A leadership challenge paper in support of UNESCO Futures of Education 2050

Imagining Possible Futures for Accreditation of Postgraduate Education in Canada: Prioritizing Trust

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The Challenge

In Canada, postgraduate medical education is governed by three national accrediting colleges that make up the Canadian Residency Accreditation Consortium (CanRAC). The approach to postgraduate (PG) accreditation follows the dominant standards based approach to quality assurance ("Rethinking Quality in Post-Secondary Education | teachonline.ca," 2015). The PG accreditation standards were overhauled through an extensive process of collaborative consultation with stakeholders across the country and a new standards framework was released in July 2017 ("CanRAC: Timeline for Policy Reform," 2018). But despite the renewal of the accreditation standards and the updates to the accreditation system we seem to be left with a remarkably similar system to the one that was previously in place. PG accreditation continues to rely heavily on documentation as evidence of compliance and includes an accreditation on-site survey visit at least every 8 years (previously every 6 years). With all of the effort that went into accreditation reform, how did we end up with something that was arguably so similar?

UNESCO has launched a global initiative to rethink how knowledge and learning can shape the planet called the *Futures of Education: Learning to Become*. "The initiative is catalyzing a global debate on how knowledge, education and learning need to be reimagined in a world of increasing complexity, uncertainty, and precarity" ("Futues of Education: Learning to Become," n.d.). UNESCO's approach looks at bringing about lasting changes by re-considering our assumptions of the way 'things are', and consequently 'have to be' and consciously deciding what direction we should be moving towards. But in order to do this we must first understand what assumptions we have taken for granted and allowed to guide our future.

In medical education the concept of the 'Hidden Curriculum' is used to unpack implicit learning that is happening throughout training (Hafferty, 1998). Hidden curriculum studies draw our attention to the fact that "it is much more difficult to see one's own culture because it appears to be not cultural at all, but rather just the way things are: common sense, human nature, truth" (Taylor & Wendland, 2014, p. 58). This may explain what happens in many renewal projects. Unless we take the time to dig deep into our understanding of our systems, including the implicit messages and underlying assumptions, true change can be elusive. When diving into the hidden curriculum we are hoping to have the experience of traveling to another country and learning as much about our own culture, as about the place we are traveling, while we are away (Phelan & Russelbaek, 2020). By experiencing another world view we can start to see the possibilities beyond what we had previously accepted as truths.

It is acknowledged that accreditation can socialize individuals or signal to them to what is important in an organization (Teodoro & Hughes, 2012). Yet the hidden curriculum of PG accreditation is not often considered. As in the case of programs, identifying the hidden curriculum is an important step in consciously deciding if those are the messages and signals

that we want to be sending and perhaps broadening our concept of education as we consider other world views.

The Task

This paper will use the casual layer analyis framework to explore the theme of trust as it plays out in the hidden curriculum of PG accreditation in Canada with the aim of conceptualizing preferred futures that we can consciously work towards that are beyond the normal discourses and mindsets.

Trust

In keeping with the UNESCO definition that education is about "sustaining the dignity and capacity of the human person" this research looks at the hidden curriculum of PG accreditation as it relates to trust. Trust may not be the most intuitive aspect of education in north American culture, but it is certainly an important aspect of sustaining dignity as we learn. And trust is a cornerstone of medicine (Fritz & Holton, 2019). It can be defined as:

"*a judgement by the trustor, requiring the acceptance of resultant vulnerability and risk, that the trustee (individual or organisation) has the competence, willingness, integrity and capacity (i.e. trustworthiness) to perform a specified task under particular conditions"* (Damodaran, Shulruf, & Jones, 2017, p. 894).

In the setting of healthcare, the importance of trust goes beyond the doctor patient relationship. Individuals place their trust in their physicians but also in the education system that trains Canadian doctors (Green et al., 2009; Nasca, Philibert, Brigham, & Flynn, 2012; Young & Elnicki, 2019). The theme of trust is pervasive throughout medicine but let us consider how the narrative of trust works within the accreditation process. Damodaran, Shulruf and Jones (2017) conceptualize trust in medicine as having both interpersonal and organizational elements. For our purposes we have expanded organizational to include the concept of industry and also added the underlying theory of program evaluation in accreditation. As such the analysis in this research focused on the role of trust in accreditation as it relates to: the underlying evaluation theory, interpersonal or relationship based elements, and the organizational or industry factors.

Causal Layer Analysis

A causal layer analysis (CLA) was conducted as the means to explore the depths of the hidden curriculum while focusing on uncovering possible futures. The CLA's 4 levels of analysis: The Litany (level 1), Systematic Causes (level 2), Paradigms and Worldviews (level 3) and Myths and Metaphors (level 4) support us to consciously consider the assumptions that are current systems are based upon and if we want to continue in those directions as we move into the future. As Inayatullah describes

"*[the] causal layered analysis includes this metaphorical dimension and links it with other levels of analysis. It takes as its starting point the assumption that there are different levels of reality and ways of knowing. Individuals, organizations and civilizations see the world from different vantage points – horizontal and vertical."* (Inayatullah, 2009, p. 10).

We will use the CLA as our mode of transportation, the train that takes us away from our home, so that we can turn and look back on it, seeing it from a different vantage point for perhaps the first time. Table 1 shows the CLA exploring the 3 elements of trust: Underlying Theory (T), Relationship Based (R), and Industry (I)] in accreditation of PG training programs in Canada.

Table 1: Causal layer analysis of hidden curriculum of trust in PG accreditation

Level 1 - Litany
• We acknowledge that accreditation is a labour intensive but it must be done (dos Santos, Snell, & do Patrocinio Tenorio Nunes, 2017; Green et al., 2009; Nasca et al., 2012) (T) • Move towards focusing on quality improvement processes rather than a pass/fail approach to accreditation (Akdemir, Lombarts, Paternotte, Schreuder, & Scheele, 2017; "CanERA Policy Manual," 2018; dos Santos et al., 2017) (R) • Postgraduate Medical Education occurs in a complex system and difficulty role of accreditation to capture complexity (Busing et al., 2015; Damodaran et al., 2017; dos Santos et al., 2017) (I) • There is a new era in accreditation (Akdemir et al., 2017; "CanRAC: Timeline for Policy Reform," 2018) (I)
Level 2 – Systematic Causes
• Self-regulating profession – reliance on other Canadian physicians within our system to act as survey team members rather than getting an outsider's perspective (dos Santos et al., 2017; Nasca et al., 2012) (T) • Limited time for in-person portion of accreditation visits impacts ability to form trusting relationships between surveyors and program stakeholders (R) • Reliance on documentation and seemingly high stakes visits (Akdemir et al., 2017; dos Santos et al., 2017) (I) • Accreditation is a business whose services can be sold internationally (Al-Lamki & Al-Lamki, 2016) (I)
Level 3 – Paradigms or World View
• Standards as a measure of quality (Akdemir et al., 2017; dos Santos et al., 2017; "Rethinking Quality in Post-Secondary Education | teachonline.ca," 2015) (T) • Writing it down makes it real or at least makes us accountable and increases bureaucracy (Akdemir et al., 2017) (T) • Outcomes focused standards (Akdemir et al., 2017; dos Santos et al., 2017) (T) • Built on the premise that faculty and learners can see their programs well enough as insiders to synthesis and provide meaningful feedback but hidden curriculum questions that assumption (Hafferty, 1998)(T) • Trust is a cornerstone of Medicine and that professional extends into accreditation as the program stakeholders place their trust in the review team members (dos Santos et al., 2017) (R) • System is built on understanding that surveyors will experience the authentic program during their brief accreditation visit but may not be the case (dos Santos et al., 2017) (R) • Accreditation systems are transportable between countries because standardization equals progress (Al-Lamki & Al-Lamki, 2016) (I)
Level 4 – Myths and Metaphors
• The standards represent what matters because we are able to name and identify that within our system (T) • A decision on if the standards are being met or not is being made by insiders to the system (T)

- The group experience of faculty and learners is privileged over the experience of individual learners and teachers (R)
- There is a distinction between outsiders and insiders even though they are both within the same paradigm and control should lie with the outsiders (dos Santos et al., 2017) (R)
- Despite the discussion of the complexity of our system, programs are distinct entities whose efficacy can be evaluated or assessed for all learners that participate in them – regardless of how varied the learners are (I)
- Time and resources are limited commodities (dos Santos et al., 2017) (T, R, I)

Future Possibilities for Trust in the Theory Guiding Accreditation

The public trusts regulating bodies to ensure that our training programs are meeting a standard of quality and producing competent physicians (Green et al., 2009; Nasca et al., 2012; Young & Elnicki, 2019). The approach has been to develop standards that measure quality and focus on outcomes rather than process (Akdemir et al., 2017; dos Santos et al., 2017; "Rethinking Quality in Post-Secondary Education | teachonline.ca," 2015). Operationaly this is done through documented evidence (Nasca et al., 2012). We privilege documentation as evidence, as though by writing it down, it becomes real. A program isn't a program unless it has a curriculum map, agendas and minutes for meetings, and pages of narrative descriptions.

"*As an example, before an onsite visit a surveyor might receive more than 1000 pages of documentation to analyze in about a week. The comments of the participants suggest that the weight given to this data makes the process stressful*" (dos Santos et al., 2017, pp. 4–5)

The burden of documentation on programs and survey team members is a real consideration that interferes with their ability to do their jobs running training programs, teaching learners and caring for patients (dos Santos et al., 2017; Green et al., 2009; Nasca et al., 2012).

The CLA identifies two myths underlying this reliance on documentation: 1. that the standards matter and 2. that they are measurable independent of norm referencing. Nationally a group of Canadian physicians collaborated extensively to develop the accreditation standards, but were they able to see their system objectively enough given that they were 'insiders' whose thinking was intimately embedded in the previous accreditation system? And then on top of that we need to recognize that the group of surveyors who assess programs during accreditation visits are conceptualized as 'external reviewers' because they come from other universities, but they are not true outsiders (dos Santos et al., 2017). When they review a program, they bring with them all their understandings of the system and determine if the program is doing a good enough job based on what they perceive as possible within the system. Rather than viewing the standards as requirements that programs must meet, we should recognize that they are actually better measures of proximity to what other programs have been able to accomplish nationally.

By moving around the myths that the standards matter and that the standards are measurable, we could conceptualize a system of accreditation that does not have a list of 37 requirements and 141 indicators that are meant to prove that a program is good enough. Surveyors may be given a list of themes to explore instead. Or they may focus on what makes sense for a specific context, without drawing firm boundaries around what is included in the program and what is a product of the context it exists within. This would require a shift in where we place our trust, as we moved from relying on documentation, to relying on the surveyor.

Future Possibilities for the Role of Trust in Interpersonal or Relationship Based Elements of Accreditation

The second element of trust included in the CLA was that of interpersonal relationships. This element includes the relationship between the survey team members (givers of feedback) and the programs (receivers of feedback) and hinges on the idea that trust is built over time (Fritz & Holton, 2019; Ramani, Könings, Ginsburg, & van der Vleuten, 2019). The concept of the importance of trust and feedback has been explored and prioritized in our implementation of competency based medical education in our training programs (Damodaran et al., 2017; Young & Elnicki, 2019) but not necessarily in accreditation. The schedule for survey team members is grueling (dos Santos et al., 2017). There isn't time for stakeholders to form relationships of trust with the survey team members before sharing their perspective on the program. There isn't time for program directors to form trusting relationships with the survey team members before receiving their feedback on the program. By prioritizing time constraints, the trust needs to be automatically conferred. To some degree we hope that the limitations of building trusting relationships in the short period of time is mitigated by the feeling that surveyors are peers who understand the process and have been through it themselves (dos Santos et al., 2017).

What would we change if we decided that trust was more important than the myth of limited resources including time? Prioritizing trusting relationships between the surveyors and program directors may allow programs to internalize the need for true change when they receive feedback instead of focusing on how to avoid being called out on that same weakness again next time. Trust may shift the experiences of survey team members who describe that "[t]he accreditation visit seems to be a theater" (dos Santos et al., 2017, p. 3) rather than an authentic look at the program. Future possibilities could include coaching relationships between program directors nationally. Instead of having a surveyor visit a program once, programs could be paired together as mentors to share ideas and trouble shoot problems for extended periods of time. The accreditation process could mandate that every program relies on an outside mentor or coach that helps to offer an in-depth perspective on how the program rather than a surveyor who visits for a single day.

Future Possibilities for the Role of Trust in Organizational or Industry Factors of Accreditation

The third element included in the CLA was trust as it is conceptualized for organizational or industry factors. A predominant litany is that medical education occurs in a complex system

(Busing et al., 2015; Damodaran et al., 2017; dos Santos et al., 2017). Yet despite the complexities of the system, programs are conceptualized as distinct entities whose efficacy can be evaluated for all learners that participate in them. Our mental model requires that we put boundaries around programs so that we can evaluate them clearly. Our mental model requires programs to be distinct entities so that the standards that govern them are transferable between contexts nationally and internationally (Al-Lamki & Al-Lamki, 2016). The process of breaking down competence into competencies and then milestones moves them from "the realm of the abstract and grounds them in a way that makes them meaningful to both learners and faculty." (Nasca et al., 2012, p. 1054). The myth that meaning comes from being able to capture something on paper, document it, and define it, is pervasive. But programs are not actually distinct entities. Let's consider an example. If a learner expresses during an accreditation visit that patients frequently discriminate against them, where does that fit into accreditation? There are standards regarding safety and wellness in the learning environment but no indicator specifically dealing with the conduct of patients (*General Standards of Accreditation for Residency Programs*, 2018). A surveyor may feel compassion towards the trainee for their lived experience but may also easily determine that that this issue is outside the boundaries of the program as defined by the accreditation system.

In a true system of continuous improvement we could conceptualize an accreditation system that does not require programs to be distinct entities and allows for ambiguity. Learners and all stakeholders could trust that the issues that impact them are up for discussion.

The Journey to 2030 for Medical School Accreditation

Accreditation is a "heavy growing machine" and even small changes take time (dos Santos et al., 2017, p. 4). Radical departures from the way that we do things are seen as risky. But right now there is an opportunity. The UNESCO *Futures of Education: Learning to Become* initiative sets the stage for thinking about deliberate future planning on the global scale. Additionally, the current reality of the Covid-19 pandemic is pushing every industry to change and adapt quickly and to become more comfortable with, or at least more practiced at, dealing with ambiguity (Durodié, 2020). What would happen if we asked "What can we achieve if we remove all barriers from the system?" (Jada, 2015). Most of the barriers we face are grounded in beliefs that we have accepted as true, and real, but are actually social constructs that could be changed if we decide it's important enough. It is that kind of 'out of the box' thinking that we need when conceptualizing possible futures.

For PG Accreditation, steps to moving forward should begin with a thorough review of the hidden curriculum in our PG accreditation system. Trust is just one facet that needs to be considered when moving forward. We need to work conscientiously to uncover the 'truths' that we have internalized prior to determining if we want to accept and keep those foundations moving forward. I anticipate this first step will be the most difficult.

The second step is to address the myth that time and resources are limited by getting an accurate picture of what is currently being put into the system and where the burden lies. We

cannot understand what the limits are unless we understand what resources and assets we are currently devoting to this work and what the "opportunity costs" of these investments are It is possible that by shifting where we place our efforts major changes in the system can be accomplished without more resources being added.

The third step is piloting at the local level. Accreditation systems struggle with the 'glocalization' of medical education; setting standards that meet global needs as well as local needs (Ho et al., 2017). Recognizing that the needs, contexts and resources are different at the local level than the national level would enable Universities to conduct their internal reviews differently. Rather than mirroring the reviews done by the national accreditation organizations, internal reviews should make space for pilot testing of radical changes in the program evaluation theory and model of PG accreditation.

There is a lot of risk in changing a system that we have put so much trust in. But instead of looking at the gains that we have made to hold programs nationally to the status quo and cling to those as measures of success, if we think about the problems within our system (lack of diversity in medicine, cost of our healthcare system per capita, barriers to individualized medicine (Jada, 2015), a lack of understanding of public health and alternative medicine) questioning our underlying paradigms becomes more than just risky, it becomes necessary.

References

Akdemir, N., Lombarts, K. M. J. M. H., Paternotte, E., Schreuder, B., & Scheele, F. (2017). How changing quality management influenced PGME accreditation: a focus on decentralization and quality improvement. *BMC Medical Education*, *17*(1), 1–9. https://doi.org/10.1186/s12909-017-0937-9

Al-Lamki, N., & Al-Lamki, L. (2016). International accreditation of postgraduate medical education: Whither its role in Oman? *Oman Medical Journal*, *31*(1), 1–4. https://doi.org/10.5001/omj.2016.01

Busing, N., Harris, K., Maclellan, A. M., Moineau, G., Oandasan, I., Rourke, J., & Saxena, A. (2015). The future of postgraduate medical education in Canada. *Academic Medicine*, *90*(9), 1258–1263. https://doi.org/10.1097/ACM.0000000000000815

CanERA Policy Manual. (2018). CanERA.

CanRAC: Timeline for Policy Reform. (2018). Retrieved July 26, 2020, from http://www.canrac.ca/canrac/am-i-affected-e

Damodaran, A., Shulruf, B., & Jones, P. (2017). Trust and risk: a model for medical education. *Medical Education*, *51*(9), 892–902. https://doi.org/10.1111/medu.13339

dos Santos, R. A., Snell, L., & do Patrocinio Tenorio Nunes, M. (2017). The link between quality and accreditation of residency programs: The surveyors' perceptions. *Medical Education Online*, *22*(1). https://doi.org/10.1080/10872981.2016.1270093

Durodié, B. (2020). Handling Uncertainty and Ambiguity in the COVID-19 Pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*, 61–62. https://doi.org/10.1037/tra0000713

Fritz, Z., & Holton, R. (2019). Too much medicine: Not enough trust? *Journal of Medical Ethics*, *45*(1), 31–35. https://doi.org/10.1136/medethics-2018-104866

Futues of Education: Learning to Become. (n.d.). UNESCO. Retrieved from https://en.unesco.org/futuresofeducation/sites/default/files/2019-11/UNESCO - Futures of Education - Brochure - ENG.pdf

General Standards of Accreditation for Residency Programs. (2018).

Green, M. L., Aagaard, E. M., Caverzagie, K. J., Chick, D. A., Holmboe, E., Kane, G., … Iobst, W. (2009). Charting the Road to Competence: Developmental Milestones for Internal Medicine Residency Training. *Journal of Graduate Medical Education*, *1*(1), 5–20. https://doi.org/10.4300/01.01.0003

Hafferty, F. W. (1998). Beyond curriculum reform. *Academic Medicine*, *73*(4), 403–407. https://doi.org/10.1097/00001888-199804000-00013

Ho, M. J., Abbas, J., Ahn, D., Lai, C. W., Nara, N., & Shaw, K. (2017). The "Glocalization" of Medical School Accreditation: Case Studies From Taiwan, South Korea, and Japan. *Academic Medicine*, *92*(12), 1715–1722. https://doi.org/10.1097/ACM.0000000000001999

Inayatullah, S. (2009). Causal Layered Analysis: An Integrative and Transformative Theory. In J. Glenn & T. Gordon (Eds.), *Futures Research Methodology* (V3 ed.). Washington D.C.

Jada, A. (2015). *Creating a Pandemic of Health*. Exponential Medicine. Retrieved from https://exponential.singularityu.org/medicine/creating-a-pandemic-of-health-with-alex-jadad/

Nasca, T. J., Philibert, I., Brigham, T., & Flynn, T. C. (2012). The Next GME Accreditation System — Rationale and Benefits. *The New England Journal of Medicine*, *366*(11), 1051–1056.

Phelan, A. M., & Russelbaek, D. (2020). Toward a "Thoughtful Lighless:" Education in Viral Times. *In Press*, 1–28. Retrieved from https://www.cairn.info/revue-informations-sociales-2005-3-page-48.htm

Ramani, S., Könings, K. D., Ginsburg, S., & van der Vleuten, C. P. (2019). Feedback Redefined: Principles and Practice. *Journal of General Internal Medicine*, *34*(5), 744–749. https://doi.org/10.1007/s11606-019-04874-2

Rethinking Quality in Post-Secondary Education | teachonline.ca. (2015). Retrieved July 26, 2020, from https://teachonline.ca/tools-trends/rethinking-quality-post-secondary-education

Taylor, J. S., & Wendland, C. (2014). The Hidden Curriculum in Medicine's "Culture of No Culture." In F. W. Hafferty & J. F. O'Donnell (Eds.), *The Hidden Curriculum In Health Professional Education* (pp. 53–62). Hanover: Dartmouth College Press.

Teodoro, M. P., & Hughes, A. G. (2012). Socializer or Signal?, How Agency Accreditation Affects Organizational Culture. *Public Administration Review*, *72*(4), 583–591. https://doi.org/10.1111/j.1540-6210.2012.02531.x

Young, E., & Elnicki, D. M. (2019). Trust as a Scaffold for Competency-Based Medical Education. *Journal of General Internal Medicine*, *34*(5), 647–648. https://doi.org/10.1007/s11606-019-04927-6