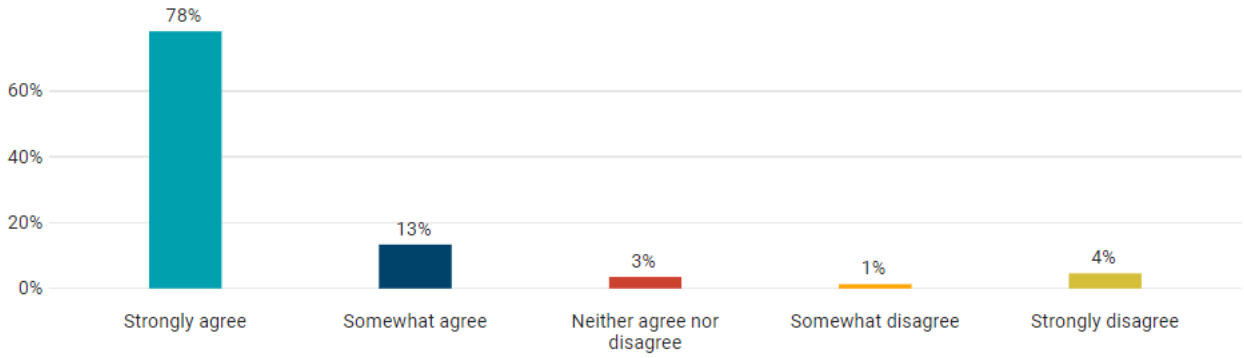


The following questions were posed to all survey respondents:

Q1. The draft policy sets out new expectations with respect to availability of Most Responsible Physicians (MRP)/Supervisors.

MRPs/supervisors must ensure that they are identified and available to assist medical students and/or trainees when they are not directly supervising them (i.e., in the same room) or if unavailable they must ensure that there is an alternative supervisor available to provide supervision.

Please indicate the extent to which you agree or disagree that this is a reasonable expectation: (n=91)



Q2. Please feel free to elaborate on your answer to the question above. (Optional) (n=12)

The majority of respondents agreed (either strongly or somewhat) that this expectation was reasonable.

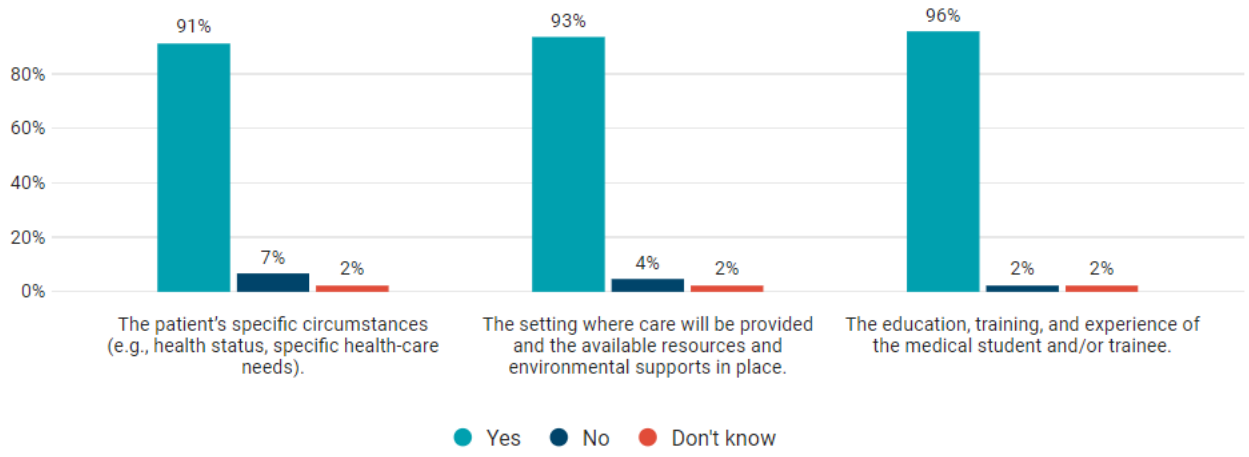
- Notwithstanding this, some physician respondents believed the draft expectations around availability and supervision would require constant on-site supervision from MRPs/supervisors.

Additional comments provided by physician respondents included:

- It should be explicit that MRP "backup" can be from home. There are some specialties (e.g., diagnostic imaging) where complete virtual supervision of the trainee is appropriate;
- Telephone and zoom teleconferences with MRPs are not sufficient. In addition, residents may be "afraid" to disturb the staff physician or to appear insecure which may lead to patient harm as signs and symptoms not be adequately presented to the supervising physician; and
- Further define "supervisor" to apply to inter-professional practice settings.

Q3. The draft policy states that the degree of availability and means of availability (by phone, pager, or in-person) is dependent on a number of factors.

Please indicate whether you agree or disagree with each of the following factors: (n=91)



Q4. Please feel free to elaborate on your answer to the question above. In particular, are there any factors not listed that should be captured in the policy? (Optional) (n=10)

The majority of respondents agreed with the factors listed in the draft policy.

Physician respondents suggested the following additional factors to consider:

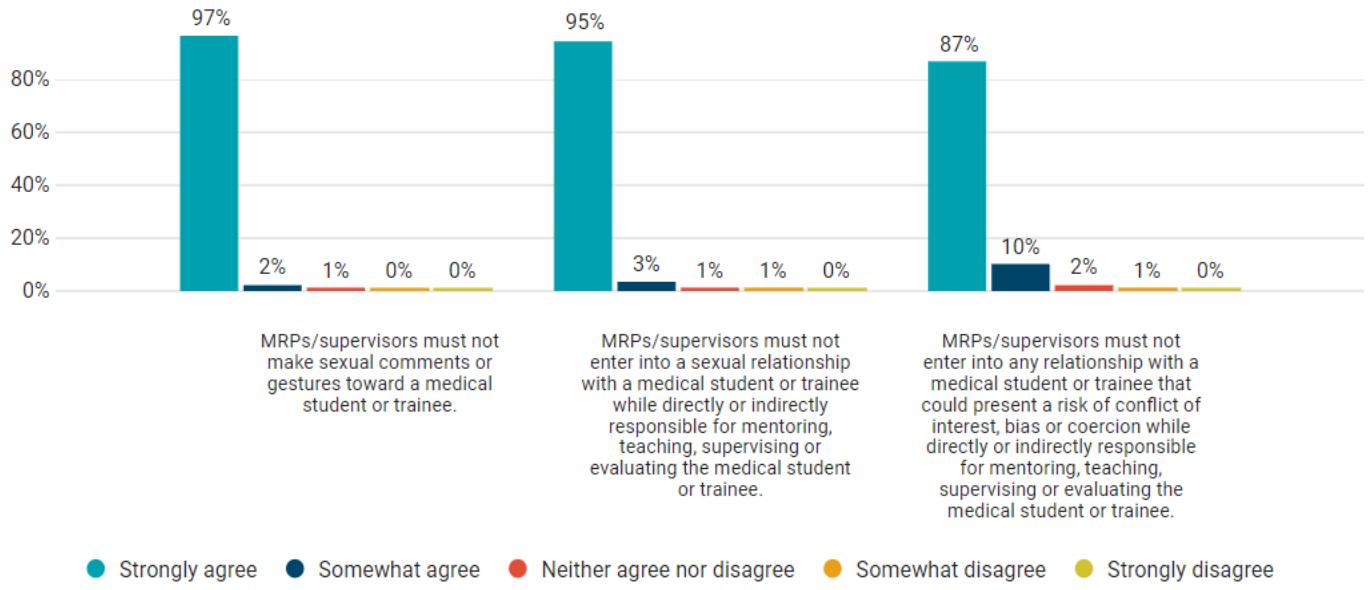
- Differences in specialties; and
- Inter-professional practice considerations.

Additional feedback from respondents included:

- One postgraduate trainee indicated that supervisors should always be easily and quickly accessible when medical students/trainees are providing care regardless of the patient's status and setting.
- One physician felt in-person supervision is needed in some situations and staff physicians should make it clear that they are available as residents may be afraid to "bother" the staff physician or do not want to appear unknowledgeable or not confident of handling the situation themselves.

Q5. The draft policy sets out expectations relating to professional relationships and boundaries between most responsible physicians (MRPs)/supervisors and medical students/trainees.

Please indicate the extent to which you agree or disagree that each of the following expectations are reasonable: (n=91)



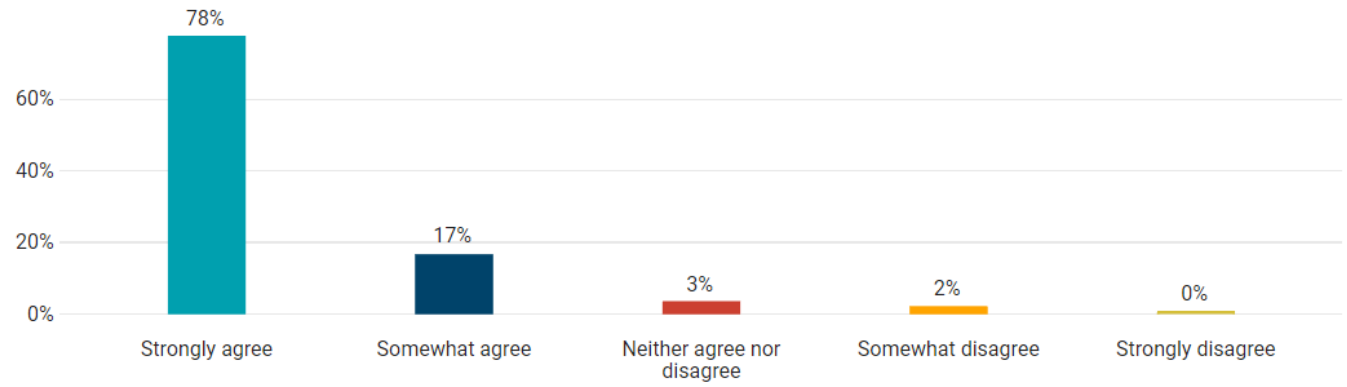
Q6. Please feel free to elaborate on your answer to the question above. (Optional) (n=19)

The vast majority of respondents strongly agreed that the draft expectations relating to professional relationships and boundaries between MRPs/supervisors and medical students/trainees were reasonable.

- One member of the public commented that they "want to feel confident that there are no issues clouding the relationship between the learner and the MRP that may possibly have an impact, however small, on my healthcare."
- A few physician respondents felt the use of "indirect" is overly broad (i.e., being part of a teaching faculty could be interpreted as being "indirectly responsible" for a medical student or trainee).
- One physician suggested referencing the professionalism expectations of the trainee's university.
- One postgraduate trainee indicated the draft expectation related to sexual comments and gestures (*lines 151—152*) does not apply to those who are already in a non-work-related relationship.
- One physician respondent questioned how this expectation could be enforced in practice.

Q7. If an MRP or supervisor (including a trainee who is a supervisor) has an existing relationship (sexual or other e.g., family, dating, business, etc.) with a medical student or trainee which pre-dates the mentoring, teaching, supervising or evaluating role of the MRP, the draft policy states that the relationship must be disclosed to appropriate member of faculty in order for the faculty member to determine whether alternative arrangements are warranted.

Please indicate the extent to which you agree or disagree that this is a reasonable expectation: (n=90)



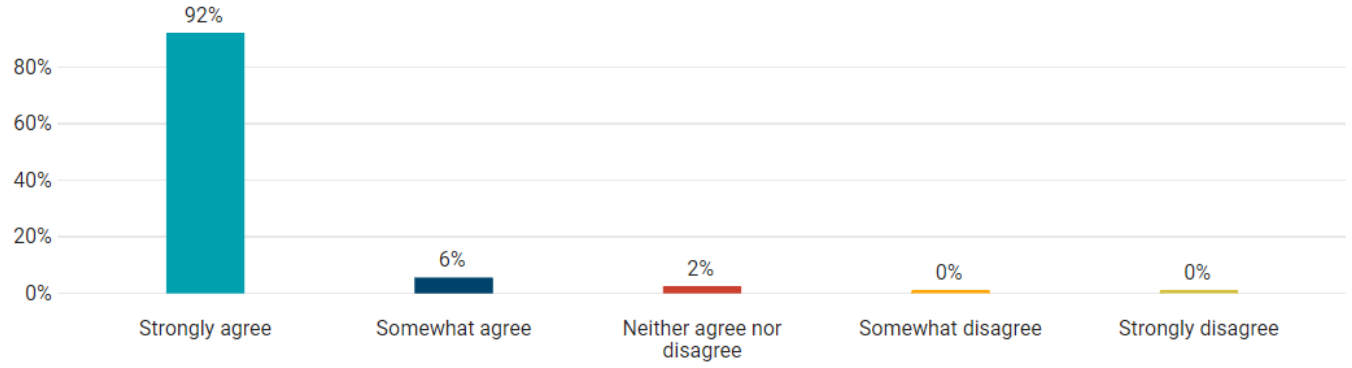
Q8. Please feel free to elaborate on your answer to the question above. (Optional) (n=15)

While the vast majority of respondents agreed (95%) that the draft expectation was reasonable, some physician respondents suggested that there might be privacy and confidentiality concerns with disclosing private information around pre-existing relationships. Concerns from these physicians included:

- "Appropriate member of faculty" is vague and clear reporting structures should be made explicit (i.e., refer to the faculty member responsible for oversight of the education program);
- Some involved may not be comfortable disclosing this sensitive information to a member of faculty they may be working with (e.g., a program director who also acts as an MRP); and
- There isn't an option for a supervisor to cite conflict of interest and instead decline supervision.

Q9. The draft policy includes a new expectation to address concerns from medical students and trainees about violence, harassment, and discrimination in the learning environment. The policy states that physicians involved in medical education must not engage in violence, harassment or discrimination against medical students and/or trainees.

Please indicate the extent to which you agree or disagree that this is a reasonable expectation: (n=90)



Q10. Please feel free to elaborate on your answer to the question above. (Optional) (n=13)

The vast majority of respondents strongly agreed (92%) that physicians involved in medical education must not engage in violence, harassment, or discrimination against medical students and/or trainees.

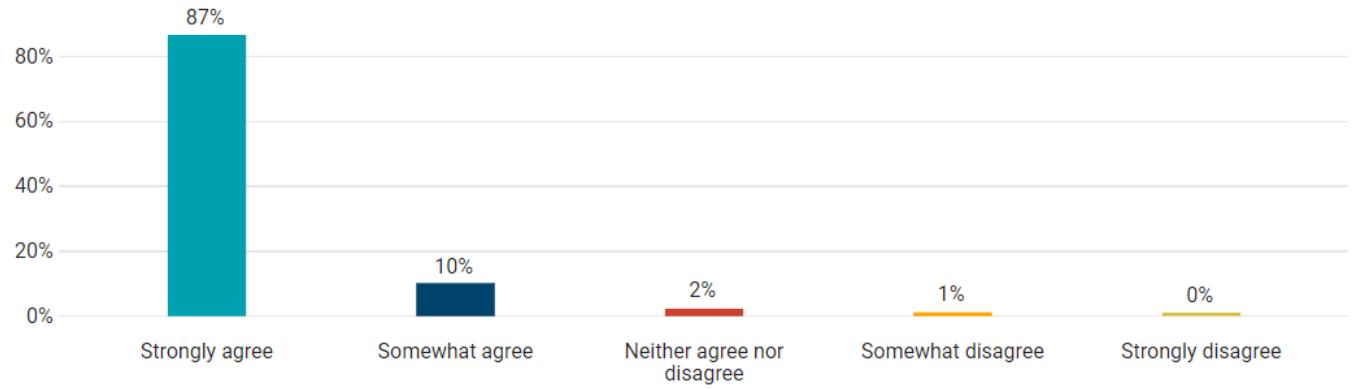
Notwithstanding this, constructive feedback from physician respondents included:

- Explicitly reference “disruptive behaviours” (including homophobia, Islamophobia, racism, sexism, and transphobia) to further define and clarify “harassment” and “discrimination;”
- “Intimidation” should be included and listed as an example of disruptive behaviour;
- Oversight is needed to prevent these disruptive behaviours; and
- Provide additional information (i.e., steps and processes) on how to report disruptive behaviour.

One physician respondent felt the policy should specify that educational leaders and institutions need to have policies in place to assist supervisors in supporting, identifying, and reporting disruptive behaviour.

Q11. The draft policy also requires physicians to take reasonable steps to stop violence, harassment or discrimination against medical students and/or trainees if they see it occurring in the learning environment.

Please indicate the extent to which you agree or disagree that this is a reasonable expectation: (n=90)



Q12. Please feel free to elaborate on your answer to the question above. (Optional) (n=15)

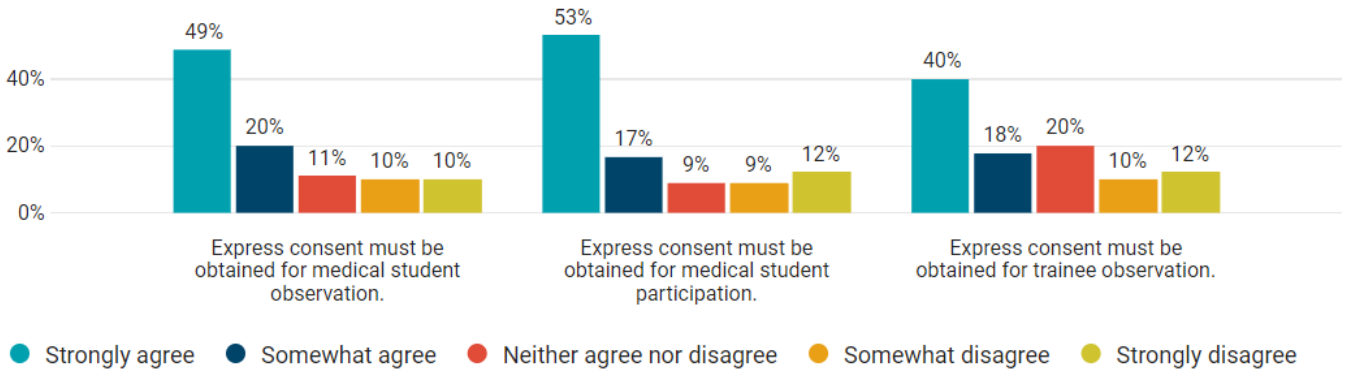
The vast majority of respondents agreed (97%) that physicians must take reasonable steps to stop violence, harassment, or discrimination against medical students and/or trainees if they see it occurring in the learning environment. Some of the written feedback from respondents included:

- Risks of reprisal or repercussions may make immediate intervention or reporting unsafe and supportive institutional policies are needed;
- Provide information on how to report and reference existing university or institutional policies and processes; and
- Supervisors should stand up for learners when they observe these behaviours from other members of the clinical team so it is clear to all parties that these behaviours are unacceptable.

Some of the written feedback highlighted concerns and risks of reprisal/repercussions (to the patient or physician) when reporting.

Q13. While the draft policy allows for flexibility in terms of who must obtain consent for medical student observation or participation in patient care and trainee observation, it sets out specific expectations regarding when consent must be obtained.

Please indicate the extent to which you agree or disagree that the following expectations are reasonable: (n=90)



Q14. Please feel free to elaborate on your answer to the question above. (Optional) (n=35)

Respondents were divided around the draft expectations outlining when express patient consent must be obtained for medical student/trainee observation and participation in patient care.

Some physician respondents were concerned the draft expectations would impose barriers to care and disrupt learning environments. Comments included:

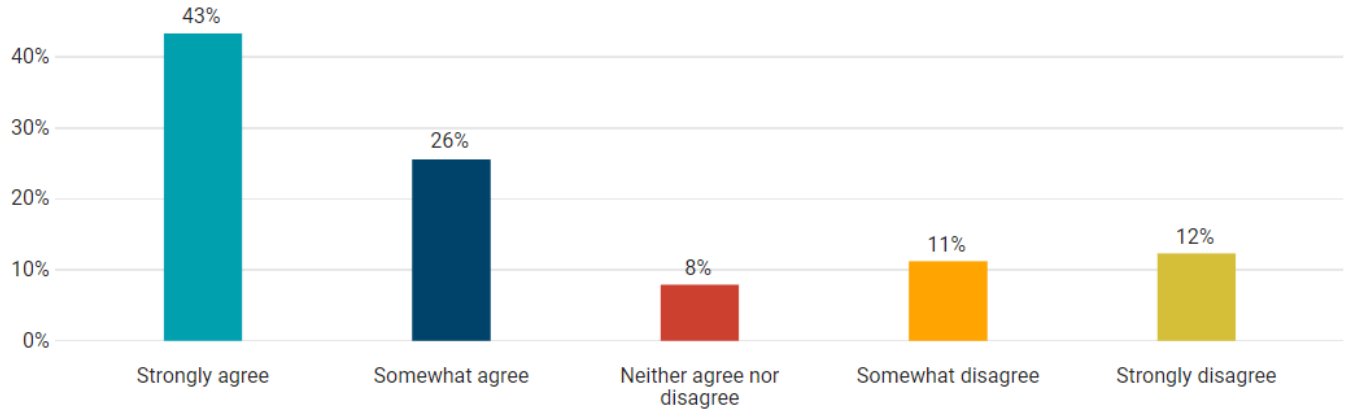
- When patients are admitted to a teaching hospital there is implicit consent and an expectation that medical students and/or trainees will be involved;
- There are instances where it is appropriate for medical students to see the patient first (e.g., overnight supervision by residents in academic hospitals; emergency departments) and it is unreasonable to require the MRP to obtain express consent.

At the same time, some respondents (including both physicians and members of the public) supported and highlighted the need to respect patient autonomy and choice. Comments included the following:

- Requiring patients to participate in medical education is unethical (express consent should be obtained before the appointment, ensure that the patient's healthcare will not be jeopardized by refusing, and that they may withdraw consent at any time);
- Patients should be informed if a medical student/trainee will be handling their appointment prior to arrival and be able to express any concerns to the supervising physician privately;
- Patients should be given the chance to refuse medical involvement if they choose so; and
- Addressing patient consent allows for a greater level of patient safety and engages patients in taking responsibility for their own health care.

Q15. In addition, the draft policy requires MRPs and/or supervisors to use their professional judgment to determine whether consent is required for trainee participation in patient care, recognizing that as trainees come to the end of their training the need for consent for their participation in care diminishes.

Please indicate the extent to which you agree or disagree that this is a reasonable expectation: (n=90)



Q16. Please feel free to elaborate on your answer to the question above. (Optional) (n=29)

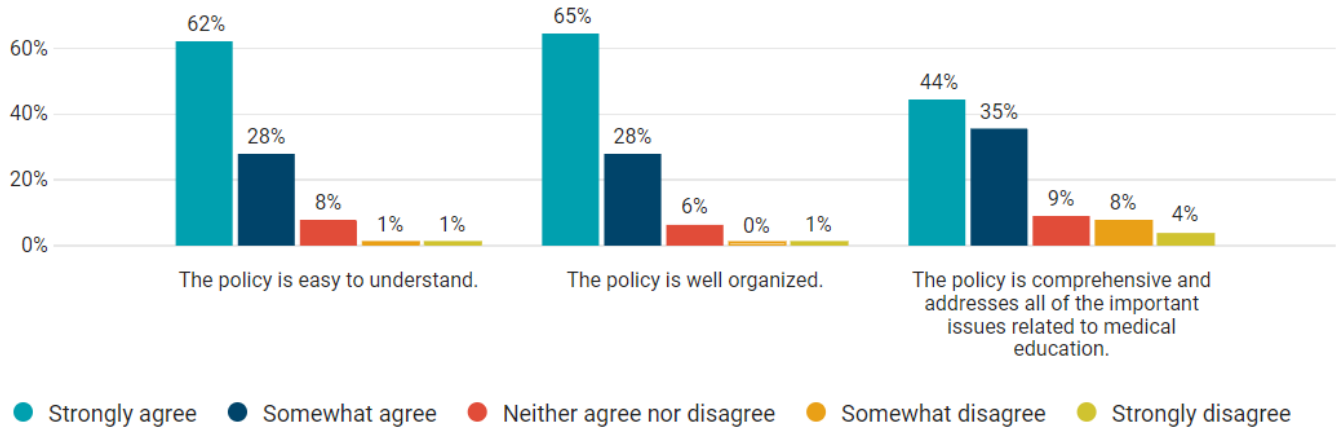
While a majority of respondents agreed (69%) that it is reasonable for MRPs and/or supervisors to use their professional judgment to determine whether consent is required for trainee participation in patient care, there were some physician respondents who had concerns with the draft expectation stating that consent for care provided by trainees care is already implicit within the academic environment.

However, other physician respondents (along with members of the public) highlighted the importance of informing patients about who will be involved in all aspects of their care and that patients should have the right to decline treatment by trainees.

The following questions were only posed to survey respondents who indicated that they read the draft Professional Responsibilities in Medical Education document:

Q18. We'd like to understand whether the draft policy is clear and comprehensive.

Please indicate the extent to which you agree or disagree with the following: (n=79)



Q19. How can we improve the draft policy's clarity? Please feel free to elaborate on your answers above or touch on other issues relating to clarity. (Optional) (n=27)

The majority of respondents felt the draft policy was easy to understand and well-organized.

Several physician respondents felt the draft expectations related to obtaining express patient consent *(lines 194—210 of the draft policy)* could benefit from further clarification and specific examples.

Additional comments from respondents to improve the draft policy's clarity included:

- The draft policy should clarify if individual supervisors must determine competency or if the undergraduate education committee or residency program committee is responsible for assessing and ensuring competency;
- Define and include examples of "disruptive behaviour," "harassment," and "discrimination" and reference existing postgraduate or other institutional policies;
- Address the supervision of residents by surgeons when outside of the operating room;
- Use specific terminology (i.e., "medical student" and "resident physician in training");
- Include information on oversight and enforcement; and
- Clarify what "unrelated to patient care" means.

Q20. How can the draft policy be made more comprehensive? (Optional) (n=17)

Suggestions from physician respondents to improve the draft policy's comprehensiveness included:

- Specify the degree of supervision of residents by surgeons in the operating room (i.e., when can a surgeon supervise a resident when the surgeon is outside the operating room);
- Reference professionalism policies that already exist in post-graduate education programs;
- Provide examples of prior relationship disclosures between MRPs and medical students/trainees;
- Provide specific information on how to report instances of unprofessional behaviour; and
- Clarify the definition of "discrimination."

The following questions were only posed to survey respondents who indicated that they read the draft Advice to the Profession: Professional Responsibilities in Medical Education document:

Q21. Are there issues or topics you think the draft *Advice to the Profession* document should address further? (Optional) (n=21)

Physician respondents suggested the following issues or topics should be addressed:

- Describe how to obtain express consent;
- Describe disruptive behaviour;
- Include more information on what might constitute retaliation for reporting
- Clarify the level of assessment and evaluation done by the individual supervisor or specific undergraduate education or residency program committee;
- Include specific examples of sufficient supervision of trainees when offsite (e.g., house calls) or different supervision settings (e.g., surgical vs. medical specialties and in clinic vs. hospital vs. operating room); and
- Set out the limits of the number of medical students/trainees that a supervisor should be supervising at once.

Additional comments provided by respondents included:

- One member of the public indicated that consent should be obtained in writing (when possible) and without the learner present.
- One physician respondent felt that supervisors should be assessed yearly to see if they continue to be competent to practise medicine.

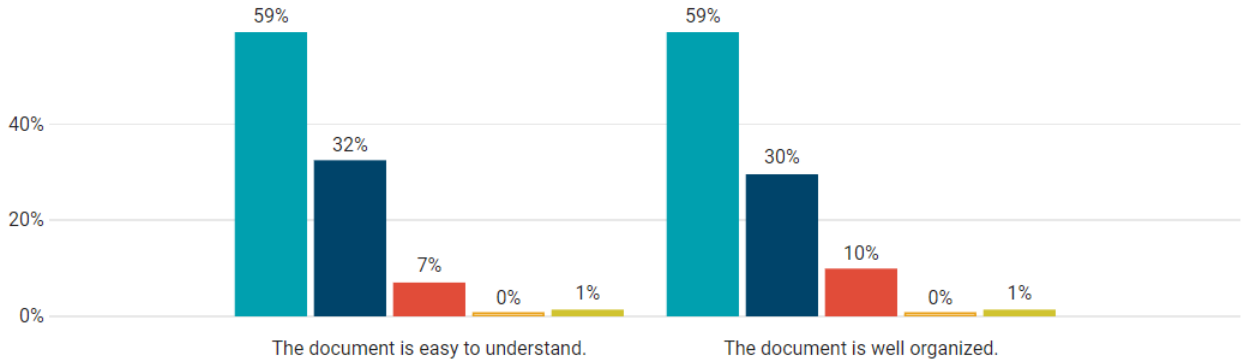
Q22. Is there any information in the draft *Advice to the Profession* document that you think is unhelpful or unnecessary? (Optional) (n=11)

Roughly half of respondents who provided written feedback did not think any of the information in the draft *Advice* document was helpful or unnecessary. However, the following comments were made:

- A few physicians felt the section on obtaining express consent (*lines 76—92*) was problematic.
- One physician respondent felt that referencing *Dialogue* articles or the Canadian Medical Protective Association (CMPA) is unnecessary, particularly as medical students are not regulated by CPSO and do not require the CMPA.

Q23. We'd like to understand whether the draft *Advice to the Profession* document is clear.

Please indicate the extent to which you agree or disagree with the following: (n=71)



The majority of respondents agreed the draft *Advice to the Profession* document was easy to understand (91%) and that the document is well-organized (89%).

The following question was posed to all survey respondents:

Q24. If you have any additional comments that you have not yet provided on either the draft policy or *Advice to the Profession* document, please provide them below, by email, or through our online discussion forum. (n=15)

Key comments provided by physician respondents that have not been provided above included:

- Clarify the role of medical students when delegating controlled acts;
- The section on procedures/exams/investigations unrelated to patient care (*lines 94—102 of the draft Advice document*) should differentiate between physical examinations that are repeated by the trainee and those that would not have been indicated and are performed by the trainee for practice;
- Medical students and residents should be given the opportunity to evaluate their supervisors in a manner that does not compromise their future in the profession;
- If supervisors are unable to fulfil the draft policy expectations, they should not be exposed to medical students or trainees at all; and
- It is problematic to combine the two current existing policies since CPSO does not regulate medical students so CPSO's role is limited to expectations related to supervision.