Author's response to reviews

Title: Examining the Educational Value of a CanMEDS Roles Framework in Pediatric Morbidity and Mortality Rounds

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Dr Ingrid Philibert
Editor, BioMed Central Medical Education

To Dr Philibert,

Thank you for your review of our manuscript, “Examining the Educational Value of a CanMEDS Roles Framework in Pediatric Morbidity and Mortality Rounds.” We feel the comments made by the reviewers to be very helpful, and have addressed them in the revised manuscript. We hope that this revised manuscript is now acceptable for publication in BMC Medical Education.

The specific comments with their responses are as follows:
Reviewer 1
1- On page 7 (Lines 156-160) the authors report that there was no difference in number of quality of care issues raised based on hospital position that could suggest that length of time from training (medical student vs resident vs subspecialty fellow vs staff physician) affected identification of specific issues and therefore, that the potential benefit of training emphasis of the CanMEDS roles spans from medical school to practicing physicians continuing medical education. What is not pretty clear from this assertion is how the authors could demonstrate that the differences observed were not based on practice experience alone? For example, I would think for them to be able to categorically state this assertion, they should have negated the effect of experience by prompting staff like they did the residents for example? I think an explanation about why the authors’ think otherwise or why this was not performed should be provided in the paper.

Thank you for this comment. The prompts given to the audience were based on the side of the room that the respondent sat on, and did not differ based on position. Thus as the reviewer suggested, we state this assertion as staff were prompted the same as residents. We have not changed anything in the manuscript based on this comment, as we feel it has been addressed in the conduct of the study.

2 – My second concern is about the authors conclusion on page 8, i.e. that by using the CanMEDS roles as prompts their study demonstrated that, attendees at the M & M rounds identified more quality of care issues than if not given a prompt. For example, how can the authors prove (based on their findings) that it was not the mere fact that they were prompted that worked instead of the “CanMEDS” prompts they use? I would think that in order to be able to differentiate this for example, the authors should have included a third group of respondents that were exposed to a different (non-CanMEDS) prompt. In that way they could reliably justify whether or not it was just the prompt or the CanMEDS prompt that worked. I would like to hear the authors’ thoughts on this and suggest a little nuance in the phrasing of the sentence to highlight that it could have been the “prompting” in itself that helped and not necessarily the fact that it had to do with CanMEDS competency prompt.
This is an excellent point, per the Royal College of Canada definition, “the CanMEDS competency framework describes the knowledge, skills and abilities that specialist physicians need for better patient outcomes. The framework is based on the seven roles that all physicians need to have, to be better doctors: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, and Professional.” Thus these prompts should by definition cover all potential issues. We have added the following to the discussion to address this point: “The limitations of this study include the fact that the prompted group may have generated quality of care issues based on simply having prompts, not necessarily because they were CanMEDS roles. This limitation would have been overcome by having a third group with a different set of prompts, however what prompts to include that were not included in the 7 CanMEDS roles is a challenge. The CanMEDS roles describe the knowledge, skills and abilities that specialist physicians need for better patient outcomes and are based on the seven roles that all physicians need to have to be better doctors. [7] Thus this study only assesses comparison with the CanMEDS competencies as prompts as we felt they encompass the majority of prompts to cover all aspects of potential issues related to the case.”

Reviewer 2
1 – *It is unclear how many of the attendees attended more than once and if so how often. I assume the majority of staff attended multiple times?*
As outlined in the methods section: “This process was repeated at four M & M rounds, each 2 months apart. The residents and medical students rotate every four to eight weeks, so an interval of 2 months ensured some new attendees at the rounds.”
In terms of staff attendees, the usual attendees are those who were involved in the case being discussed. As all the cases represented different subspecialties, there was definite variety in staff attendees. This has been added to the methods section: “. Also, the attending staff involved in the case usually attended the rounds, so by having different types of cases being presented, new attending physicians attended the rounds.”

2 – *For multiple attendees: did they fill out the same type of questionnaire every time? (this could have easily been checked easily if attendees were asked for an alias only they could make up and remember like their mother’s birthday + initials). Or at least a question if they have filled out a questionnaire previously and was it the same?*
The questionnaire was the same for every M & M rounds. But the side of the room given the particular questionnaire was changed for each rounds. This was the best way we felt to avoid having participants at multiple rounds in the same group. This has been added to the discussion.

3 – *Did everybody attending fill out a questionnaire?*
Everyone was given a questionnaire and asked to complete it. They were collected by the investigator and a research assistant asked all those leaving for their questionnaire, and almost all attendees completed them. Not all attendees who left before the end of the rounds completed the questionnaire but this number was very small.

4 – *It needs to be discussed if filling out a structures questionnaire might influence the answers the next time, when randomized to an unstructured on (carry over effect). Indeed this could be a problem, and the following is in the methods section:” This process was repeated at four M & M rounds, each 2 months apart. The residents and medical students rotate every four to eight weeks, so an interval of 2 months ensured some new attendees at the rounds. As well, this was felt to prevent contamination if an attendee was placed in a different group during subsequent data collection times. Also, the attending staff involved in the case usually attended the rounds, so by having different types of cases being presented, new attending physicians attended the rounds.”

5 – *Were always the same side of the room given the same kind of questionnaire? Staff who attend regularly might sit on the same place every time. The type of questionnaire given to each side of the room was alternated at each rounds to avoid this problem. This has been added to the methods section.

6 – *I would explain more how the discussion was monitored. The discussion was lead by the resident presenting the case, and supervised by a staff physician who supervises all M & M rounds. There is not a prescribed monitoring method, but the staff generally ensures the discussion stays on topic.

7 – *How many people observed the rounds? Even after reading the manuscript several times I am still unsure what was counted: the answers in the questionnaire or the issues during the discussion after filling out the questionnaire. For the 4 rounds, 111 people observed the rounds and completed the questionnaire. This has been clarified in the methods section.

We hope that the manuscript is now acceptable for publication. If you have any further comments please do not hesitate to let us know.

Thank you

Donna Johnston