The Privacy and Exchange of Learning Information in PGME

Disclaimer: Individuals may be subject to mandatory reporting obligations by the legislation or policy governing the regulation of physicians, including trainees. This document is not intended to and does not supersede any such regulatory requirements or any individual privacy rights guaranteed by provincial or federal privacy legislation. Please contact your medical regulatory authority for more information.*

In a competency-based system, the focus on learner outcomes and formative support is a key success factor. Highlighting learner strengths and offering positive steps for improvement are effective in ensuring future success of the individual.[1, 2] This statement is intended to guide the Postgraduate Medical Education (PGME) community in processes for sharing learning information across transitions in education, to ensure residents are ready for independent practice.

To ensure efficient and accurate provision of ongoing support to a learner, and to ensure that past efforts to optimize tailored learning are preserved and not duplicated, it is important that those taking on supervisory functions have some information about the individual's learning needs, state of learning, and current educational goals. The Learner Education Handover (LEH) project is currently addressing one of the key transition points, from Undergraduate Medical Education (UGME) to PGME, but multiple transition points exist during PGME where similar processes could be of use. The PGME Collaborative Governance Council recognized that proposals to share individual learning information within and across PGME institutions are in need of deeper analysis, and struck a working group to make recommendations on the matter.

As explained in appreciative inquiry theory, information sharing can be used as an instrument for improving performance in motivated professionals and can be a positive factor driving career success.[3] In this model, the professional is involved in an interview or process focusing on the positive, which leads to advancing individual strengths. [2] On the other hand, feedback, which can focus on negative factors as opposed to only internal factors of an information exchange exercise, can lead a motivated person to a decline in performance.[3] Correctly done, information exchange can build from a state of positive imaging and messaging to shape the learner for career success in the future. [1, 2, 3] Consistent with a mentorship model, this information exchange must be formative, transparent, clearly communicated and learner-centered, to increase buy-in and acceptance from both learners and faculty. On top of the benefits for

* ***For example, in Ontario, specific statutory reporting obligations may apply and in Québec, there are specific regulations that may apply.***

individuals involved in medical education, more comprehensive assessments will help improve social accountability to health system funders and the communities we serve.

In creating this document, opinions from a broad community were considered. It was felt that information exchange should be viewed through an educational lens concerning issues of "learning" and not of "learner" (such as issues concerning professionalism or regulatory outcomes). It is thus accepted that in this learning context, a learner's right to privacy must be respected and information exchange must be transparent and require explicit informed consent.

The following key principles and recommendations are intended to help programs, learners and leaders understand and better plan for implementing education information sharing processes in medical education. Ongoing inquiry is also required to help guide future work on useful information to transfer, specific protocols and regulations for transferring learning information, ownership and protection of data/information, and the role for Learner/Student Affairs offices. Attention must also be given to the inherent challenges and risks for medical schools and their faculty, including: workload/capacity, faculty development to ensure standardization of information collected and transferred, potential litigation and outcome disputes from learners, and the influence of the hidden curriculum and bias on assessment in medical education.

Key Principles
1- The main purpose of postgraduate medical education is to prepare learners for independent practice and lifelong learning.
2- Learner information exchange must be undertaken transparently with explicit learner consent.
3- Learner information exchange must be formative to improve learner outcomes, focused on principles of education.
4- Information exchange must be of value for the learner, faculty and program.
5- Processes and procedures should be in place to govern the appropriate access, use, sharing, and secure storage of learning information, as well as a dispute resolution process.
6- A senior educational lead, informed on appropriate use of learner information, should be responsible for managing the process.
7- Learning information exchange tools should be standardized across all institutions and programs.
8- To ensure maximum effectiveness, processes should be adopted by all Canadian medical schools.

Potential Time Points for Information Exchange[†]
From UGME to PGME (post-CaRMS match) *LEH project covering this transition
Between rotations within PGME
From specialty to subspecialty
From a FM program to an Enhanced Skills program
On transfer to another PGME program

[†] Taking into consideration the stated objective of sharing educational data between institutions involved in medical education, the 'PGME to Practice' time point was voluntarily omitted since presently the management of a practicing physician's life-long learning becomes their professional responsibility and not an outside institution's responsibility. This omission in no-way discounts the value of creating end-of-training reports to help learners continue to build on their educational path.

Recommendations
1- The PGME Collaborative Governance Council endorses a system for exchange of learner information across the PGME spectrum.
2- A central project team comprised of PGME Deans, learners, FMRAC, program directors, a CaRMS representative, an UGME Dean, a Student Affairs Dean, a consumer and faculty representatives will oversee the implementation work done locally in each school.
3- A schools' system should adhere to the principles outlined above.
4- The process should align with the AFMC Learner Education Handover protocol.
5- The goal is to develop a national document specifying the content of information exchanged and the process related thereto. This will ensure not only that similar practices are carried out within institutions, but also that information can be consistently exchanged between institutions.
6- The PGME Collaborative Governance Council should oversee the work of the project team and support uptake of the eventual national document.
7- The PGME Collaborative Governance Council should request that the AFMC continue to support the work of the project team as secretariat and ensure alignment with other elements within the education spectrum (UGME and CPD).
8- The PGME Collaborative Governance Council should plan an approach to ensure widespread adoption, including working with the national accrediting Colleges to incorporate the final recommended document into accreditation standards when appropriate.
9- The PGME Collaborative Governance Council, project team and the AFMC leadership should offer for 2 years a workshop on this project for adoption at the Canadian Conference for Medical Education (CCME), starting at CCME 2019.
10- The PGME Collaborative Governance Council acknowledges that the specific time point of transition to practice is not being addressed by this project, but is a point of potential information exchange that needs to be explored by all involved.

Bibliography

1. Goldsmith, M. (2003). Try feedforward instead of feedback. *Journal for Quality and Participation*, 38-40.
2. Budworth, M. H., Latham, G. P., & Manroop, L. (2015). Looking forward to performance improvement: a field test of the feedforward interview for performance management. *Human Resource Management*, *54*(1), 45-54.
3. Kluger, A. N., & Van Dijk, D. (2010). Feedback, the various tasks of the doctor, and the feedforward alternative. *Medical education*, *44*(12), 1166-1174.