It's Time to Re-examine Dual Relationship Practice Standards and Policies

Work-in-Progress Presentation

Author: Andrea Gingerich
Presenter: Andrea Gingerich
Time: 1:00 – 2:00

What problem have you identified and/or tried to address?

The assertion that dual relationships—interacting with someone through personal and professional roles--will necessarily impair professional judgment and must therefore be avoided in all but extreme circumstances seem valid on its face but empirical evidence to support that claim is not easily located. Meanwhile, evidence grows that health professionals' quality of life can be negatively impacted by dual relationship practice standards that provide guidance either incompatible with, or impractical in, real-life situations. This is especially troubling because those who practice in communities where dual relationships are inevitable, but struggle to live well while maintaining professional boundaries, leave those already medically underserved communities.

What are you doing or planning (a description of methods and/or innovation)?

I have been collaborating with different teams to study dual relationships. We learned from physiotherapists about the paradoxes of providing care in rural communities while practicing in violation of practice standards. We learned from rural physicians about the strategies they use to navigate dual relationships. We are learning from urban physicians about the complexities of a doctor-patient relationship when the doctor is a doctor-colleague and the patient is a physician-patient. We are about to learn how medical students are impacted by dual relationships during clerkship. Additional studies are being launched soon.

Why would the findings or lessons learned be important (implications)?

If we were to have transformative conversations about dual relationship policies, what evidence would we need to inform those conversations?

"How Much Do I Push?" Physicians' Reflections on Autonomy and Patient-Centeredness in Primary Care

Work-in-Progress Presentation

Author(s): Bjorn Watsjold, Jeffrey Krimmel-Morrison, Judith Bowen, Gabrielle Berger, Jonathan Ilgen
Presenter: Bjorn Watsjold
Time: 1:00 – 2:00

Introduction: Clinical reasoning is often framed in the literature as decision making or medical problem solving, with the implication that correct answers will lead to appropriate care. However, in practice, providers often struggle with ill-defined problems, uncertain treatment options, and unreliable patient participation. In this study, we explore primary care providers' approaches to clinical reasoning in situations without apparent solutions.

Methods: Following constructivist grounded theory, we conducted semi-structured interviews with primary care physicians to explore recent challenging clinical experiences. After initial line by line coding, we used focused coding to define two subsets of data, excerpts in which the provider is trying to manage a patient's illness experience and those in which the provider is struggling with uncertainty in their understanding of the clinical situation. We are in the process of theoretical coding, using wicked problems and sensemaking as sensitizing concepts, and have identified three major categories: navigating differences in problem definition, reconciling patient autonomy with patient-physician relationships, and responding to distress.

Implications: Examining clinical reasoning as a contextualized process in which physicians and patients work together to manage wicked problems allows us to elaborate on constructs of clinical reasoning as problem solving. We will present empirical examples of problem definition and task orientation as critical aspects of clinical reasoning, and will incorporate patient-centeredness in clinical care, and patient autonomy as a principle, into our model. We anticipate future questions regarding how to manage tensions between patients and physicians with asymmetrical problem formulations.

Unpacking Construct-Alignment in Entrustment-Based Workplace-Based Assessment

Author(s): S. Gauthier, A. Gingerich, S. Ginsburg, L. Melvin, D. Taylor, R. Hatala
Presenter: Rose Hatala
Time: 1:00 – 2:00

Problem:
Workplace-based entrustment-supervision scales are key components of assessment in postgraduate competency-based medical education (CBME). While the literature supports construct-aligned entrustment-based scales, it is unclear why construct-aligned assessment instruments generate stronger validity evidence.

Methods:
We iteratively developed a construct-aligned entrustment instrument designed to assess senior residents on the internal medicine Clinical Teaching Unit. Ten faculty members were interviewed to assess for construct-alignment. After using the instrument to assessment senior residents they were supervising, seven faculty supervisors participated in cognitive interviews. The research team conducted thematic analysis to understand supervisor perspectives on the instrument.

Findings:
The assessment instrument aligned with supervisors' perceptions of the construct of supervision for senior medical residents. The rating scale focused on supervisor's self-perception of their own supervisory behaviour (ex, "I had to step in much more than usual"). By focusing on the supervisor's behaviour, as opposed to resident actions, and by self-referencing to the supervisor's usual practice, the assessment felt less judgmental, facilitated constructive feedback and potentially controlled for inter-rater variability.

Implications:
Our construct-aligned instrument is a novel assessment approach for a field that has struggled with misaligned entrustment rating scales that lack validity evidence to support using them. While language is important to ensure construct-alignment, our findings suggest that construct-alignment requires more than simply using the right words on an entrustment scale. Understanding how supervisors view their own supervision was integral to developing the instrument, and elements of norm-referencing to supervisor (not resident) behaviour seems key to the construct-alignment of this tool.

What Do Educators Mean by Professionalism? Exploring Core Concepts

Author(s): Laura Yvonne Bulk, Kelly Allison, Jessie Chai
Presenter: Laura Yvonne Bulk
Time: 1:00 – 2:00

The concept of professionalism is embedded in health professions education and is often seen as synonymous with ethical, accountable, and relational care. However, professionalism standards have been defined by white supremacy culture where codes of conduct, standards of dress, and behaviour reflect dominant cultural norms and devalue and discriminate against some ways of being and interacting. Consequently, we seek to understand what we are trying to teach when using the concept of professionalism. What are the core values/skills we want to teach and what is the best way to teach these? What does professionalism mean through a JEDI lens?

We conducted a literature review and focus groups with educators, and are constructing key themes using a constructivist approach to qualitative data analysis. Preliminarily, based on our literature review we are exploring professionalism as a dynamic relational contract between providers and patients that allows for flexibility within each patient-provider context and recognizes sociocultural, temporal, and geographical influences. Focus groups are underway and will be concluded and analyzed by September 2024. It is vital for educators to have a clear understanding of what is meant by professionalism and professional behaviour so we can effectively support learners in developing these, and so we can be aware of potential biases that may limit opportunities for learners from equity-denied groups.