Wednesday, October 28, 2020
Session 1: Old spaces, New views
Moderator: Victoria Boyd
Time Limit: 10-min presentation followed by 5-min Q&A
https://events.myconferencesuite.com/Virtual_Research_Week/reg/landing

Time	Pod #	Title	Authors	Presenter
1:00-1:15	1.1	New ways of 'seeing' – using systems thinking in the development of competency frameworks	Alan Batt, Brett Williams, Madison Brydges, Matthew Leyenaar, Walter Tavares	alan.batt@monash.edu
1:15-1:30	1.2	Morbidity and mortality rounds as epistemic practice: A critical interpretive synthesis	Paula Rowland, Nathan Cupido, Mathieu Albert, Simon Kitto	paula.rowland@uhn.ca
1:30-1:45	1.3	Making visible our philosophical positions: What goes unsaid when we assess intrinsic competencies?	Walter Tavares, Paula Rowland, Stella Ng, Ayelet Kuper, Farah Friesen, Kathryn Hodwitz, Katherine Shwetz, Ryan Brydges	walter.tavares@utoronto.ca
1:45-2:00	1.4	Safe is as safe does: A study of the SSC using a Safety II approach	Melanie Hammond Mobilio, Sydney McQueen, Elise Paradis & Carol-anne Moulton	Melanie.HammondMobilio@uhn.ca
2:00-2:15	1.5	Medical communication beyond medical education: A critical scoping review	Jacquelin Forsey, Stella Ng, Paula Rowland, Risa Freeman, Connie Li, Sabrina Teles, Nikki Woods	jacquelin.forsey@gmail.com
2:15-2:30	1.6	How does technology impact our definitions of a "good death?" A scoping review and discourse analysis	Michal Coret, Tina Martimianakis	michal.coret@mail.utoronto.ca

PODIUM 1.1 -- 1:00-1:15 [10 min presentation followed by 5 min Q&A]

New ways of 'seeing' – using systems thinking in the development of competency frameworks.

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Introduction

Competency frameworks provide a link between professional practice, education, training, and assessment. They support and inform downstream processes such as curriculum design, assessment, accreditation and professional accountability. However, a lack of organizing frameworks, and difficulties in representing complex professional practice result in uncertainty regarding the validity and utility of competency frameworks. This necessitates additional ways of "seeing" practice when developing competency frameworks. We highlight what a systems-thinking conceptual framework can offer when developing competency frameworks.

A Systems-Thinking Approach

Mirroring shifts towards systems thinking in program evaluation and quality improvement, we suggest that similar approaches that identify and make use of the role and influence of system features and contexts can provide value when developing competency frameworks. We framed a systems thinking approach first by adapting Ecological Systems Theory (EST). EST offers a realist perspective of the person and environment, and the evolving interaction between the two. Second, we utilized complexity thinking, which obligates attention to the relationships and influences, to explore the multiple complex, unique, and context-embedded problems that exist within the messy, real-world system.

Summary

The ability to represent clinical practice when developing competency frameworks may be improved when features that may be relevant, including their potential interactions, can be identified and understood. A systems thinking approach makes visible features of a practice in context that may otherwise be overlooked in the development of competency frameworks.

PODIUM 1.2 -- 1:15-1:30 [10 min presentation followed by 5 min Q&A]

Morbidity & Mortality Rounds as Epistemic Practice: A Critical Interpretive Synthesis

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Introduction: Morbidity and mortality rounds (MMRs) are a learning practice that have been a part of medicine for more than 100 years. More recently, MMRs have become a site of interest for educators, hospital administrators, and governing bodies. As such, MMRs occupy a hybrid organizational space with multiple accountabilities. To date, there have been few examinations of processes of learning as they are emerging in new iterations of MMRs, specifically how those logics of learning are interacting, complicating, or confounding one another.

Methods: To address this conceptual problem, we conducted a review of the literature on MMRs using a critical interpretive approach. The aim of the review was to document how MMRs are constructed in the published literature and to interpret what those constructions imply about the nature of professional knowledge and learning within hybrid organizational spaces.

Findings: Current literature reflects a wide range of competing imperatives manifesting in the design, delivery, and evaluation of MMRs. Some scholars have reflected on the possible implications of a single learning practice attempting to serve both individual learning needs and organizational performance requirements. Despite this, there have been few empirical studies of the potential impact of these multiple imperatives acting on a single learning practice.

Discussion: MMRs serve as an ideal site to explore the epistemic interactions between individuals, organizations, professions, and policy-makers. Understanding how knowledge is produced, contested and maintained across these boundaries is increasingly important for educators seeking to support clinical learning environments and lifelong learning in clinical workplaces.

PODIUM 1.3 -- 1:30-1:45 [10 min presentation followed by 5 min Q&A]

Making Visible Our Philosophical Positions: What Goes Unsaid When We Assess Intrinsic Competencies?

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Introduction: The diversification of philosophical positions informing assessment has broadened views on the nature of constructs, as well as assessment and justification approaches. This diversity may, at times, risk incompatibility in the assumptions underlying one's choices within and between these assessment features, potentially undermining efforts. We investigated how authors used philosophical positions in assessment design and decision-making, in the context of assessing intrinsic roles. We focused on the (in)compatibility of assumptions across assessment features.

Methods: Using a representative sample of studies focused on performance-based assessment of intrinsic roles (e.g., professionalism) we extracted and interpreted information signaling authors' philosophical positions across three key features in assessment: 1) conceptualizations of constructs, 2) structure and delivery of assessment activities (including the role of the rater), and 3) methods of justification and validation.

Results: A total of 50 papers were reviewed from Academic Medicine (n=21), Medical Education (n=9) and Advances in Health Sciences Education (n=20). We found some variability in which philosophical positions appeared to inform each feature of assessment but this required a high degree of inference. This led to uncertainty about authors' underlying assumptions and commitments and therefore compatibility across assessment features could not be examined.

Conclusions: Authors appear to have adopted varying approaches to assessment without clearly articulating how their underlying assumptions justify their decisions. Leaving such details implicit threatens interpretation for those wishing to build on, use, or evaluate the work. As such, interpreting compatibility, and thus defensibility, appears to depend more on who is interpreting, rather than what is being interpreted.

PODIUM 1.4 -- 1:45-2:00 [10 min presentation followed by 5 min Q&A]

Safe is as safe does: A study of the SSC using a Safety II approach

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Background: Most safety-related research is rooted in the Safety I model, which centres on isolating and mitigating error. This approach has helped make healthcare safer, yet has important limitations. For instance, it can result in rigid policies and additional rules that aim to constrain healthcare workers but do not align with the complexities of actual workflows. An alternative approach, Safety II, suggests that it is helpful to consider what "usually goes right." Using ethnographic methods and guided by Safety II, we explored the practice of the Surgical Safety Checklist (SSC) over a two year period.

Methods: Fifty-five observations days, eight semi-structured interviews, and two surveys of OR staff were conducted. Data were collected and analyzed iteratively by the study team.

Results: Despite not following the SSC step by step in the manner predicted by Safety I, we observed that clinicians: 1. consistently put patient safety first in the OR; 2. use (and tacitly acknowledge) workarounds that allow them to be adaptive in their safety practices and meet the demands of their workflows; and 3. are resistant to use safety tools that do not align with their practice.

Conclusions: Using a Safety II framework, we illustrated clinicians' patient safety practices, and described the limitations of Safety I tools like the SSC in the context of one large teaching hospital. We argue that advocating for and ensuring patient safety will require more than rigid protocols: it will require close attention and adaptation to the local practices that constitute safe healthcare delivery.

PODIUM 1.5 -- 2:00-2:15 [10 min presentation followed by 5 min Q&A]

Medical communication beyond medical education: A critical scoping review

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Background/Purpose: Strong verbal communication [VC] skills are essential for physicians. Despite the wealth of medical education research exploring communication skills training, learners struggle to become strong communicators. Beyond medical education a broad literature presents the opportunity to advance teaching of VC in medicine. Social sciences and humanities offer empirical data and theoretical support pertinent to the questions of physician-patient communication and provide insight for translating this knowledge into applications for medical education.

Methods: Combining the search methodology of Arksey and O'Malley with a critical analytical lens, we conducted a critical scoping review of literature in linguistics, cognitive psychology and communications to determine: what is known about VC at the level of word choice in physician- patient interactions? Studies were independently screened by three researchers during two rounds of review. Data extraction focused on theoretical contributions associated with language use and variation. Analysis linked patterns of language use to broader theoretical constructs across disciplines.

Results: The initial search returned 15,851 studies and 210 studies were included in the review. Articles from medicine represented 50% of the included articles, while the remaining 50% divided evenly between linguistics, psychology, and communications. The dominant themes reflected in the results were: (1) explicit language, (2) negotiating epistemic knowledge, (3) activating language, (4) affiliative language, (5) managing transactional and relational goals.

Conclusion: This in-depth exploration supports and contextualizes theory-driven research of physician-patient communication. The findings may be used to support future communications research in this field, and educational innovations based on a solid theoretical foundation.

PODIUM 1.6 -- 2:15-2:30 [10 min presentation followed by 5 min Q&A]

How does technology impact our definitions of a "good death?" A Scoping Review and Discourse Analysis

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The "good death" has been diversely explored, but there is no research, to our knowledge, on the role technology plays in its definition. It is important to explore this topic so that healthcare providers can appropriately integrate technology into their care of dying patients.

This project is a scoping review and discourse analysis of peer-reviewed papers and non-peer-reviewed sources (e.g. news articles, blog posts). We looked for statements related to "good death" and noted associated practices, particularly with regard to the use of technology in the delivery of care.

Our preliminary analysis shows that a dominant discourse in defining a "good death" is the patient being in control. This can be subdivided into control over four elements: end-of-life matters (e.g. financial arrangements), dying process (e.g. controlling the physical environment in palliative care), dying event (e.g. controlling where the death will be), and time after death (e.g. planning one's own funeral). Discourses on technology have more variation, ranging from "technology increases the distance between the patient and doctor" to "technology is under-utilized in palliative care." Notably, technology is seen to be both contributing to patient control (e.g. the patient has access to information to make decisions) and hindering it (e.g. technology has medicalized death and reduced patient autonomy).

Elucidating the discourses on "good death" and technology helps healthcare providers be more aware of the presence and impact of technology in the dying process. This will hopefully lead to more compassionate and patient-centered care during the complexity of the end of life.