

# Day 1: Absences and Tensions

Wednesday October 19

9:30-12:30pm

## Theme 1: Absences

These presentations share an interest in what is missing: absences in understandings of practice, blank spots of curricular focus, and contributions rendered otherwise invisible in health professions education.

**Podium sessions:** Presentation: 12 min; Discussion: 6 min; Transition to next presentation: 2 min

**Rapid report sessions:** Presentation: 3 min; Discussion: 2 min

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## RAPID REPORT 1.1 - 9:35-9:40am

### Educating Future Physicians for Francophone Official Language Minority Communities in Canada: A case study

Yeuchy, T.<sup>1</sup>, Elhafid, M.<sup>1</sup>, Nyhof-Young<sup>2</sup>, J., Schrewe, B<sup>3</sup>.

1. Temerty Faculty of Medicine, University of Toronto

2. Department of Family & Community Medicine, Temerty Faculty of Medicine, University of Toronto

3. Department of Pediatrics, Faculty of Medicine, University of British Columbia

Tatiana Yeuchy [t.yeuchy@mail.utoronto.ca](mailto:t.yeuchy@mail.utoronto.ca)

**BACKGROUND:** In Canada, over 1 million Francophone Canadians live in official language minority communities (OLMC) outside of Québec. Healthcare availability in French is often limited or absent, leading to reduced access to and quality of care. To address this gap in health equity, one effective strategy is training Francophone/Francophile medical students at Anglophone faculties of medicine in medical French. Our purpose is to understand what drives the development of skills required to respond to the needs of OLMCs, and how the Association of Faculties of Medicine of Canada's program FrancoDoc has affected student perceptions of the former. In analyzing these phenomena, we can better support their professional development towards this goal in the next chapter of FrancoDoc.

**METHODS:** A qualitative case study is underway using constructivist grounded theory and an exploratory approach. Semi-structured interviews have been conducted with twelve medical students involved in FrancoDoc. Interviews were transcribed and analyzed using a constant comparative approach until saturation of concepts was attained.

**RESULTS:** Four main themes were prevalent during our data analysis supported by quotes from all participants: factors facilitating French language learning; barriers to French language learning; broader issues shaping the provision of linguistically appropriate health care; and specific recommendations to improve health care education in the interest of better preparing learners to provide care to OLMCs.

**CONCLUSION:** Our needs and motivations analysis has allowed us to propose concrete adjuncts to Anglophone faculties of medicine, making them better positioned to deliver on their mission of social accountability to Francophone patients and OLMCs.

## **PODIUM 1.2 - 9:40-10:00am**

### **Psychosocial support for siblings of children with poor prognosis cancers: Reflections on current practices**

Preet Walia<sup>1,2</sup>, Tina Martimianakis<sup>2</sup>, Sonia Lucchetta<sup>2</sup>, Angela Punnett<sup>2</sup>, Fyeza Hasan<sup>2</sup>

1. Temerty Faculty of Medicine
2. The Hospital for Sick Children

Preet Walia [preet.walia@mail.utoronto.ca](mailto:preet.walia@mail.utoronto.ca)

**Background:** The provision of psychosocial support for siblings has been identified as a standard of care in pediatric oncology. In practice, however, this standard is inconsistently implemented, and barriers to supporting siblings are not well understood, particularly in the context of poor prognosis cancers and anticipated bereavement. In addition, education and training on sibling support in pediatric oncology has not been studied.

**Methods:** We used interpretive description to conduct and analyze 13 semi-structured interviews with oncology healthcare providers (HCPs) at a Canadian pediatric oncology centre. Interviews explored perspectives on supporting siblings of children with poor prognoses, and HCPs' training on sibling support. Analysis was inductive, whereby emergent themes were identified, and deductive, using a theoretical framework based on literature and study team knowledge.

**Results:** Participants identified siblings as underserved individuals who would benefit from additional support. Support is typically provided either directly to siblings or indirectly through caregiver psychoeducation. Despite HCPs' desire to help siblings, there are several factors that influence their ability to do so, including sibling preferences, parent openness to discussing poor prognoses, focus on the ill child, scopes of practice, and systemic factors. Across multiple disciplines, training around sibling support is mostly informal and through role modelling.

**Conclusions:** These findings contribute to our understanding of the barriers to providing sibling support in pediatric oncology, and further our knowledge of how family-centered care works in practice. Formal training should be provided for HCPs to support them in recognizing, reflecting on, and managing challenges related to sibling support.

## PODIUM 1.3 – 10:00-10:20am

### Advocacy in Postgraduate Education

Jennifer Hulme<sup>1</sup>, Sarah Wright<sup>2</sup>, Katherine Rouleau<sup>1</sup>, Jonathan Sherbino<sup>3</sup>, Kate Hayman<sup>3</sup>, Alex McKnight<sup>4</sup>, Megan Landes<sup>1</sup>, Malika Sharma<sup>3</sup>, Andrew D. Pinto<sup>1,7,8,9</sup>, Kate Atkinson<sup>5</sup>, Madeline McDonald<sup>6</sup>, Conor Lavelle<sup>3</sup>, John Ihnat<sup>1</sup>.

1. Department of Family and Community Medicine, University of Toronto
2. Wilson Centre
3. Department of Medicine, McMaster University
4. Public Health Ontario
5. Parkdale Queen West CHC
6. Department of Surgery, McMaster University
7. Upstream Lab, MAP, Li Ka Shing Knowledge Institute, Unity Health Toronto
8. Department of Family and Community Medicine, St. Michael's Hospital
9. Dalla Lana School of Public Health, University of Toronto

[Jennifer.Hulme@uhn.ca](mailto:Jennifer.Hulme@uhn.ca); [Hannah Girdler hgirdler@ghem.ca](mailto:Hannah.Girdler@ghem.ca)

**Background:** Health advocacy is a core competency of all physicians, and helps shape healthy public policy. Urgent work is needed to understand the current state of health advocacy training in Canadian family (FM) and emergency (EM) postgraduate medical education. We aim to understand the existing barriers and facilitators to health advocacy training, with the goal of informing curricula that can better meet the needs of trainees and the communities that they serve. **Methods:** In 2019, we published a narrative literature review to understand the state of health advocacy training in Canadian FM and EM postgraduate medical education. This informed the semi-structured interview guide, which inquired about health advocate role being taught, modeled, and evaluated at the micro, meso and macro level; the core elements of advocacy culture, supports, successes and challenges; and the role of accreditation. A criterion sampling strategy was employed, inviting program directors of Canadian FRCPC (EM) and family medicine programs to interview, with additional informants identified by snowball sampling. We are using a qualitative description approach to interpreting interviews as well as document analysis of the existing literature and accreditation documents.

**Results:** To date we have completed 22 interviews, 16 of which were representatives from family medicine programs and 6 from emergency medicine programs. Two authors (JH, AM) conducted the initial coding of the interviews conducted to date. Preliminary findings suggest that programs' primary focus is often on advocating for individual patients and trainee assessment is based on micro-level activities. Macro-level activities are rare, most often resident-led, and not part of formal curriculum. Mentorship, local champions, and longitudinal partnerships with local community-based organizations were cited as the key to successfully supporting trainees in meso and macro-level advocacy, but the risk and fear of being too political and "drifting" to less serious medicine, and the resulting discomfort of faculty and lack of mentors were major ongoing barriers.

**Discussion/Future Directions:** Early results suggest that we should prioritize long term partnerships with community based organizations and actively recruit and support faculty who as local champions can effectively mentor residents. Defining advocacy competencies may help drive this change. Future directions include interviews with Accreditation Committee members at both the RCPSC and CFPC, opinion leaders, and residents to situate our findings at the program director level.

## PODIUM 1.4 – 10:20-10:40am

### **A Foucauldian-inspired discourse analysis of administrative staff and faculty relations in health professions education**

Morag Paton<sup>1</sup>, Cynthia Whitehead<sup>2-4</sup>, Stephanie Waterman<sup>1</sup>, Ayelet Kuper<sup>4-6</sup>

1. Leadership, Higher, and Adult Education, OISE, University of Toronto
2. Department of Family & Community Medicine, Temerty Faculty of Medicine
3. Family & Community Medicine, Women's College Hospital
4. Wilson Centre
5. Department of Medicine, Temerty Faculty of Medicine
6. Division of General Internal Medicine, Sunnybrook Health Sciences Centre

[morag.paton@utoronto.ca](mailto:morag.paton@utoronto.ca)

Administrative staff in higher education have been described as invisible (Eveline, 2004; Szekeres, 2004) and characterized as being “non-academic, non-faculty, non-teaching, [and] non-professional” (Losinger, 2015, p. 157). Staff are also often absent in HPE documents, literature, and reports. With few exceptions, if staff appear in the HPE literature it is as a passive object, often as a resource, a possession, or a liability. If staff appear in institutional reports, it is often within an acknowledgement section rather than a list of authors. These absences are felt in everyday staff experiences: staff may be overlooked in meetings, feel uncomfortable contributing knowledge, or feel devalued or invisible in their roles. The increasing professionalization of staff roles due to neoliberalism, occurring as health professionals experience their own shifts in power and prestige, can lead to tensions, if not toxicity, in the health professions education space.

I build and examine an archive to conduct a Foucauldian-inspired discourse analysis. I identify discourses that regulate the work of and power relations between administrative staff and faculty in HPE. I engage with feminist and decolonial critical theories throughout my analysis.

Staff have been discursively constructed as devoted caregivers, controlling matriarchs and as professionals. These three discourses regulate staff and faculty relations to the present day. To navigate the tensions produced by discourses and structure, I work to rebuild agency through staff voices, resistance, and recommendations for practice.

## PODIUM 1.5 – 10:40-11:00am

Setting the tone for team performance in the operating room: a constructivist grounded theory study

Hillary Lia<sup>1,2</sup>, Melanie Hammond Mobilio<sup>1</sup>, Frank Rudzicz<sup>2,3,4</sup>, Carol-anne Moulton<sup>1,2</sup>

1. The Wilson Centre, University of Toronto, Toronto, ON, Canada
2. Institute of Medical Science, Temerty Faculty of Medicine, University of Toronto, Toronto, ON, Canada
3. Department of Computer Science, University of Toronto, Toronto, ON, Canada
4. Vector Institute for Artificial Intelligence, Toronto, ON, Canada

[Hillary.lia@mail.utoronto.ca](mailto:Hillary.lia@mail.utoronto.ca); [Melanie.HammondMobilio@uhn.ca](mailto:Melanie.HammondMobilio@uhn.ca);

**Background:** Teamwork in the operating room (OR) has been studied using various approaches. Literature suggests the presence of a “tone” in the OR which is set by the attending surgeon and modified by the OR team. Though tone may be an important factor for team functioning, there does not exist a framework which clearly defines tone, explains how tone emerges, and explores its impact. Our research aims to develop a conceptual framework for tone in the OR, with the aim to contribute to the understanding of the mechanisms of team performance in the OR.

**Methods:** Semi-structured interviews were conducted and analyzed using a constructivist grounded theory methodology. OR staff across professions (i.e., surgeons, anesthesiologists, nurses, and perfusionists) were recruited to capture a variety of experiences and viewpoints. Study recruitment and data analysis remains ongoing.

**Results:** Tone is experienced differently by the varying health profession groups. Data suggest the surgeon is primarily responsible for *setting* the tone, “*you know in the orchestra, if you don't have a conductor, everyone is gonna be kind of doing everything on their own, right?... It's really about running the team, making sure that we reach the goal.*” S1. Other members of the team described *responding* and *adjusting* the existing tone: “*...what I would like to do is prevent ambient tension from forming. And if I know what these surgeon's triggers are, I can avoid [them].*” A2

**Conclusion:** Tone is an emergent, relational state steeped in context and interpersonal interactions which shapes team functioning.

# Day 1: Absences and Tensions

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9:30-12:30pm

## Theme 2: Exploring tensions

Long-standing and new tensions shape the dynamism of health professions education. These presentations share an interest in exploring these tensions and their possible effects.

**Podium sessions:** Presentation: 12 min; Discussion: 6 min; Transition to next presentation: 2 min

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### PODIUM 2.1 – 11:10-11:30am

#### Exploring the impact of redeployment on the professional identity of family medicine residents

Nathan Cupido<sup>1</sup>, Laura Diamond<sup>2</sup>, Kulamakan Kulasegaram<sup>1,3</sup>, Tina Martimianakis<sup>1,4</sup>, Milena Forte<sup>1,2,3,5</sup>

1. The Wilson Centre
2. Temerty Faculty of Medicine, University of Toronto
3. Department of Family & Community Medicine, University of Toronto
4. Department of Paediatrics, University of Toronto
5. Mount Sinai Hospital, Toronto

[nathan.cupido@mail.utoronto.ca](mailto:nathan.cupido@mail.utoronto.ca)

The redeployment of family medicine residents in response to the COVID-19 pandemic has impacted residents' learning opportunities within their postgraduate training; however, little attention has been given to the impact of redeployment on their professional identity formation (PIF). For residents, PIF requires a complex negotiation between their role as learners and providers of care—both of which attach meaning to experiences during training. The goal of this study was to explore the impact of redeployment on the professional identity of family medicine residents.

22 family medicine residents were interviewed between September 2020-July 2022. Using symbolic interactionism as a theoretical framework, thematic analysis explored the meanings residents attributed to both experiences disrupted due to redeployment, and new experiences that resulted from redeployment.

From the perspective of learning, the pandemic represented a loss of the presupposed learning experiences that residents expected of their training and redeployment challenged their perceived agency as self-directed learners. Meanwhile, regarding the provision of care, redeployment accelerated residents' sense of membership in the healthcare community and re-affirmed their value in independent care settings.

Participants' responses to redeployment highlight the challenge of PIF in postgraduate training: the different roles required of residents can result in different meanings attributed to experiences. Although tensions may exist between learning and the provision of care—as seen in responses to redeployment—residents must negotiate expectations related to both roles as they develop their professional identity. The results of this study accentuate how meanings aligned with these roles can define residents' experiences in training.

## PODIUM 2.2 – 11:30-11:50am

### **Critical Tensions in Evaluation Work: An Empirical Examination of how Paradoxes Orient Evaluation Practices & Impact**

Betty Onyura<sup>1,2,3</sup>, Abigail Fisher<sup>1,3,4</sup>, Qian Wu<sup>1</sup>, Shrutikaa Rajkumar<sup>5\*</sup>, Sarick Chapagain<sup>6\*</sup>, Judith Nassuna<sup>5\*</sup>, Latika Nirula<sup>1,8</sup>

1. Centre for Faculty Development, Faculty of Medicine, University of Toronto at Unity Health Toronto, Toronto, Canada
2. Department of Family and Community Medicine, University of Toronto, Toronto, Canada
3. The Wilson Centre, Toronto, Ontario, Canada
4. Ontario Institute for Studies in Education (OISE), University of Toronto, Toronto, Ontario, Canada
5. University of Toronto, Toronto, Ontario, Canada
6. Department of Biology, Toronto Metropolitan University, Toronto, Ontario, Canada
7. Department of Psychiatry, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada

\*These co-authors were former Research Summer Students at the University of Toronto

[Abigail.fisher@utoronto.ca](mailto:Abigail.fisher@utoronto.ca);

**Background:** Program evaluation has become routine practice in health professions education (HPE). However, there is scant research on the experience, utility, or impact of evaluation work in the field. To address this gap, our research focuses on the experiences of those who are tasked with the responsibility of leading/implementing evaluation mandates. Drawing on organizational paradox theory, we examine the tensions that HPE evaluators must navigate in doing evaluation work.

**Methods:** We recruited 29 evaluators/persons who work within evaluation across 26 academic health science institutions and 4 countries to participate in semi-structured interviews on their evaluation practices. Thematic and matrix analysis were used for data analysis.

**Results:** Results identified that evaluators encountered *paradoxes, confusion about the role of evaluation, and dilemmas* in their day-to-day practice. We surfaced 5 paradoxical tensions including *performing, learning, organizing, belonging, and publicizing along with multiple sub-themes*. For example, sub-themes of the publishing paradox revealed tensions around data ownership and access. Sub-themes of the performing paradox disclose the tension between balancing the demands and interests of multiple stakeholders against professional standards.

**Discussion:** Our study unveils the underlying paradoxes that evaluators encounter. Participants acknowledge that these paradoxes can negatively affect their practice. Additionally, evaluators' creative navigation of challenges can be hampered or facilitated by positional authority and organizations' evaluation culture.

**Conclusion:** Claims of evaluation as integral to the academic mission may have misaligned institutional support. To be socially accountable, institutions need to better understand the entrenched tensions of evaluation practice and invest in the structural support and capacity building required to navigate them.

## PODIUM 2.3 – 11:50-12:10pm

### **The experiences of healthcare professionals in providing care to unvaccinated Covid-19 critically ill patients: a qualitative study.**

Candice Griffin<sup>1</sup>, Christie Lee<sup>1,4</sup>, Phil Shin<sup>1,5</sup>, Andrew Helmers<sup>1,6</sup>, Csilla Kalocsai<sup>1,3</sup>, Wendy Ye<sup>1</sup>, Dominique Piquette<sup>1,2,3</sup>

<sup>1</sup>University of Toronto

<sup>2</sup>Wilson Centre

<sup>3</sup>Sunnybrook Health Sciences

<sup>4</sup>Mount Sinai Hospital

<sup>5</sup>North York General Hospital

<sup>6</sup>Sick Kids Hospital

[candice.griffin@medportal.ca](mailto:candice.griffin@medportal.ca)

The Covid-19 pandemic has placed immense pressure on healthcare systems, and resulted in increasing rates of moral distress, compassion fatigue and burnout amongst healthcare workers<sup>1-6</sup>. The development of the Sars-CoV-2 vaccine has been instrumental in reducing viral transmission; however, has been accompanied by public resistance against vaccination mandates<sup>7-9</sup>. Healthcare providers have faced new challenges providing care to unvaccinated patients with severe, yet potentially preventable, respiratory failure. Our study explores the experiences of medical personnel caring for unvaccinated patients admitted with Covid-19 infections in intensive care (ICU).

ICU nurses, physicians, fellows, residents, and respiratory therapists at Sunnybrook, Mount Sinai, and North York General Hospitals were invited to participate in a semi-structured interview to discuss their experiences and opinions pertaining to the provision of care to critically ill unvaccinated Covid-19 patients. Interviews were transcribed, coded and thematically analyzed to identify emerging themes that assist in understanding participants' experiences and impacts of caring for unvaccinated Covid-19 patients.

At the time of submission, seventeen interviews were conducted. Unanimously, respondents reported feeling a compelling ethical responsibility to provide standard of care for all Covid-19 patients, regardless of vaccination status. Many recognized biases and frustration towards unvaccinated patients, often driven by patients' resistance to other therapeutics and mistrust in healthcare, burnout, personnel shortages, and public backlash against healthcare providers during vaccine protests. Biases were suppressed and compartmentalized to preserve therapeutic relationships. ICU providers reported a strict and proactive adherence to the highest standard of care while navigating complex interactions with unvaccinated Covid-19 patients and their families.