

## Day 1: Tuesday October 10, 2023

9:30am-11:35am

### Theme 1: Innovation and Program Development

**Podium sessions:** Presentation: 12 min; Discussion: 5-7 min; Transition to next presentation: 2 min

**Rapid report sessions:** Presentation: 5 min; Discussion: 3-5 min

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#### RAPID REPORT 1.1 - 9:35-9:45am

##### **A Pilot Study - Evaluating attitudes towards and the suitability of two novel communication skills e-modules for Family Medicine and Palliative Care residents' learning serious illness conversation skills**

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**Background:** Serious illness conversations (SIC) are essential to meet the needs of seriously ill people, but most clinicians receive little SIC communication skills training and no national standard exists to teach them. To address this, a prior qualitative study done in the Department of Family and Community Medicine (DFCM) identified resident and faculty needs for learning and teaching about SIC communication, which informed the development of two e-modules teaching skills using a time-efficient, structured, and evidence-informed method.

**Methods:** An online survey was emailed to DFCM/Division of Palliative Care postgraduates and faculty at two teaching sites with existing SIC curriculum to assess their post-viewing perceptions towards the novel e-modules. Learners completed a follow-up survey 1 month later to assess skill adoption.

**Results:** Survey completion rate was 36% (18/50) for learners and 22% (13/60) for faculty. Most participants agreed that the e-modules provided valuable core communication skills training and would be a useful addition to other teaching methods. Learners felt more confident in their ability to empathetically support patients and to lead SICs. Most learners and all faculty would recommend the e-modules to a colleague. Video demonstrations were identified as the most useful teaching method. At the 1-month follow-up, most learners reported using the SIC skills in their clinical practice.

**Conclusion:** Scalable teaching methods are urgently needed to address a serious-illness skill gap. Two e-learning modules were created to introduce foundational evidence-informed SIC tools that can be incorporated into teaching opportunities. This may improve SIC quality and lead to increased high-quality care.

## **RAPID REPORT 1.2 - 9:45-9:55am**

### **Emergency Medicine Continuing Professional Development in Ethiopia from the Ground Up: A Co-Creation Approach**

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The Toronto Addis Ababa Academic Collaboration in Emergency Medicine (TAAAC-EM) is a partnership between the University of Toronto (UT) and Addis Ababa University (AAU). Through this partnership over the past ten years, AAU has graduated Ethiopia's first 54 emergency medicine specialists. Literature on continuing professional development (CPD) for faculty and staff physicians in Emergency Medicine (EM) global health partnerships is limited. We conducted a qualitative analysis to assess the perceived needs, methods of delivery, and success criteria for continuing professional development and support among EM Faculty at AAU.

This co-creation approach to curriculum design necessitates stakeholder involvement in addressing and verifying our research results. As active participants in curriculum development, research informants are also active in the research that underlies it.

The research team conducted 12 one-on-one interviews with faculty participants from across Ethiopia. The interviews were guided by questions to solicit perceived knowledge, practice, skills, and confidence gaps which the participants wish to address through CPD, means of CPD delivery, available in-country resources that could help facilitate a self-sustaining CPD program, and success criteria. Interviews were recorded and transcribed, with key themes emerging across areas of interest. These include topics of interest (e.g. medical legal and mental health), delivery methods (e.g. in-person small groups preferred to online lectures) and new learnings about how CPD activities are and should be recorded for certification purposes.

The research team is in the process of compiling these themes to present back to EM faculty for feedback, to guide future CPD activities.

## RAPID REPORT 1.3 - 9:55-10:05am

### **The Compassionate1 Educational Tool: A communication model for patients receiving involuntary orders for mental health emergencies**

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Compassion is a fundamental value in health care, particularly when caring for people with serious mental health concerns. The Compassionate1 Project is an integrated educational and research initiative designed to enhance and evaluate compassionate care and its effects on involuntary psychiatric admissions in the emergency department.

The primary objective of the Compassionate1 Project is to develop, implement, and evaluate a department-wide compassionate care bundle for patients receiving involuntary mental health evaluations (PRIME). Does a department-wide educational intervention designed to improve compassionate care result in individual learning and changes in provider behavior and experiences when interacting with PRIME?

Our education intervention includes simulation and non-simulation formats and will be delivered to consenting clinical and non-clinical staff working in the Emergency Department and Mental Health Emergency Services Unit at St. Joseph's Health Centre. Our training program includes an innovative communication framework, developed based on best practices from palliative care and oncology for sharing bad news with patients and families. This patient-centered initiative places compassion at the heart of communicating the decision to order an involuntary psychiatric assessment. The model was developed with a range of interdisciplinary emergency mental health providers including clinicians, security personnel, and patient representatives.

We plan to evaluate *provider behavior and experience* qualitatively using staff interviews conducted one month after the educational curriculum and intervention launch. A quasi-experimental pre-post-survey approach will be used to quantify the effect of the training on provider knowledge.

## RAPID REPORT 1.4 - 10:05-10:15am

### Enhancing Teacher Performance: Exploring tensions within a coaching-based faculty development program

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Faculty development is a crucial resource for health professionals, who are often least well-prepared for their roles as educators. The field has traditionally targeted resources to self-motivated faculty who can take advantage of its structured programs, and underserved those who may lack self-awareness, motivation or energy to seek out offerings – that is, those who arguably would benefit from it the most. Meanwhile, the need to support struggling faculty with identified teaching performance issues is growing, especially as teaching and learning environments in health professions education (HPE) are becoming increasingly complex. The Centre for Faculty Development (CFD) in Toronto developed a coaching-based faculty development program to address this need.

Scientific literature supports coaching as an effective intervention for teaching improvement, but has focused primarily on individuals who self-identify a need for it, and remediation literature is primarily focused on learners rather than clinical educators. Implementation in this context may be fraught with tensions unique within faculty development and remain largely unexplored. Tensions may emerge, for example, associated with who and how faculty are identified as being in need of support; in the determination of how coaches and coaches are matched; during coaching sessions where both coach and coachee's priorities and accountabilities must be balanced; and in assessing potential career consequences upon completion.

We will present evaluation findings from this unique program, including insights from coaches and coachees about implementation challenges, to contribute to a much-needed discourse about how best to support struggling faculty to adapt to the changing clinical teaching environment.

## PODIUM 1.5- 10:15-10:35am

### Accelerating the Appropriate Adoption of Artificial Intelligence in Health Care: Clinician Champions Program Evaluation

David Wiljer<sup>1-3</sup>, Bemnet Teferi<sup>1</sup>, Dalia Al-Mouaswas<sup>4</sup>, Megan Clare<sup>4</sup>, Rebecca Charow<sup>1,2</sup>, Azra Dhalla<sup>5</sup>, Caitlin Gillan<sup>2</sup>, Jessica Jardine<sup>1</sup>, Tharshini Jeyakumar<sup>1</sup>, Inaara Karsan<sup>1</sup>, Nadim Lalani<sup>5</sup>, Maram Omar<sup>1</sup>, Jillian Scandiffio<sup>1</sup>, Jane Mattson<sup>4</sup>, Mohammad Salhia<sup>4</sup>, Jillian Scandiffio<sup>1</sup>, Sarah Younus<sup>1</sup>, Melody Zhang<sup>1</sup>

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**Background/Purpose.** The advancement of artificial intelligence (AI) has created opportunities to transform healthcare and improve health outcomes. The Clinician Champions Program was created to address gaps in AI literacy among healthcare professionals (HCP) to enable responsible adoption.

**Methods.** The multi-methods study was guided by the Knowledge-to-Action<sup>1</sup> and the Health Equity and Inclusion Frameworks<sup>2</sup> to develop, disseminate, and evaluate a series of evidence-based, certificate AI programs. The Clinician Champions Program consisted of three cohorts conducted over an 8-week period, including weekly assignments, reflection exercises, and a capstone project. Data collection included learner pre-post-evaluation surveys, course artifacts (e.g., Blackboard data), and interviews. Purposeful sampling and thematic analysis was performed. Findings were triangulated with the educational team's debriefing data.

**Results.** A total of 116 clinicians completed the program (73%), representing a diverse range of HCPs, including physicians, nurses, researchers, and other clinicians. 17 interviews were conducted: 5 instructors and 12 learners.

Three themes emerged from participants' feedback: 1) the importance of designing courses that are accessible, accommodating various learning needs and facilitating professional development. 2) Learners valued diverse perspectives in reach for understanding the program's content to foster interdisciplinary collaboration and specialty-specific insights for AI implementation. 3) Participants emphasized equipping learners to prepare for AI implementation to navigate the evolving AI landscape equitably for future directions.

**Discussion.** AI educational programs are valuable for transforming the strategic direction of AI use in healthcare. These findings highlight the importance of taking an integrative knowledge translation approach to responsibly adopt and implement practical AI education in healthcare.

#### References

1. Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: time for a map?. *The Journal of continuing education in the health professions*, 26(1), 13–24. <https://doi.org/10.1002/chp.47>
2. Centre for Addiction and Mental Health (2021). *Health Equity and Inclusion Framework for Education and Training*. Toronto: CAMH.

## PODIUM 1.6- 10:35-10:55am

### **A Program Evaluation of the Family Medicine and Enhanced Skills (FAMES) Integrated Residency Program Pilot**

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**Background/Purpose:** In 2022, the College of Family Physicians of Canada announced its plan to develop an expanded, 3-year residency training program. In anticipation of this curricular change, our team piloted a program where the current two-year family medicine training is integrated with an enhanced skills area over three years. This program evaluation seeks to evaluate the feasibility and sustainability of the pilot's implementation to help inform the changing landscape of family medicine training in Canada.

**Methods:** Using a descriptive, multiple-case study approach, we conducted semi-structured interviews with key stakeholder groups, including program directors, faculty, residents and administrators. Thematic analysis was used to review the de-identified transcripts through the lens of Normalization Process Theory (NPT) to better understand the cognitive work participants engaged in.

**Results:** Four main themes included: 1. Participants identified program elements to both continue and adapt to ensure sustainability and improvement 2. Collective action occurred through strong resident-program relationships that were perceived as a buffer against uncertainty 3. Contrasting internalization of program values was noted, with mixed reactions to the program's goals. Residents and faculty felt that this integrated approach to curricular planning helped support and drive the development of adaptive expertise 4. Relational work around participation in the program helped to sustain the curricular intervention.

**Discussion:** Program modifications were implemented as the pilot evolved to meet the emerging needs and feedback of key stakeholders. Participants felt the current iteration of the pilot was sustainable; however, questions arose about how an expanded program could be resourced and supported.

## PODIUM 1.7- 10:55-11:15am

### CPD by the Minute: An Innovative Smartphone-Enabled Application Mobilizing Continuing Professional Development in Medicine

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**Background:** Self-assessment activities are crucial for physician practice change to improve patient outcomes<sup>1</sup>. However, barriers such as lack of coordination and time constraints hinder physician engagement in continuing professional development (CPD). This study evaluated the acceptability, relevance, and potential impact of the CPD by the Minute (CPD-Min) mobile application as a CPD activity.

**Methods:** CPD-Min, a smartphone-enabled web-based, application underwent three phases of development prior to deployment: application design, peer-reviewed question development, and usability testing. CPD-Min disseminated two weekly 1-minute multiple-choice questions with feedback and references.

A multi-method study assessed the app using pre-post surveys, semi-structured interviews, and app usage data. Interview data was analyzed deductively, using the RE-AIM framework<sup>2</sup>, then inductively to identify overlapping themes.

**Results:** 104 Canadian anesthesiologists completed 110 questions each over 52 weeks. The average completion rate was 75% ( $\pm 33.0$ ), where most unanswered questions occurred after week 26. Majority of participants expressed their likelihood to continue using the app as an ongoing CPD activity, finding it a valuable resource and relevant to their practice. Interview participants also found the app: (1) had a practical design that facilitated its adoption; (2) was a knowledge tool for continuous learning; and (3) had cultivated an independent learning attitude through its low-stakes testing environment.

**Discussion:** The CPD-Min application can enhance longitudinal self-assessments that promote lifelong learning among physicians. The high engagement of clinicians supports its value as an innovative method for continuous learning. Future research should investigate the application's impact on physicians' practice and explore alternative methods, (e.g., ChatGPT) for generating questions.

#### References

1. Price DW, Davis DA, Filerman GL. Systems-integrated CME: The implementation and outcomes imperative for continuing medical education in the learning health care enterprise. *NAM Perspectives*. Discussion, National Academy of Medicine, Washington, DC. doi: 10.31478/202110a.
2. Gaglio B, Shoup JA, Glasgow RE. The RE-AIM Framework: A systematic review of use over time. *Am J Public Health* 2013 Jun;103(6):38-46. doi: 10.2105/ajph.2013.301299.

## PODIUM 1.8- 11:15-11:35am

### **Creating a Teachable Moment: Exploring the Reflexive Questions Storytellers Ask Themselves in Sharing Their Story in Health Professions Education**

Latika Nirula<sup>1,2,3</sup>, Qian Wu<sup>1,3</sup>, Helen Sklarz<sup>3</sup>, Brett Diaz<sup>4</sup>, Sacha Agrawal<sup>2,4</sup>

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Patient and family partners (PFPs) are increasingly being engaged as teachers through the pedagogy of storytelling in health professions education, including Continuing Professional Development (CPD). The current study addresses a rarely examined aspect of PFP storytelling, which is what PFP storytellers take into consideration when building and telling their stories.

Eleven PFPs were recruited from a pool of PFP volunteers at an academic hospital in Toronto. Data includes (a) a personal healthcare story—a story creation prompt was provided; (b) a semi-structured interview, and (c) an online demographic survey. We thematically coded the interview, gleaned from them the considerations that PFPs grapple with in creating and telling their stories. These considerations were then formed into reflexive prompts from the perspectives of PFP storytellers.

Insights on PFP storytellers' considerations reveal the complexity of storytelling and the amount and depth of work it involves. Key considerations were identities and motivation of PFP storytellers, validity and value of stories, context of storytelling, handling emotions, emotional framing of story, bringing change, making story compelling, competence and ethics of storytelling.

Our study shows that PFP storytellers do not just tell their stories, but rather carefully and intentionally construct their stories in ways that can deliver “teachable moments” in order to bring positive changes. This knowledge will inform clinical educators on how to be more thoughtful of storytellers' intentions and hopes when engaging with them. We suggest expanding their roles in CPD curricular design and delivery for more meaningful and equitable partnership.

## Day 1: Tuesday October 10, 2023

1:00pm – 3:05pm

### Theme 2: Discourses: Invisible and Productive

**Podium sessions:** Presentation: 12 min; Discussion: 5-7 min; Transition to next presentation: 2 min

**Rapid report sessions:** Presentation: 5 min; Discussion: 3-5 min

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### PODIUM 2.1 – 1:05pm – 1:25pm

#### Compartmentalization: A critical narrative review.

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**Introduction:** Compartmentalization is a surgical colloquialism often used to describe the practice of leaving emotions outside of the operating room with the goal to achieve superior focus and performance during a surgical procedure. In psychology, compartmentalization can have pragmatic utility, as in the practice of “therapeutic compartmentalization”. However, it can also have problematic consequences, as in the practice of dissociation. Despite its common presence as a phrase to describe separating extraneous emotion and other distractions from ‘focused operative practice,’ compartmentalization within surgical practice has yet to be explored.

**Objectives:** We are conducting a critical narrative review to understand how compartmentalization is featured in fields outside of surgery.

**Methods:** We followed the Scale for the Assessment of Narrative Review Articles and searched across medical and social sciences databases in June 2023 for manuscripts discussing compartmentalization in medicine, psychology, humanities, social science and performance literatures. A narrative review was chosen to produce a deeper understanding of how the concept of compartmentalization is understood to advance scholarly conversations. Grey literature searches and review of reference lists were also conducted. After screening and selection, content analysis was performed.

**Results:** This study is currently underway. All analyses will be complete for the 2023 Richard K. Reznick Wilson Centre Research Week.

**Implications:** Compartmentalization is often discussed in surgery, but we lack a clear understanding of what it means. This study will build our understanding of how the concept is understood in other fields and literatures. Future work will explore the lived experience of compartmentalization among surgeons.

## PODIUM 2.2 – 1:25pm – 1:45pm

### What's in a name? The development of trust and familiarity in dynamic interprofessional operating room teams

Tobi Lam<sup>1,5</sup>, Melanie Hammond Mobilio<sup>1</sup>, Jacob Hirsh<sup>2</sup>, Dean Lising<sup>3</sup>, Tulin Cil<sup>1,4</sup>, Edyta Marcon<sup>5</sup>, Carol-anne Moulton<sup>1,4</sup>

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**Background:** Operating Room (OR) teams often function with dynamic personnel changes and uncertainty. Trust between coworkers requires familiarity of individual competence, benevolence and integrity. Without familiarity, temporary work groups depend on Swift Trust from professional role expectations. Interventions (i.e. Surgical Safety Checklist, TheatreCapChallenge) have looked at improving role clarity and identifying individuals by name. The aim of this project was to explore the experience of knowing and using names, and its impact on teamwork in the OR.

**Methods:** 16 semi-structured interviews were conducted, transcribed and de-identified. Through concurrent and iterative qualitative data analysis, two emergent themes were identified: the importance of trust, and variable levels of familiarity in the OR. Concepts of swift trust and confidence were applied as analytical frameworks.

**Results:** Name use provided a scaffold for trust between team members. Based on task interdependencies, varying types of trust were experienced. Participants used strategies to adapt to variable trust such as: 1. automatic assumptions of Confidence in institutions (“we have enough checks and balances in our system”), 2. role-based Swift trust (“I expect them to have certain competence or certain skill”), 3. Individuated or person based trust (“I kind of get really excited that I get to work with that person”). Results demonstrated that individuated trust was developed with shared experiences. With variability in familiarity across personnel, team trust as an emergent state may be more challenging in certain contexts.

**Relevance:** While teams can function with interchangeable people, psychological safety requires individuated trust and more personalized connections.

## PODIUM 2.3 – 1:45pm – 2:05pm

### **Jockeying for position: A critical discourse analysis of the interplay of discourses of disability in clinical letters**

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**Background:** For disabled children, clinical letters written by health professionals are a valuable form of currency enabling access to school-based healthcare. While clinical letters typically centre the biomedical discourse of disability, through critically reflective practice, health professionals introduce alternative discourses into these documents. Drawing on Mikhail Bakhtin's concept of double-voiced discourse, this study explores how alternative discourses of disability manifest in critically reflective letters, and how alternative (centrifugal) discourses interact with the dominant (centripetal) biomedical discourse.

**Methodology:** We drew on an approach to critical discourse analysis called contrapuntal analysis to examine how discourses of disability manifest and interact. We analyzed 22 clinical letters written for fictional children with developmental disabilities. The analysis involved two interrelated phases: first, we examined the letters to identify discourses of disability; second, we examined how those discourses interact with the biomedical discourse.

**Findings:** We identified four centrifugal discourses of disability competing with the biomedical discourse: an agency discourse, an affirmative discourse, a social discourse, and a relational discourse. We uncovered three ways that these centrifugal discourses push against the centripetal biomedical discourse, including: interrupting (agency discourse), opposing (affirmative discourse), and subverting (social and relational discourses).

**Conclusions:** While discourses of disability are often examined and described as isolated categories or models, our study generates an understanding of how competing discourses intersect and interact in critically reflective letters. Our study illuminates modes of discursive resistance at play as competing discourses jockey for dominant positions. Our study captures a snapshot of an ongoing struggle playing out between models of disability in healthcare.

## PODIUM 2.4 – 2:05pm – 2:25pm

### Ghostwriting Grants: A Critical Conversation About the Invisible Contributors to HPE Research Grants

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Grant capture is essential to health profession education (HPE) researchers' academic and professional careers. Grant authorship bestows social and financial benefits, conferring credit, recognizing valued contributions, and validating expertise. Grantwriting is rarely completed alone. Envision the patient partners, research coordinators, librarians, subject matter experts, grant support specialists, and clinicians that make grant writing possible. While research is largely collaborative, some contributors might be missing on grant submissions. Why does some essential grant writing work go unacknowledged/unrepresented and what are the impacts of this 'invisible' work?

Our literature review found that research on ethical issues in manuscript authorship abound, but there is currently limited attention to the adjacent practice of grant authorship. The existing grantwriting literature is predominantly instructional rather than critical; it focuses on how to play the game rather than questioning the way the game is played.

Informed by the literature and through a series of reflexive conversations about our various perspectives and experiences, we spotlight three dilemmas that illuminate 'on the ground' practices and processes influenced by current academic structures that instigate invisibility in grant writing.

The three dilemmas that (re)produce invisibility in grant writing are: choosing career or contract; gaming eligibility; and institutionalizing invisibility. These dilemmas are often themselves largely invisible because they contravene explicit codes and can be construed as 'unethical.' As HPE researchers, educators, administrators, and leaders, elucidating these dilemmas allows critical examination of the unwritten rules governing grantwriting practices and processes. We can then begin to recognize, challenge, and hopefully dismantle the structures and practices that reproduce invisibility.

## PODIUM 2.5 – 2:25pm – 2:45pm

### **Discourses of Shared Decision-Making in Perinatal Clinician Education Materials**

Laura Brereton<sup>1</sup>, Ayelet Kuper<sup>1,2</sup>, Cynthia Whitehead<sup>1,3</sup>, Paula Rowland<sup>1,4</sup>, Kellie Murphy<sup>5</sup>

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There is a lack of clarity surrounding the term ‘shared decision-making’ in HPE, and studies show a discrepancy between how patients and clinicians experience it. Regarding perinatal care specifically, qualitative studies and published narratives convey a sense of disempowerment felt by both birthing patients and their clinicians. As part of a case study examining how institutional power influences perinatal patients’ and clinicians’ experiences of decision-making, we undertook a document review of obstetrics and midwifery education materials. We aimed to identify currently operating discourses relating to communication and shared decision-making in childbirth. Discourses are tacit ‘truths’ or understandings mediated by language and reproduced through social interaction.

Our archive included clinical practice guidelines, Canadian and Ontario-specific policy briefs, continuing medical education resources, as well as post-graduate education materials used at the case site (e.g. residency lectures, grand rounds presentations). This review was informed by Foucauldian critical discourse analysis (CDA) as well as Dorothy Smith’s concepts of institutions, actors and texts. Our method was adapted from Whitehead and Kuper’s (2014) and Greckhamer and Cilesiz’s (2014) approaches to CDA and rigor in qualitative discourse analysis. We find conflicting discourses on the predominance of biomedical knowledge and the value of patient preference, both within and between obstetrics and midwifery texts. Discourses absent from obstetrics texts but present in published narratives and concurrent participant interviews are those on accountability, clinician emotion, and patient self-knowledge. Whether or not these conflicts and absences are explicitly addressed in HPE, learners will face them in making care decisions with patients.

## PODIUM 2.6 – 2:45pm – 3:05pm

### Understanding tone in context: a constructivist grounded theory study of tone emergence in the operating room

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**Introduction/Objectives:** The tone of the operating room (OR) is an under-studied concept shaping team dynamics and performance. Using theories of social emotion and emotional contagion, the aim of this study was to construct a framework for understanding tone, its emergence, and effect on teamwork.

**Methods:** 25 semi-structured interviews were conducted and analysed using a constructivist grounded theory methodology. Study participants included surgeons, nurses, anesthetists, and perfusionists across various specialties and experience levels. Data were analysed iteratively.

**Results:** Participants described OR tone as emerging from team interaction. Several antecedents to tone were identified, each with the potential to affect how team members interact. Antecedents of tone were nature of the case, system pressures, personal circumstances, team composition, and culture. A surgical trainee explained that though the surgeon is perceived to set the tone, there are contextual antecedents, some of which are beyond the surgeons' control, *“Ultimately it is the perception that the surgeon is the one setting the tone. [But there are] different factors that set the surgeons' mood, whether that's due to people or situations in or outside of the room.”* ST2. The tone of the operating room was described as dynamically shaping team factors including shared mental model, psychology safety and resilience.

**Conclusions:** The tone of the operating room is a social construct that emerges from team interaction to shape team processes and factors. In future work, we aim to understand how antecedents can be modified or managed to promote high quality teamwork.

## Day 2: Wednesday October 11, 2023

9:30am – 11:45am

### Theme 3: Learning and Leading: Current Competencies and Future Professionals

Podium sessions: Presentation: 12 min; Discussion: 5-7 min; Transition to next presentation: 2 min

Rapid report sessions: Presentation: 5 min; Discussion: 3-5 min

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#### RAPID REPORT 3.1 – 9:35am – 9:45am

##### Physician Handoff in the Era of Competency-Based Medical Education

Ali Al-Maawali<sup>1</sup>, Allan Puran<sup>2</sup>, Kent Hacker<sup>3</sup>, Catherine Walsh<sup>4</sup>, Daniel West<sup>5</sup>, Zia Bismilla<sup>4</sup>

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**Introduction:** Handover is an integral component of medical practice and describes the act of transferring information, responsibility and authority for patient care between clinicians. I-PASS is a well established handover curriculum which includes assessment of handover using the I-PASSco assessment tool. However, the I-PASSco was developed prior to the implementation of CBME in North America. A novel tool, the Handover Competency Assessment Tool (HCAT) was developed to assess handover skill and make entrustment decisions within a CBME context. Establishing validity evidence for the HCAT tool is essential to support the success and safety of handover within a competency-based postgraduate medical education context in Canada.

**Methods:** Handover was assessed at 2 tertiary care pediatric institutions in Canada using the I-PASSco and the HCAT. Validity evidence for the HCAT was generated in 4 categories: internal structure, relationship to other variables, response process and educational usefulness.

**Results:** 40 trainees were observed for at least 2 handovers each institution. The HCAT had strong validity evidence in all 4 categories.

**Conclusions:** The HCAT is a novel competency-based handover assessment tool with validity evidence for use within a CBME context.

## RAPID REPORT 3.2 – 9:45am – 9:55am

### Defining the Competencies for Pediatric Hospital Medicine Training in Canada

Ali Al-Maawali<sup>1</sup>, Peter Vetere<sup>2</sup>, Allan Puran<sup>3</sup>, Catherine Walsh<sup>4</sup>, Suzette Cooke<sup>2</sup>, Zia Bismilla<sup>4</sup>

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**Background:** The field of pediatric hospitalist medicine (PHM) has grown exponentially over the last three decades and reflects a consolidated effort by many healthcare professionals to directly address care provided to a new generation of infants, children, and youth requiring admission to hospitals. PHM has gained momentum as a potential Area of Focused Competence in Canada, and currently five institutions have developed PHM fellowship programs to provide additional training following the core four-year residency programs in general pediatrics. Despite significant advances in PHM training in Canada, no standard set of competencies has been established at a national level.

**Methods:** Using the Delphi methodology, iterative rounds of questionnaires and controlled feedback was used to obtain consensus on the competencies required for the practice of PHM in Canada.

**Results:** A total of 176 competencies were identified for evaluation by experts in the field of PHM using the Delphi method. 38 participants completed the first round of iterative surveys and 35 participants continued on to the second round. Consensus was reached after the second round with a Cronbach's alpha of 0.97. 110 competencies across 7 CanMEDs roles were established as important for PHM training in Canada.

**Conclusion:** 110 competencies across all CanMEDS roles are important to the practice of PHM in Canada. Canadian PHM fellowship training programs should target these competencies when developing curricula aimed at training the pediatric hospital medicine physicians of the future.

## PODIUM 3.3 – 9:55am – 10:15am

### Using Tests to Promote Knowledge Differentiation to Prepare for Future Learning

Sally Binks<sup>1</sup>, Ryan Brydges<sup>2</sup>, Nicole Woods<sup>2</sup>, Jaimie Coleman<sup>3</sup>, Vyshnave Jeyabalan<sup>4</sup>, Kulamakan Kulasegaram<sup>2</sup>

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**Purpose:** Mobilizing prior knowledge is necessary to maximize current and future learning. We examined how the design of multiple-choice questions (MCQ) in formative tests—or tests intended to promote rather than assess learning—influences how learners recruit prior conceptual knowledge.

**Methods:** Undergraduate nursing and medical students were recruited to participate in a “think-aloud” protocol, in which they verbalized their thought processes as they worked through either the “competitive” (plausible response options) or “non-competitive” (less plausible response options) version of a basic science MCQ test. The think-aloud sessions were recorded, transcribed and coded inductively by a researcher blinded to the study hypotheses. The response processes engaged in by participants in the competitive and non-competitive versions of the test were compared. Analysis of the response process data is currently underway.

**Results:** We expect that 1) participants in the “competitive” condition will recruit a greater degree of their basic science knowledge than those in the “non-competitive” condition; and 2) participants in the “competitive” condition will differentiate this knowledge to a greater degree than those in the “non-competitive” condition. By “differentiate” knowledge, we mean noticing specific features that differentiate similar concepts within a category which in turn can aid clinical reasoning.

**Conclusions:** Testing basic science knowledge using competitive response options in a MCQ test may promote the operation of specific cognitive processes that may optimally prepare learners to benefit from future instruction on a new, related clinical topic. We plan to test this hypothesis in future work.

## PODIUM 3.4 – 10:15am – 10:35am

### Virtual vs. in-person medical school admissions interviews predicting future clinical communication skills: a natural experiment

Conrad Tsang<sup>1,4</sup>, Mark Hanson<sup>5</sup>, Hana Lee<sup>6</sup>, David Latter<sup>6,7</sup>, Kulamakan Kulasegaram<sup>1,6,8</sup>

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Medical school admissions should predict future clinical performance, but 2019-2020 admissions faced significant disruptions when interviews shifted to virtual format. We used this as a natural experiment where both in-person and virtual interviews were used in one application cycle. Due to the timing of COVID-19 public health measures, applicants were effectively 2:1 quasi-randomized to in-person vs. virtual interviews based on their interview date. Using the matriculant cohort (n=244), we modelled the association between the format and score of the admissions interview to our outcome of the Year 2 OSCE Communication score (continuous from 1.00-5.00). We chose this outcome given previous association with interview score and because interviews are the only opportunity during admissions to evaluate non-written communication skills. We used generalized estimating equations (GEE) to control for clustering by interview track. We controlled for metrics used in admissions decisions, including GPA, MCAT subscores, autobiographic sketch score, personal statement score, and reference letter ratings. There was no difference between interview format predicting the Year 2 OSCE Communication score (beta 0.000; 95% confidence interval [CI] -0.082 to 0.081; p=0.996). Each point on the interview score from 1.0-50.0 was associated with a 0.011 increase in OSCE Communication score (95% CI 0.001 to 0.021; p=0.030). There was no interaction between interview format and interview score. No other covariate was statistically significant. Our results add to growing validity evidence for using virtual interviews in admissions. Still, interview performance is statistically significant and weak predictor, demonstrating that admissions processes have room for further optimization.

## RAPID REPORT 3.5 – 10:35am – 10:45am

### An Exploration of Decision-Making within an MD Program Student Progress (Competency) Committee

Tim Mickleborough<sup>1</sup>, Maria Mylopoulos<sup>1,2</sup>, Glendon Tait<sup>2</sup>, and Kulamakan (Mahan) Kulasegaram<sup>1,2</sup>

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**Background:** A key principle of programmatic assessment is that high-stakes decisions regarding student promotion are made in a credible and transparent manner by a committee using a holistic approach. There is limited research to understand how such committees build and evolve expertise in considering data for decisions at a point in time. In this study, we investigate the decision-making of members of a Student Progress Committee (SPC) at the Temerty Faculty of Medicine and whether, over time, they have developed a shared mental model for approaching academic decision making.

**Methods:** To date, 9 semi-structured interviews were conducted (8 members of the SPC and one non-voting member). Interviews are being analyzed using a grounded theory approach. Study recruitment and data analysis is ongoing.

**Results:** Initial results demonstrate how members build expertise in making high stakes decisions through a shared mental model that centres on a series of “checks and balances.” Personal and professional biases are checked through internalized principles of holistic assessment including reflection, active listening and balancing one’s own perspectives with that of other committee members. Having a broad representation of members and dedicated time and space to deliberate decisions is essential to the process.

**Discussion:** Preliminary results can inform how holistic approaches to decision making might improve and could be informative to other undergraduate and postgraduate competency committees. A shared mental model centred around holistic principles ensures that the process has integrity and decisions regarding student promotion are fair and robust.

## PODIUM 3.6 – 10:45am – 11:05am

### **Mind the Gaps Before Boarding the Education Scholarship Train: Programmatic recommendations from staff interviews and a website environmental scan.**

Joyce Nyhof-Young<sup>1</sup>, Susan Hum<sup>2</sup>, Theresa Kay<sup>3</sup>

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**Background:** A key responsibility of academic healthcare institutions is to examine our teaching and contributions to health professions education, broader scholarship, and patient care. Therefore, the Academics Program at Women's College Hospital sought to understand the 'state of the art' of educational scholarship (ES) in healthcare broadly and among our staff to enhance our capacity and impact, while supporting our mandate to revolutionize and ensure equitable healthcare and systems.

#### **Methods**

- (1) Healthcare websites were iteratively identified, ES content examined, and ES assets descriptively categorized and appraised.
- (2) Semi-structured, key informant interviews explored ES experiences, challenges and motivators. Interviews were recorded, transcribed and descriptively thematically analyzed. Recommendations for WCH ES capacity building were generated.

#### **Results**

- (1) 63 websites were inductively organized in 7 categories and content sorted into assets: conferences, rounds/seminars/events, awards/grants, resources, programs, memberships, donors, and collaborators.
- (2) Twenty-nine interprofessional, administrative and research staff participated in 23 interviews and discussed ES motivators/strengths and challenges faced by MD and non-MD staff/clinicians, department leads, and the institution.

**Conclusions:** Recommendations for WCH included developing an applied, participatory, community-centric ES program and culture prioritizing equity, diversity, and inclusion; clinician teacher partnerships/collaborations/training; strategic communications, and ES grants and scholarships, all grounded within program evaluation strategies.

Results are informing our program development strategies and providing ideas, resources, recommendations, and approaches for ES capacity building (e.g., for training programs, incentives, awards, and websites) that align with the needs and priorities of our staff and external partnership networks.

## PODIUM 3.7 – 11:05am – 11:25am

### Conceptualizing and developing leadership in student-led experiences: A scoping review

Dean Lising<sup>1,3</sup>, Jodie Copley<sup>2</sup>, Anne Hill<sup>2</sup>, Julia Martinek<sup>1</sup>, Kathryn Parker<sup>1</sup>, Freyr Patterson<sup>2</sup>, Teresa Quinlan<sup>2</sup>

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**Introduction:** To prepare future providers for complex systems, students require leadership development within their health professional programs. Student-led experiences (SLEs) are workplace-based opportunities where learners provide leadership to services and/or address a gap in the system. Examples include interprofessional training wards, service-learning projects and student-run clinics. However, it is unclear to what extent leadership theory and pedagogy are adopted in developing and implementing SLEs in practice curricula. This scoping review aimed to answer the question: How is student leadership conceptualised and developed within student-led experiences?

**Methods:** The review was conducted in accordance with best practices in scoping review methodology with research protocol registration. This included identification of research question, identifying and selecting relevant studies, study selection, charting the data, collating, summarizing, reporting results and consultation. Inclusion/exclusion criteria scoped SLE literature to health professional students with student-led activities in the practice curriculum. The research team consisted of SLE faculty, knowledge experts and health science librarian.

**Results:** The research team screened 3213 abstracts, identified 275 articles for full text review and selected 99 articles for data extraction and interpretative synthesis with themes of SLE activities, definitions/concepts, objectives, curricular integration, facilitation/supervision and assessment.

**Discussion:** A definition of student leadership is largely absent from the SLE literature. Results show a gap in both how student leadership is conceptualized and how it is taught and assessed within the structure of an SLE. Leadership concepts, roles, alignment of leadership and learning models, facilitation strategies and curricular integration are proposed to optimise SLE service vs learning outcomes.

## PODIUM 3.8 – 11:25am – 11:45am

### Is a Leader a Leader? Validating a potential CPD Leadership competency framework

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**Background:** While leadership is an established competency for physicians, little is known about leadership in Continuing Professional Development (CPD). For over a decade a local education program was designed around four concepts of CPD leadership: adaptive expertise, collaboration, leadership, and systems. During a 2020 redesign, we revisited the foundations of these choices, questioning if the evidence had shifted in the wake of new scholarship and crisis.

We conducted a scoping review of CPD leadership literature, a qualitative study with CPD leaders and leadership program participants; and a descriptive qualitative study exploring experiences of CPD decision-making during COVID-19.

As these studies concluded, we questioned if our original leadership model need revision.

#### **Research Question(s)**

What are the components and competencies of CPD leadership?

**Methods:** Through a process of discussion and expert analysis, we worked through how the findings from the three studies advanced our thinking about the decade-old CPD leadership model. Using scoping review and interview data we constructed a preliminary model of CPD leadership.

**Preliminary Findings:** The preliminary model positions CPD leadership into four key domains: Integration with Systems, Evidence-Informed CPD, Partnerships and Collaboration, and Agent and Advocate for Change, with various sub-domains within each.

**Discussion:** As we test this framework out among the scholarly community, some question if CPD leadership requires its own framework at all, or if, indeed, is “a leader a leader”? This presentation will introduce the preliminary model and invite discussion on the use of a CPD-specific model.

## Day 2: Wednesday October 11, 2023

1:00pm – 3:00pm

### Theme 4: Seeking Equity, Creating Justice

**Podium sessions:** Presentation: 12 min; Discussion: 5-7 min; Transition to next presentation: 2 min

**Rapid report sessions:** Presentation: 5 min; Discussion: 3-5 min

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### RAPID REPORT 4.1 – 1:05pm – 1:15pm

#### Anti-Muslim Discrimination in Medical Training: The Experiences of Resident Physicians

**Abstract submission: The Richard K. Reznick Wilson Centre Research Week**

#### Podium presentation

Meerab Majeed<sup>1,2</sup>, Dr. Abbey Susan<sup>1,2</sup>, Dr. Arfeen Malick<sup>1,3</sup>, Dr. Hashim Khan<sup>1,2</sup>, Dr. Umberin Najeeb<sup>1,4</sup>, Dr. Javeed Sukhera<sup>5</sup>, Dr. Juveria Zaheer<sup>1,6</sup>, Dr. Mohamad Matout<sup>7</sup>, Dr. Danyal Ladha<sup>1</sup>, Dr. Zainab Furqan<sup>1,2</sup>

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**Background:** Anti-Muslim discrimination is on the rise in North America, including Canada, where hate crimes against Muslims tripled from 2012-2015. Over 46% of Canadians hold negative views about Islam. Healthcare settings also witness religious discrimination, with American physician studies reporting rates of 24%-75%. However, a lack of literature exists on this concerning issue in Canadian healthcare. It is imperative that data is gathered about experiences of discrimination within residency training so that medical schools and residency training programs can act appropriately and proactively to ensure the safety of all learners. This study aims to estimate the prevalence of anti-Muslim discrimination experienced by Muslim residents and explore the meaning and impact of anti-Muslim discrimination on residents.

**Methods:** This study adopts a mixed methods approach, employing quantitative and qualitative methods in a triangulation-convergence design. The quantitative arm involves a descriptive survey to examine the prevalence and nature of perceived discrimination among Muslim resident physicians. The qualitative arm utilizes constructivist grounded theory, involving interviews with 25 participants exploring their experiences of discrimination. Data collection and analysis will be simultaneous. An accompanying educational toolkit will disseminate knowledge and skills to address anti-Muslim discrimination in residency programs.

**Results:** This study is currently underway and preliminary analysis will be available before the Research Week.

**Conclusions:** Upon completion, this study will provide a comprehensive understanding of anti-Muslim discrimination experienced by Muslim residents in Canadian healthcare. The findings will identify areas for interventions to address and mitigate discrimination in residency programs.

## PODIUM 4.2 – 1:15pm – 1:35pm

### The influence of resident and faculty gender on assessments in anesthesia competency based medical education

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**Background:** Competency-based medical education (CBME) relies on frequent workplace-based assessments of trainees, providing opportunities for conscious and implicit biases to reflect in these assessments. We aimed to examine the influence of resident and faculty gender on performance ratings of residents within a CBME system.

**Methods:** This retrospective cohort study took place from August 2017 to January 2021 using resident assessment data from two workplace-based assessments, the Anesthesia Clinical Encounter Assessment (ACEA) and Entrustable Professional Activities (EPAs). Self-reported gender data were also extracted. The primary outcome was a gender-based difference in entrustment ratings of residents on the ACEA and EPAs. T-tests and chi-square tests were used to test for significant differences.

**Results:** In total, 14376 ACEAs and 4467 EPAs were analyzed. On the ACEA, across all training levels, 49.11% of female resident assessments were entrusted, compared to 53.02% of male resident assessments ( $p=0.00038$ ), with male faculty entrusting 50.13% of all female resident assessments compared to 54.59% of male ( $p=0.00038$ ). However, after controlling for training level, the proportion of assessments rated as entrusted for female and male residents were not significantly different. For EPAs, there were no differences in the entrustment ratings of male versus female residents. Male faculty provided more comments about strengths for male residents than for female residents in PGY-2 and 3 on EPAs ( $p=0.0038$  and  $p<0.00038$ , respectively).

**Discussion:** Following correction for training level, we found no gender-based differences in entrustment ratings for both the ACEA and EPAs. The higher proportion of male residents receiving comments warrants further investigation.

## PODIUM 4.3 – 1:35pm – 1:55pm

### Ten Million Pounds of Linen and Other Stories: Historical Analysis as a Pedagogical Tool

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Hospitals have never been neutral spaces. They are sites of power and evaluation, of preference and priority. Understandably then, the discourses of a hospital's workforce are far from an unbiased account of labour. Knowledge and analysis of the priorities, conflicts, and collaborations that have shaped past work environments constitutes vital knowledge for health professions education. What has it meant to be a (valued) member of a health care team? Whose contributions have been championed? Whose were rendered less—or even barely—visible? In 1989 TGH's housekeeping staff handled almost 10 million pounds of soiled and clean linen, yet this contribution and others like it remains unacknowledged in historical accounts.

Using the archival records of the University Health Network, we conducted historical and discourse analysis on the identities of profession, gender, and race, to assess key assumptions about the role of members of a health care team. Through this process, it became readily apparent that historical records reveal significant workplace tensions. They demonstrate, for example, a clear preference for specific roles in health care namely, physicians and later nurses, as well as a preference for workforce qualities grounded in problematic hierarchies, including professional status, gender, and race.

To shy away from critical historical examination is to risk perpetuating inequities, devaluing the work of caring by all health providers, and lessening the quality of patient experience. This presentation argues that historical consciousness and historical methodologies offer health professions educators a pedagogical tool that can foster a critical reflexivity of contemporary practice.

## PODIUM 4.4 – 1:55pm – 2:15pm

### **The Conditional Inclusion of Muslims in Medicine: A History of Muslim Medical Students at the University of Toronto's Temerty Faculty of Medicine from 1887-1964**

Roshan Arah Jahangeer<sup>1,4,7</sup>

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#### **Abstract**

##### **Background:**

Although historical research has unearthed processes of exclusion that have impacted the experiences of marginalized communities at Canadian Medical Schools, the history of Muslim Medical students is little known. Our research is the first known study to examine when Muslim Medical Students were first admitted to the University of Toronto's (UofT) Faculty of Medicine (FoM) and their experiences.

##### **Methods:**

This is an exploratory case study with no clear, single set of expected outcomes. We consulted the UofT's Archive & Record Management Services and looked for students who self-identified as Muslim in primary documents from the FoM between 1887-1964, which included student record cards; admissions application forms; letters, reports, and memos from the Dean's Office; photographs; and yearbooks. We used thematic analysis to code and analyse the data for emerging themes.

##### **Results:**

We found six ( $n = 6$ ) Muslim-identifying medical school applicants, who were admitted between 1945 and 1961 and graduated between 1948 and 1966. We also found four ( $n = 4$ ) postgraduates from one South Asian country who may have been Muslim, and who were granted fellowships from the Canadian government.

##### **Conclusions:**

Muslim-identifying students were first admitted to the UofT's FoM in 1945 and continued to be admitted infrequently until 1964. Data on race and religion was no longer requested on application forms after 1964. These early students' experiences included financial hardships despite having privileged backgrounds; discrimination due to being foreign; and conditional inclusion while in medical school. We discussed the study's limitations, as well as directions for future research.

## PODIUM 4.5 – 2:15pm – 2:35pm

### **Discomforts as Growth Points: Multi-case Study of Anti-oppressive Faculty Development Programs in Health Professions Education**

Qian Wu<sup>1,2</sup>, Abigail Fisher<sup>3</sup>, Malika Sharma<sup>2,4</sup>, Hollie Mullins<sup>1</sup>, Lindsay Baker<sup>1,2,5</sup>

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Institutions are increasingly initiating faculty development programs to better prepare faculty to manage issues related to equity, diversity, and inclusion (EDI) across health professions education (HPE) systems. Given the novelty of these programs, little is known about what faculty developers have to navigate when designing, implementing, and sustaining the programs. This study aims to fill this research gap by exploring (a) what tensions arise for anti-oppressive faculty development programs; and (b) how these “discomforts” can potentially be growth points for the programs, as inspired by a pedagogy of discomfort.

This research study adopts a multi-case study design, featuring five faculty development programs situated in Canada and the US. Data includes semi-structured interviews with program coordinator/leads, faculty developers, and facilitators, publicly available and internal records and documents, participant information survey, and cross-case focus groups. Data underwent thematic analysis.

Our findings highlight that despite the various lengths, format, and themes in the anti-oppressive faculty development programs in HPE, there are some common tensions that these programs face. These tensions are finding the sweet spots in program delivery modality; learning anti-oppression: new approaches vs. the norm; never reaching enough people; sustainability vs. financial support; maintaining reliable facilitators vs. capacity of facilitators and staff; and defining success: tensions with evaluation.

This paper will inform academic health science institutions and faculty development programs in the development and delivery of anti-oppressive related programs, in nuanced, ethical, and sustainable ways. All of these efforts take place with a commitment to continually creating a more ethical, anti-racist, society.

## PODIUM 4.6 – 2:35pm – 2:55pm

### **“Disadvantaged from the Start”: An Intersectional Exploration of Experiences of Inclusion and Exclusion in Residency Training Programs**

Justin Lam<sup>1,2</sup>, Han Yan<sup>3</sup>, Ryan Giroux<sup>4</sup>, Adelle Atkinson<sup>2</sup>, Christopher Forrest<sup>2</sup>, Abhaya Kulkarni<sup>2</sup>, Tina Martimianakis<sup>1,2</sup>

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**Introduction:** Although North American postgraduate medical education (PGME) have committed increasing resources to equity, diversity, and inclusion (EDI) issues, trainees continue to experience discrimination and harassment. Excavating the mechanisms for ongoing discrimination is critical to meaningfully align institutional EDI priorities with learner experiences and patient care. To accomplish this, we explored resident experiences of inclusion, exclusion, and discrimination in paediatrics, neurosurgery, and plastic surgery PGME programs.

**Methods:** Participants were recruited using purposive and snowball sampling. We conducted semi-structured interviews until saturation was reached. We used intersectionality theory as an analytic lens for a qualitative thematic analysis to identify how different identities related to experiences and mechanisms of discrimination. Two research team members completed initial coding. An anonymized coding summary was shared with the research team for a second layer of deductive analysis.

**Results:** 12 participants were interviewed. Exclusion experiences were related to degree of discordance between participant and dominant identities in their program. Participants’ exclusion experiences stemmed from implicit assumptions and biases grounded in a patriarchal, Eurocentric medical culture, manifesting as unintentional microaggressions rather than explicitly exclusionary practices. Resident experiences conflicted with programs’ formal EDI commitments. Many participants reported that their marginalized identities advantaged them in caring for patients with concordant identities.

**Discussion/Conclusion:** Aversive racism, through social dominance, implicit bias, and in-group favoritism, mechanistically accounts for ongoing trainee discrimination experiences. Addressing these mechanisms are important for improving equity and inclusion in learning environments.