A Scoping Review on The influence of prior performance information on ratings of present performance: Implications for learner handover

AUTHOR(S):
- Susan Humphrey-Murto, University of Ottawa, Ottawa, Canada (Presenter)
- Aaron LeBlanc, University of Ottawa, Ottawa, Canada
- Claire Touchie, Medical Council of Canada, Ottawa, Canada
- Debra Pugh, University of Ottawa, Ottawa, Canada
- Timothy J. Wood, University of Ottawa, Canada
- Lindsay Cowley, University of Ottawa, Ottawa, Canada
- Tammy Shaw, University of Ottawa, Ottawa, Canada

ABSTRACT

Introduction: The system of training at many medical schools and at the postgraduate level is fragmented and organized in blocks through which trainees rotate. In a competency-based medical education (CBME) framework, however, assessment and feedback should be continuous. Since longitudinal supervision is often not possible, sharing information about the learner across rotations may enable more efficient and effective tailoring of the educational experience. Learner handover (LH), also called forward feeding, is defined as the sharing of information about learners between faculty supervisors involved in their education. Although many faculty and learners favor the practice, others have expressed concerns that LH may cause stigmatization leading to bias of future assessments. (1) Does the literature support these concerns? There is little information in the medical education literature, but the psychology literature is replete with studies surrounding the potential for bias. (2) When a rater is provided with knowledge of prior performance the following context effects may occur: bias toward the direction of the prior performance level (i.e., assimilation effect), bias away from the direction of the prior performance level (i.e., contrast effect), or no effect whatsoever. These prior performance context effects are undoubtedly relevant to LH. The purpose of this review was to summarize key concepts across disciplines surrounding the influence of prior performance information (PPI) on subsequent ratings.

Methods: Using the Arksey and O'Malley framework, a scoping review was completed to systematically select and summarize the literature from multiple cross-discipline databases. Inclusion criteria were selected to represent PPI relevant to LH; namely, the information must be indirect (i.e. from an external source) and within-subject (i.e. the information is about the same person as the target performance). Using the OVID platform, we searched OVID MEDLINE, including Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Embase, ERIC, PsycINFO, ABI/INFORM (ProQuest) and Business Source Complete (Ebsco) from 1970- January 2018. Since this topic was noted to be very dispersed in the literature and was indexed inconsistently, we added a snowballing-type review and an author search for 16 key authors. A data extraction form was used, and study results were combined using quantitative and thematic analyses.

Results: Of 24,442 records initially identified, 24 studies met inclusion criteria. Research settings included students rating teachers (n=8), job performance evaluations (n=9), employment interviews (n=2), music assessments (n=2), and teachers evaluating students (n=1). Most studies revealed an assimilation effect (i.e., when compared to no PPI, raters exposed to negative or positive PPI scored the same target performances lower or higher respectively). Factors observed to modify this effect included (1) knowledge of poor (negative) PPI were associated with larger effect sizes than those corresponding with knowledge of good (positive) PPI; (2) general standards for performance provided to raters led to greater assimilation than specific standards; (3) increasing processing demands on the rater increased context effects; (4) increasing rater motivation reduced assimilation; (5) rater expertise and training revealed mixed results.

Conclusions: When raters are provided with indirect (external) prior performance information about an individual, an assimilation bias was demonstrated across multiple settings. It is not clear if these findings are generalizable to the medical education milieu, but these results should be considered by educators in the context of learner handover.

Patient involvement in health professionals’ education: A meta-narrative review

AUTHOR(S):
- Paula Rowland, University of Toronto, Toronto, Canada (Presenter)
- Melanie Anderson, University of Toronto, Toronto, Canada
- Arno K Kumagai, University of Toronto, Toronto, Canada
- Sarah McMillan, University Health Network, Toronto, Canada
- Vijay Sandhu, University of Toronto, Toronto, Canada
- Sylvia Langlois, University of Toronto, Toronto, Canada

ABSTRACT

Introduction: More than 100 years ago, William Osler inspired educators to consider health professions education (HPE) as intricately reliant on patients. Since that time, patient involvement in HPE has taken on many different meanings. The result is a disparate body of literature that is challenging to search, making it difficult to determine how to continue to build knowledge in the field. To address this problem, we conducted a review of the literature on patient involvement in HPE using a meta-narrative review (MNR) approach. The aim of this review was to synthesize how questions of patient involvement in HPE have been considered across various research traditions and over time.

Methods: MNR is a form of knowledge synthesis concerned with exploring the history, guiding assumptions, and key findings that exist within disparate research traditions comprising a scholarly field. Procedures for this study followed the guidelines published by RAMESES and evolved through three main phases: collecting the archive, analysis, and interpreting intersections between higher order concepts. The search process and resulting analytical procedures were informed through ongoing consultations with an expert advisory council. Sources included in the review included primary studies, review articles, conceptual pieces, and editorials related to patient involvement in health professions education. We excluded from our search articles that were solely concerned with patient involvement in clinical care and were not explicitly linked and/or theorized in relation to learning or education. To manage the scope of the review, we excluded sources that were concerned with patient involvement in patient education. Our final archive included 295 sources for analysis.

Results: In this paper, we focus on three meta-narratives of patient involvement in HPE. These meta-narratives refer to coherent ways of thinking in which patients are constructed in particular ways, specific rationales for patient involvement are offered, and different research traditions are put to use in the field. We labelled these three meta-narratives in terms of their main areas of concern: (1) democratization of health professions education, (2) creation and maintenance of reproducible learning and assessment practices, and (3) developing social understandings of learning in care contexts.

Discussion: Attending to the intersections between these three meta-narratives, we focus on a core concept in patient involvement in HPE: the notion of “active patient engagement”. In our analysis, we came to understand three different ways in which the “active patient” was conceptualized: politically, instrumentally, and theoretically. These different constructions of “active patient engagement” lend themselves to different program designs, scholarly traditions, and possible debates.

Conclusion: Patient involvement in HPE is being performed in multiple ways simultaneously. The outcomes of these performances invariably differ, as does their potential for unintended consequences. For example, where patient involvement performs as a political exercise, questions of patient voice, representation, and representativeness become relevant, but accountabilities to learners along the principles of transparent assessment practices and equitable learning opportunities may be less visible. When patient involvement performs as an instrumental endeavour, accountabilities to learners may be more explicitly addressed, but unintended and unexplored paternalism towards patients may persist. Future research into patient involvement in HPE may not be best served by asking “does this work?”, but instead by asking “what work does this patient involvement do?”, “for whom?”, and “how will we know?”.  

Educational implications of clinical service divisions: a Bakhtinian analysis

AUTHOR(S):
- Clare Whitehead, University of Manitoba, Winnipeg, Canada (Presenter)
- Brett Schrewe, The University of British Columbia, Victoria, Canada
- Jeffrey Hyman, University of Manitoba, Winnipeg, Canada
- Ayelet Kuper, University of Toronto, Toronto, Canada

ABSTRACT

Introduction: Delivering compassionate, person-centred care is at the heart of medical practice. Specific learning contexts, including different residency rotations, may shape how trainees learn to provide such care. At our study site, patients are admitted to one of three general paediatrics services depending on where they live and whether their primary care provider is a paediatrician. While Services B and C primarily admit children who either live in the urban centre where the hospital is located or in communities in the south of the province, Service A admits patients who come to hospital from remote and isolated communities in northern Canada. Most of these are Indigenous communities with no road access or running water, high costs of living, and overcrowded substandard housing. In this project we sought to examine what the separation of patients into inpatient services based on their socio-demographics might be teaching paediatric residents about the delivery of effective person-centred care.

Methods: The theoretical framework for this project derives from the work of Russian linguist and literary theorist Mikhail Bakhtin. We drew on Bakhtin's concepts of dialogue and monologue, including the finalization that results from monologic interactions. Bakhtin describes finalization as an idea becoming fixed, such that it can no longer be challenged or questioned, often resulting in a person being portrayed without nuances to distinguish them from broad societal ideas about their identity. Our methodology was an instrumental case study with three embedded units (Services A/B/C). We iteratively gathered data via semi-structured interviews with current paediatric residents, focusing on their experiences interacting with patients and families on the three inpatient services. We coded and analyzed the interview transcripts using Bakhtin’s concepts as a theoretical lens, seeking to understand how trainees described patients and families on each service and how this shaped the care they had learned to provide. The subset of findings in this abstract focuses on one of these services (Service A), with the other two services acting as comparators.

Results: We found that paediatric residents quickly learn to finalize patients and families admitted to Service A, describing them as a homogeneous group. Their families are described as being physically absent from the hospital; disengaged from their child's care; and not understanding what is happening in hospital. This finalization has negative consequences for effective communication (which is often not seen as possible) and for advocacy for systems change (at the hospital or within the broader system). Residents articulate being aware of, and indeed deeply troubled by, this finalization and its implications. They do not believe that it is a desired outcome of their educational program, but they also do not know how to move beyond it within the constraints of their hospital setting.

Discussion & Conclusions: The system for dividing up inpatients into the three different general paediatrics services at this children's hospital in Canada was developed based on historical factors. This project identifies the resulting finalization of patients and families on one specific service, leading to troubling implications for education, resident wellbeing, and ultimately patient care. Our analysis has implications for understanding structural barriers to person-centred care in clinical contexts and points to potential educational interventions to mitigate their effects.

References:
#8F Research Papers - Review of Literature

**8F4 (105)**

**Date of Presentation:** Tuesday, 27 August 2019  
**Time of Presentation:** 1500-1520  
**Location of Presentation:** L6, Level 1

**Factors influencing autonomy supportive consultation: a realist review**

**AUTHOR(S):**
- Joyce Kors, Amsterdam UMC, Vrije Universiteit Amsterdam, Research in Education, VUmc School of Medical Sciences, Amsterdam, Netherlands (Presenter)
- Emma Patternotte, Meander Medisch Centrum, department gynecology & Obstetrics, Amersfoort, Netherlands
- Linda Martin, Amsterdam UMC, Vrije Universiteit Amsterdam, Midwifery Science, AVAG, Amsterdam Public Health research institute, Amsterdam, Netherlands
- Corine Verhoeven, Amsterdam UMC, Vrije Universiteit Amsterdam, Midwifery Science, AVAG, Amsterdam Public Health research institute, Amsterdam, Netherlands
- Linda Schoonmade, Vrije Universiteit Amsterdam, Medical Library, Amsterdam, Netherlands
- Saskia Peerdemans, Amsterdam UMC, Vrije Universiteit Amsterdam, Research in Education, VUmc School of Medical Sciences, Amsterdam, Netherlands
- Rashmi Kusurkar, Amsterdam UMC, Vrije Universiteit Amsterdam, Research in Education, VUmc School of Medical Sciences, Amsterdam, Netherlands

**ABSTRACT**

**Introduction:** Traditionally the patient-healthcare professional relationship was paternalistic, in which the professional made the decisions on behalf of the client. There has been a paradigm shift away from this type of encounter toward a more patient-centered care, in which the patient is more empowered, informed, and autonomous. We know that there is room for improvement in the way professionals facilitate patient’s empowerment and autonomy during consultation. Autonomy supportive consultation is theoretically based on the Self-determination Theory, a general theory of human motivation. By satisfaction of three fundamental psychological needs: autonomy, competence and relatedness professionals could facilitate more autonomous forms of self-regulation of health among patients (Ng et al, 2012). The aim of this review is to determine how contextual factors support or hinder the development of an autonomy-supportive climate and identify the factors which influence the mechanisms to support a patient’s autonomy before, during and after decisionmaking in consultations and the outcomes.

**Methods:** We conducted a systematic review of the literature using the realist synthesis method guided by RAMESES guideline (Wong et al, 2013). A realist review allowed us to analyze heterogeneous evidence to understand an underlying mechanism. The data are analyzed using the model of context, mechanism and outcome. Literature searches were performed by an experienced information specialist in Pubmed, Embase, PsycINFO and Cinahl. These databases were searched using a combination of the following keywords and synonyms: Autonomy, Support, Consultation/communication and Intervention. The titles and abstracts of the articles were screened independently for inclusion by two authors. Second two authors assessed the full texts of the remaining articles for inclusion. The focus was on empirical studies involving autonomy support of clients or patients in an individual interaction in a healthcare setting. Any disagreement was discussed and resolved through consensus. Data extraction, analysis and synthesis was finalized with the full research team.

**Results:** Out of 2200 articles which were found through the search, 16 met the inclusion criteria. Five of these articles investigated the provider perspective and 11 articles used the patient perspective. We first filtered the context factors and found that the work organization, the attitude and competence of a professional are important factors for creating an autonomy-supportive climate during a consultation. As mechanisms we found overarching factors and ones which were important before, during and after the decision-making. The most crucial overarching factor was knowing the client. During the decision-making process respectful interaction on rational and emotional issues was important. Two relevant patients outcomes we found were higher perceived decision satisfaction and higher compliance for treatment or behavior change.

**Discussion & Conclusions:** Healthcare providers like to give information but hardly provide autonomy support during consultation. In this review we found that to realize an autonomy-supportive climate the attitude and competence of professionals play a crucial role. To facilitate the transition to become a more autonomy-supportive professional, training is required. Based on the new insights generated into context and mechanisms of autonomy support we intend to develop a framework for training.
