COLLÈGE DES MÉDECINS DU QUÉBEC

Guide

ROLE AND RESPONSIBILITIES OF THE LEARNER AND THE SUPERVISOR

2ND EDITION

09/21

PUBLICATION OF THE COLLÈGE DES MÉDECINS DU QUÉBEC

COLLÈGE DES MÉDECINS DU QUÉBEC
Suite 3500
1250, René-Lévesque Boulevard West
Montreal (Quebec) H3B 0G2
Telephone: 514 933-4441 or 1 888 MÉDECIN
Fax: 514 933-3112
Website: www.cmq.org
Email: info@cmq.org

Publishing
Communications and Public Affairs Division

Legal deposit: 3rd trimester 2021
Library and Archives Canada
Bibliothèque et Archives nationales du Québec
ISBN 978-2-924674-37-6

Note: In this publication, the masculine is used without discriminatory intent and solely for ease of reading.

TABLE OF CONTENTS

FOREWORD

The first edition of this guide was published five years ago, in 2016. In keeping with its mission to protect the public, the Collège des médecins du Québec (CMQ) was innovative in creating a collection of practical statements aimed at defining the roles and responsibilities of learners and supervisors in quality of care and the delivery of safe care to their patients in the context of clinical learning. This guide was also developed with the goal of making the *Code of ethics of physicians* more concrete and applicable, without in any way claiming to replace it.

In the past five years, the world has continued to evolve very rapidly. Issues of social interest were examined and explored from an ethical perspective. For example, the issue of discrimination in health care on the basis of gender identity or ethnic origin, including discrimination against patients from Indigenous communities,[21a, 21b] was raised. Practices have also evolved, in particular with the development of virtual care and the strengthening of shareable activities and interprofessional collaboration. Furthermore, reports received at the CMQ suggest that some of the messages in the statements in the first edition of the guide needed to be reinforced. An update had become necessary.

The working group was reactivated and, after careful reflection and a review of the relevant literature, produced this second edition of the guide. Many of the statements were modified and certain themes were reaffirmed.

Learners and supervisors, employees of the CMQ or other professional orders, academic authorities and the public will find useful answers in simple language in the guide. We sincerely hope that this second edition will respond even better to the needs of all those involved in training future physicians and that patient care will be delivered with even greater attention. The delivery of care will also have to take into account the emergence of new medical, health, social and cultural realities and a growing concern for the protection of the public.

INTRODUCTION

Medical education programs have to continually meet the numerous challenges imposed by advances in technology, science and education as well as by social change. Medical education must reflect these developments and consider the public's values and expectations with respect to health care today.

Learning medicine is a twofold challenge: on the one hand, to develop the requisite medical competencies and, on the other hand, to ensure the quality and safety of the care provided to the patient, with whom partnership is essential to ensure learning. The learner is exposed to a variety of settings where diverse health care teams, patients and their families, including informal caregivers and legal representatives, interact. There is no doubt that these multiple and sometimes complex situations lead the learner to constantly adjust and spur them to show intellectual, emotional and organizational agility.

Fortunately, these medical training programs are governed by comprehensive and rigorous rules and procedures. To ensure quality medicine at the service of the public, learners in medicine and supervisors must be aware of the applicable rules, the health care environment, the competencies to be developed, the nature of the patient-physician relationship, modes of interaction between care providers, the codes of conduct that govern the medical profession and the legislation that governs the health care system in Quebec. The learner and the supervisor must have a common understanding of their respective roles and responsibilities and of those of other health professionals.

Numerous reference documents already provide a framework for medical education, in particular competency-based training frameworks, the CanMEDS framework, the *Code of ethics of physicians* (hereafter "Code"), the *Professional Code* as well as the regulations of institutions, faculties of medicine, universities and the Collège des médecins du Québec (CMQ). This unique guide complements these documents. To ensure consensus on its relevance, it was written in collaboration with Quebec's four faculties of medicine, the Fédération médicale étudiante du Québec and the Fédération des médecins résidents du Québec.

This guide is intended to provide a framework for learning surrounding the delivery of patient care with safety of care being the central concern. Note, however, that while the guide draws heavily on fundamental ethical principles, it in no way replaces the *Code of ethics of physicians* or the other codes and frameworks but is an important additional aid in their application. This is why the CMQ, in keeping with its role in monitoring quality of practice, believes it is important to focus on the supervision of training during the delivery of patient care.

The different statements in the guide are intended to standardize, in a single document, principles regarding the role and responsibilities of the learner and the supervisor They come from real stories of patients, learners and supervisors. These experiences, sometimes unfortunate or embarrassing, point to certain gaps, sometimes substantial, in the understanding of these roles and responsibilities. The statements in this guide have preventive value for all those who commit to applying them, as of now, on a day-to-day basis in their respective roles. Patients themselves will have a better understanding of the health care contexts in which they are contributing to training the next generation.

Who is the guide for?

The guide is intended for both learners and supervisors. Usually, the supervisor is a physician who must teach and act in accordance with the same standards and ethical principles as any practicing physician.

The statements in the guide refer specifically to the physician's role as supervisor. They do not apply to the many other roles a practicing physician or teaching physician may undertake as part of their other university obligations. Usually, the supervisor will be a physician who is given this responsibility by the faculty of medicine or training site. A resident, a fellow or another learner may also be given this responsibility.

Structure of the guide

The guide identifies five types of clinical interactions depending on the roles and responsibilities of the learner and the supervisor with respect to:

- The patient or their legal representative, their family and their loved ones
- Training sites: health care institutions, non-hospital facilities, universities
- Health care teams in a health care delivery context and in an educational context
- The CMQ, the discipline and profession of medicine
- Themselves

The first section of the guide is entitled *General principles* and groups together some fundamental statements concerning the roles and responsibilities of both the learner and the supervisor in an undifferentiated way. It is an equally important section of the guide to consult.

Most statements contain one or more hyperlinks for anyone who would like to further their understanding of the problem. A glossary is also provided at the end of the guide to define the concepts discussed throughout the guide. Finally, the guide ends with a list of references and a short conclusion.

Warning

The statements in the guide are a practical expression of ethical obligations and the standards of practice expected by the CMQ and universities. Moreover, the learner and the supervisor must also use their judgement when applying these statements in the different learning contexts.

In the statements that follow:

- An asterisk (*) refers the reader to the glossary.
- A superscript number indicates a hyperlink the reader can click on.
- A hyperlink is provided to each section of the *Code of ethics of physicians* that is referenced.

GENERAL PRINCIPLES

Certain roles and responsibilities apply equally to the learner and the supervisor, for both learning activities and clinical activities. They are presented together in the following statements:

1. Demonstrate fundamental behaviours in relation to the trust the public places in the profession while respecting the privileges conferred on physicians by society.

2. Ensure care is patient-centred and that patient care is the priority within the learning process.

3. Acknowledge the patient as a partner in care.*

4. Know the rules regarding free and informed consent to care as stipulated in the *Code of ethics of physicians* and the *Civil Code of Québec*.

ss. 28, 29, 30 of the *Code of ethics of physicians*

ss. 1 to 21 of the *Civil Code of Québec*

    a. Recognize the patient's right to give or refuse consent before providing care of any nature: targeted physical examination, in particular of the genitourinary system, paraclinical examination, specimen collection, treatment or any other medically necessary intervention.

    b. Know that consent to care not required by a person's state of health, to the alienation of a part of a person's body, or to research that could interfere with the integrity of his person shall be given in writing.

s. 24 of the *Civil Code of Québec*

    c. Recognize that the application of free and informed consent to medically necessary care is the result of a rigorous and rational clinical approach on the part of the physician, as well as a genuine dialogue between the physician and the patient, to determine the options for investigation and the appropriate treatment, if any.

    d. Recognize that consent is a dynamic and ongoing process. Know the legal requirements governing the consent of minors and of adults who are incapable of giving consent to care; and the exceptions to obtaining consent.

    e. Know the exceptions to consent in clinical emergencies.

    f. Know the different tools people may use to express their wishes regarding their care and for planning care (advance medical directives [AMDs] within the meaning of the *Act respecting end-of-life care*, protection mandate, end-of-life will, level of medical intervention, do-not-resuscitate decision).

5. Ensure the safety of the patient, the learner and team members at all times. Comply with training site infection prevention and safety standards.

6. Establish exemplary communication in all its aspects, including cultural competencies, in person or virtual, for all types of supervision, and recognize its fundamental value in the quality and safety of care.

7. Supervise and assign professional activities to learners based on their level of autonomy and competence, taking patient safety considerations into account.

8. Ensure safe continuity of patient care by both the supervisor and the learner and remain vigilant to ensure that no patient is abandoned,* particularly in the patient care pathway and in the follow-up of investigation results.

9. Ensure effective communication between team members in order to provide safe care.

10. Know the mission, the role and the organizational structure* of training sites as well as the profiles of the care they provide.

11. Comply with the policies, regulations and procedures of the university, the training site* and the CMQ. Comply with the *Code of ethics of physicians* and training site requirements, including codes of conduct, dress codes and codes of ethics.

12. Behave in a professional manner, with honesty, respect and integrity: respect the dignity of the medical profession. Demonstrate collegiality, respect, civility and courtesy in all forms of interaction with all patients and with everyone on or off the training site.

ss. 4, 5 of the *Code of ethics of physicians*

s. 59.2 of the *Professional Code*

13. Demonstrate social responsibility through the judicious and respectful use of human, environmental, technical, electronic or other resources.

14. Assume responsibility for one's learning and the maintenance of one's competence* in order to meet the needs of the patient and the public while satisfying training requirements.

s. 44 of the *Code*

15. Foster a healthy and equitable learning environment.

s. 17 of the *Code*

16. Receive and treat every patient, or any other person, with respect, fairness and inclusiveness, without discrimination, irrespective of illness or disability, pregnancy, age, culture, religious denomination, beliefs, morals, ethnic origin, citizenship status, including Indigenous peoples,[21a, 21b] gender identity, sexual orientation, socioeconomic status, language or any other form of personal, social, political and cultural diversity.

17. Oppose and consider being an active witness of any form of physical, verbal or psychological abuse, inappropriate behaviour, sexual misconduct or assault, harassment or intimidation[3] against an individual. In these situations, a complaint or report about a person, whether in a hierarchical position or not, may be filed with the competent authorities in accordance with recognized procedures and in accordance with the *Code of ethics of physicians*.

18. Prevent, prohibit and report any defamatory comments, fraud and plagiarism.

ss. 110, 111 of the *Code*

19. Acknowledge each health professional's or other care provider's essential role and promote interprofessional collaboration in patient care. Recognize that health professionals other than physicians are now authorized to carry out certain diagnostic and/or therapeutic activities. Apply a collaborative model so that each action, act or intervention is coordinated, integrated and centred on the patient's care and well-being.

s. 112.1 of the *Code*

20. Recognize situations that jeopardize one's physical and psychological health; take the necessary steps to remedy the situation using the appropriate resources.

PART 1

THE LEARNER* (STUDENT,* RESIDENT,* FELLOW*): PROFESSIONAL ROLE AND RESPONSIBILITIES

A. Towards the patient or their legal representative,* their family and their loved ones

1. Identify oneself, inform the patient of one's role as care provider and learner* and state one's level of training, providing explanations if necessary. Give the patient the name of one's supervisor,* both the name of a more senior learner supervisor and the name of the physician and the name of the physician most responsible for the patient's care (if different from the supervisor) and inform the patient about the latter's role. Consider the negative repercussions on communication, collaboration and quality of care that may result from a patient not knowing the learner's identity and role. Remember that the patient is entitled to know exactly who is going to be treating them.

2. Use clear and understandable language in all communications with the patient and validate the patient's understanding.

   s. 29 of the *Code*

3. Obtain the patient's free and informed consent[4a] to being treated by a learner under supervision. More specifically, obtain the patient's free and informed consent before undertaking a physical or mental examination, investigation, procedure or treatment alone. The patient must also be informed of the supervisor's name and role. Acknowledge the patient's right to refuse to be treated by a learner.

   ss. 28, 29, 30 of the *Code*

4. Acknowledge the patient's autonomy to participate in the decision-making process concerning the most appropriate care for them and their ability to be a partner in care.*

5. Acknowledge that the learner assumes responsibility for patient care based on their level of training.

6. Respect the limits of one's competence and refrain from performing a medical or surgical activity that exceeds one's capabilities. Seek guidance from one's supervisor, where applicable. — s. 42 of the *Code*

7. Ensure continuity of care and that all handovers of care* are done safely and diligently. — ss. 32, 33, 35 of the *Code*

8. Discuss any incidents*/accidents* that one has knowledge of with one's supervisor as well as the principles, procedures and stages involved in the disclosure of accidents[5, 6] to the patient. Know when and how to document and report incidents/accidents in accordance with the policies in place.[5, 7] — s. 56 of the *Code*

9. Be aware of the influence of one's values and convictions on patient care and discuss them with one's supervisor, where applicable. — ss. 23, 24 of the *Code*

10. Maintain professional secrecy, in all forms of communication, in accordance with the *Code of ethics of physicians*. Recognize and validate exceptions to professional secrecy with the supervisor[4b]. — ss. 20, 21 of the *Code*; s. 60.4 of the *Professional Code*

11. Ensure one's professional conduct towards the patient is beyond reproach; maintain a healthy distance between oneself and the patient; avoid conflict and prevent abuse in the relationship. — ss. 17, 22, 25 of the *Code*; s. 59.1 of the *Professional Code*

12. Use social networks, smartphones, text messages and email, or any other communications technology, in a professional and secure manner.[9b, 9c]

B. Towards training sites (health care institutions, non-hospital facilities and universities)

1. Obtain and maintain, at all times, in accordance with one's status as student, resident or fellow, a valid certificate of registration* or training card* issued by the CMQ.

2. Provide care only to patients admitted to or registered with training sites that are accredited or approved by the CMQ and do not provide a diagnosis and/or prescription to anyone who is not a patient at the training site or provide medical advice via social media.

3. Comply with the standards and regulation governing record keeping* and follow the recommendations in the relevant practice guidelines.[8, 9a, 9b, 9c, 10] Know that the medical record is not just a memory aid for the physician, that it must contain the rationale behind the clinical approach and is therefore an essential communication tool that will be read by various people. Know that the medical record is also used for practice assessment and clinical research. Therefore, it must be structured, orderly, clear, relevant and legible.

4. Follow established policies and procedures for dealing with reports or complaints, irrespective of whether they are dealt with by the university, the training site or the CMQ.[11]

5. Inform those in authority of any unforeseen circumstances that prevent one from completing one's teaching and clinical duties, including on-call duty, without delay.

s. 37 of the *Code*

6. Be mindful of the use of resources throughout one's clinical reasoning and avoid or give the rationale for seemingly inappropriate requests, including the duplication of tests or consultations, where applicable.

ss. 12, 44, 46 of the *Code*

7. Contribute constructively to practice improvement as well as the evaluation of training programs, supervisors and training sites.

C. Towards professional teams (including supervisors, students, residents, fellows, attending physicians, consultants and all health professionals) in a collaborative inter- and intraprofessional practice*

I. In a health care delivery context

1. Validate expectations, modalities and objectives of supervision with one's supervisor.

2. Cooperate fully with the supervisor, including the supervisor who is assigned temporarily during on-call hours.

3. In addition to the usual information collected in the case history, progress notes and investigations for a patient, communicate any relevant information regarding the following situations to the supervisor and/or the health care team:

    a. admission/discharge/departure/transfer or death of the patient;
    b. urgent condition or risk identified with respect to the patient;
    c. significant change in the patient's condition or their treatment modalities;
    d. any discussions concerning the level of medical intervention* for the patient;
    e. any relevant request made by the patient.

4. Request or respond to a request for a consultation in accordance with training site rules and the following conditions: — ss. 112, 112.1, 113 of the *Code*

    a. timeframes must be appropriate to the clinical situation;
    b. the information provided must be complete and relevant;
    c. information must be transmitted to professionals in a secure and vigilant manner.

5. Foster a work climate that is respectful and conducive to learning as well as an environment that is free of intimidation or harassment and report any instances where such issues arise.[3, 11] Also report any serious or recurrent situations or behaviours that are in contravention of the *Code*. — ss. 110, 111 of the *Code*

6. Contribute to maintaining the professional, psychological and physical safety* and well-being of everyone in one's environment and report any unsafe situations to the supervisor or another person in authority.

7. Contribute to the fair and equitable sharing of on-call and clinical duties.

8. Provide assistance when requested by a colleague in all emergency or non-emergency clinical situations in accordance with one's capabilities, during or outside on-call hours. — s. 114 of the *Code*

9. Accept and manage the patients assigned by the supervisor in accordance with one's limits and capabilities and one's competence.

10. Document the clinical approach and interventions clearly in the record so that they can be easily understood by health care teams.[8, 9a, 9b, 9c, 10]

11. Recognize that one's behaviour, attitude and emotional reactions can influence quality of care.

12. Demonstrate initiative and leadership[17a] in accordance with one's capabilities, when required by the situation.

II. In an educational context

1. Respect the role and responsibilities of the supervisor and other professionals on the team.

2. Be a role model*. — ss. 14, 15 of the *Code*

3. Be responsible and sensitive to other people by fostering an environment that is conducive to learning and a healthy and pleasant workplace.

4. Serve as supervisor for other learners under one's responsibility as assigned by the supervisor or other persons in authority. — ss. 14, 15 of the *Code*

5. Provide educational support to other learners and acknowledge that cooperation promotes learning.

6. Recognize the potential repercussions of the non-official curriculum, commonly known as the hidden curriculum,* which refers to the transmission of practice standards, principles, values or beliefs that are parallel or contradictory to the official curriculum or in contravention of the *Code*, and learn lessons from these situations.

7. Apply the principles of interpersonal conflict prevention, management and resolution.[17b]

8. Comply with ethical principles and ethical obligations while participating in a clinical research project and while providing care.

ss. 30, 31, 45, 48, 61, 78, 87 of the *Code*

9. Contribuer au partage équitable des responsabilités pédagogiques.

10. Be proactive in asking for feedback on one's knowledge, competence and behaviour, and receive it with openness.

D. Towards the CMQ, the discipline and profession of medicine

1. Comply, in the same manner as practicing physicians, with the *Code of ethics of physicians*,[1] the *Regulation respecting standards relating to prescriptions made by a physician*[12] and the *Regulation respecting records, places of practice and the cessation of practice by a physician*,[8] in particular.

2. Respond with diligence to requests from the CMQ in the required time period, including questions regarding declarations in CMQ forms. Understand that making a false declaration is a breach of professional ethics.

ss. 116, 118, 120 of the *Code*

3. As prevention, acknowledge acts or behaviour that are likely to result in a criminal offence or a disciplinary decision and that may lead to the certificate of registration or training card being revoked.[14, 15, 16]

4. Avoid putting oneself in a situation of illegal practice of medicine during one's training, for example by providing diagnostic or consulting services, virtual or otherwise, without supervision and outside the training framework, and letting the public believe that these services are provided by a fully licensed physician.

5. Adjust one's career goals throughout one's training based on one's skills, capabilities, interests and population needs.

6. Ensure that one's professional and personal behaviour respects the dignity of the profession both on and off training sites, including on social media as well as on any online professional or personal profile. Avoid reacting impulsively or inappropriately on social media and assess the repercussions of posts, comments, videos or photos on one's professional life and credibility. Use social media in accordance with training site policies.

ss. 17, 20 of the *Code*

7. Read the *Regulation respecting mandatory continuing education for physicians* and no later than towards the end of one's specialized training, begin to consider how to ease the transition to a practice that meets the requirements of this regulation.

E. Towards oneself

1. Refrain from investigating one's own medical condition and comply with the prohibition on self-prescribing medication, including psychostimulants or other controlled substances, or obtaining it, whether for one's own personal use or for family members and loved ones or for any other person or patient outside the context of one's training.

s. 70 of the *Code*

2. Avoid behaviours that could compromise one's physical or psychological health, one's credibility (substance abuse, excessive cannabis use,[20] deviant behaviour, etc.), one's learning and the profession's image. Use appropriate resources (university, Quebec Physicians Health Program [QPHP], training sites, Fédération des médecins résidents du Québec [FMRQ], Fédération médicale étudiante du Québec [FMEQ], etc.) to remedy these situations. As prevention, ensure a healthy work-life balance.

ss. 16, 43 of the *Code*

3. Be vigilant with respect to one's own health problems and be open to feedback from one's supervisor, colleagues or immediate circle, in particular regarding mental health issues, including burnout, or alcohol and substance abuse, and do not hesitate to consult health professionals if necessary.

4. Protect one's psychological, physical and professional safety.* Inform those in authority if one's safety is threatened.

5. Take into consideration any factors that contribute to fatigue and develop strategies to minimize their impact on one's performance.[13]

6. Ensure that one maintains appropriate liability insurance at all times.

PART 2

THE SUPERVISOR* (PHYSICIAN, STUDENT,* RESIDENT,* FELLOW*): PROFESSIONAL ROLE AND RESPONSIBILITIES

A. Towards the patient or their legal representative,* their family and their loved ones

1. Identify oneself to the patient and explain that, at a training site, care is provided in close collaboration with a team that includes the learner.* Explain the supervisor's* and the learner's roles to the patient more specifically.

2. Obtain the patient's free and informed consent[4a] to being treated by a learner under supervision. Obtain the patient's consent when the learner is the main person who undertakes an examination, investigation, procedure or treatment. Respond to the patient's concerns regarding the learner's involvement. Acknowledge the patient's right to refuse to be treated by a learner.

ss. 26, 28, 29, 30 of the *Code*

3. Be aware of one's responsibility regarding the decision to assign professional activities to the learner, based on the latter's capabilities, level of autonomy and limits.

s. 11 of the *Code*

4. Ensure, with the learner's cooperation, that the patient is properly informed of any accident or complication that is likely to have or that has had a significant impact on their state of health or physical integrity.

s. 56 of the *Code*

5. Maintain professional secrecy when exchanging information with the learner, irrespective of the method of communication used.

s. 20 of the *Code*

6. Follow the rules of good practice set out by the CMQ for telemedicine[9b, 9c].

B. Towards the learner

1. Ask the learner to state their level of training and level of autonomy, including their limits and capabilities, with respect to their proficiency in the expected competencies, as well as their educational and personal needs.

2. Be cognizant of the competencies the learner is required to develop and know what stage the learner is at in their competency trajectory.

3. Support the learner in developing their professional autonomy in accordance with their competency trajectory while maintaining patient safety.

4. Clearly state one's expectations of the learner and define the latter's duties and responsibilities.

5. Provide regular formative feedback on the learner's overall competence, in particular regarding serious or dangerous behaviour or learning problems. Respect constructive feedback principles. Ensure feedback is rigorous and is not lenient. Avoid bias and undue delays.

6. Respect the confidentiality of the learner's academic record.

7. Be diligent and make oneself available to the learner in all supervisory situations, including during on-call hours. If unavailable, appoint a replacement.

s. 37 of the *Code*

8. Ensure the learner is adequately supervised at all times in accordance with the following criteria in order to maintain the quality and safety of care as well as the professional, physical and psychological safety of learners and other health professionals involved in the episode of care:

    a. The characteristics of the learner: their level, their competency trajectory, their autonomy, their limits and capabilities, their self-assessment, their educational needs and certain personal situations.

    b. The specific requirements of the university, a training program, a clinical department or service.

    c. The specific clinical context of a patient / patient group / population / community.

    d. The specific challenges of telemedicine and its issues: technology, confidentiality, limited access to some clinical information (in particular a physical examination), management of medical emergencies, verification of the patient's understanding and consent.

    e. The physician's ethical obligations.

9. Recognize that countersigning progress notes, case histories, treatment plans, etc., written by the learner, is an attestation of supervision, determined by the supervisor in accordance with the above criteria.

10. Establish a procedure for communicating with the learner that ensures patient and team safety.

11. Help the learner to obtain access to any relevant patient information.

12. Maintain clinical and teaching competencies that are specific to one's role as supervisor. — s. 44 of the *Code*

13. Clearly document the judicious use of resources in one's clinical approach and avoid or give the rationale for the duplication of investigations or consultations, where applicable. — ss. 12, 44, 46 of the *Code*

14. Respect the learner's obligations with respect to training program requirements.

15. Refer the learner to appropriate resources in the event of medical, personal or educational need. — s. 70 of the *Code*

16. Recognize one's influence as a role model* on the learner and be aware of the repercussions of one's own personal values and convictions in one's teaching.

17. Recognize the non-official curriculum, commonly known as the hidden curriculum,* which refers to the transmission of practice standards, principles, values or beliefs that are parallel or contradictory to the official curriculum or in contravention of the *Code*, and explain the repercussions on training.

18. Report any conflicts of interest that could interfere with learner supervision and evaluation to the relevant authorities.

19. Contribute to the professional, psychological and physical safety* and well-being of everyone in one's clinical or educational environment and report any unsafe situations to the relevant authorities.

C. Towards training sites (health care institutions, non-hospital facilities and universities)

1. Create learning opportunities for the learner and adapt clinical duties to the training program's competency trajectory.*

2. Comply with deadlines for submitting learner evaluations.

3. Take the necessary steps (remove the learner from the site, refer them to an attending physician, remove patients from their list of responsibilities, report the issue) to ensure the patient's and the team's safety in the event of reprehensible or dangerous behaviour on the part of the learner.[11] — s. 119 of the *Code*

4. Report any serious or repeated lack of professionalism on the part of the learner in accordance with the mechanisms in place.[11] — s. 119 of the *Code*

5. Follow established policies and procedures for dealing with reports or complaints depending on whether they are dealt with by the university, the training site or the CMQ.[11] — s. 119 of the *Code*

6. Contribute constructively to practice improvement and the evaluation of training programs and sites.

D. Towards the CMQ and the profession

1. Obtain and maintain, at all times, a valid permit to practice or a certificate of registration and/or training card issued by the CMQ.

2. Comply with the *Code of ethics of physicians*,[1] integrate its principles into one's teaching and role modelling*. This integration should include the *Regulation respecting the standards relating to prescriptions made by a physician*,[12] the regulation and guides on record keeping[8, 9a, 9b, 9c, 10] and the position statements of the CMQ.[18]

3. Comply with accreditation standards and quality criteria for training programs and sites. — s. 2 of the *Code*

4. Be familiar with the CMQ's reporting procedure and understand its position and role with respect to other reporting procedures at training sites or universities.[11] — s. 119 of the *Code*

E. Towards oneself

1. Demonstrate self-criticism in one's role as supervisor in order to ensure patient safety in one's teaching interventions at all times.

2. Avoid behaviours that are likely to compromise one's personal and professional credibility with respect to one's role as physician and supervisor, irrespective of the context, including the use of social media. Avoid reacting impulsively or inappropriately on social media and assess the repercussions of posts, comments, videos or photos on one's professional life and credibility. Use social media in accordance with training site policies. — s. 43 of the *Code*

CONCLUSION

The quality of medical training in Canada and Quebec is indisputably recognized. The main objective of this guide on the roles and responsibilities of learners and supervisors is to ensure the Collège des médecins du Québec fulfils its mission to protect the public, even during this training.

It is important to remember that the learner and the supervisor must use their judgement when applying the statements in the guide in the different learning contexts. The document is not normative and is not intended to extend the scope of the *Code of ethics of physicians* but to promote the behaviours expected of the learner and the supervisor.

The authors would like the guide to be even more widely used and to stimulate constant reflection and dialogue among learners and supervisors based on their respective roles and responsibilities. This will ensure the guide will evolve alongside our ever-changing society and systems.

GLOSSARY

LEARNER

Any person engaged in a learning process as part of a medical or medical specialty program, most often involving competency-based learning. In the guide, a learner may be a medical student, resident, fellow or a practicing physician who is completing a period of refresher training.

SUPERVISOR

Any person who has been given the responsibility of overseeing a learner's clinical work and learning. Most of the time, the supervisor will be a physician who was given this responsibility by the faculty of medicine or teaching facility. A resident or another learner may also be given this responsibility.

ABANDONMENT

The term *abandonment*, in the context of patient care, means failing to diligently ensure the continuation of the process of clinical or paraclinical investigation, intervention or treatment during a specific, one-off episode of care or during the global management of a patient in a context of continuity of care.

ACCIDENT

Under Quebec law, an "*accident*" means an "action or situation where a risk event occurs which has or could have consequences for the state of health or welfare of the user, a personnel member, a professional involved or a third person."

Source: *Act respecting health services and social services.*

ALDO-QUÉBEC

Document that provides information about the legal, ethical and organizational aspects of medical practice in Quebec. Participation in the ALDO-Québec educational activity is mandatory and is a prerequisite to the issue of a permit to practice.

CanMEDS

"Framework that identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve. These abilities are grouped thematically under seven roles: medical expert, communicator, collaborator, leader, health advocate, scholar and professional".

Source: Royal College of Physicians and Surgeons of Canada.

CERTIFICATE OF REGISTRATION

Issued by the CMQ, a certificate of registration authorizes a learner (student, resident or fellow) to perform, under supervision, professional activities required to complete their training.

CODE OF ETHICS OF PHYSICIANS

Set of rights and duties that govern the medical profession, the conduct of physicians engaged in the profession and relations between physicians and the public. Students, residents and fellows must also comply with the *Code*.

COLLABORATIVE PRACTICE

"Dynamic interactive process consisting of information sharing, education and decision making. It is a practice whereby the entire team of health professionals contributes to a coordinated intervention by providing personalized, integrated and continuous care."

Collaborative practice is intended to foster both interprofessionalism (between individuals from different professions) and intraprofessionalism (between individuals from the same profession, in this case, between physicians).

Source: The Canadian Interprofessional Health Consortium, 2010.

COMPETENCE

"Complex knowledge of how to act based on the mobilization and effective combination of a variety of internal and external resources within a family of situations" (Tardif, 2006; translated from the French). Body of knowledge and skills (how to be, do and act) that must be repeated and integrated into different, increasingly complex tasks. Developing competence requires a cognitive investment, constant exposure to the area of expertise, reflection on one's learning and personal commitment through experience. Competence requires time, repetition, integration and sustainability.

COMPETENCY TRAJECTORY

Progression in the gradual development of a competency based on the learner's level of training. The competency trajectory is defined by the training program.

DISCLOSURE OF ACCIDENTS

"Action of bringing to the attention of the user or their family any necessary information regarding an accident that occurred and that has consequences for the user. The measures taken to address the consequences and prevent such an accident from recurring must also be disclosed. This disclosure must be made to the user as soon as possible or as soon as their condition allows, or to the representative of a user of full age under legal incapacity, or, in the event of the user's death, to the persons provided for by law. If the situation requires, support measures must also be proposed to the user or their family, including appropriate care."

This definition applies to both intra- and extra-institutional disclosure.

Source: Ministère de la Santé et des Services sociaux [Translated from the French].

FELLOW

Person who completes advanced training in a university program or in a host or exchange program approved by a faculty of medicine in Quebec or the government authorities. Fellows must also have a certificate of registration and a training card.

HANDOVER

"A handover is the transfer of responsibility and accountability for some or all aspects of care for a patient or group of patients, on a temporary or permanent basis."

Source: Canadian Medical Protective Association.

HEALTH CARE TEAM

Members of staff and professionals who intervene directly or indirectly with a patient. In an educational context, this team also includes all learners who contribute to care and have one or more supervisors.

HEALTH INSTITUTION

Administrative structure defined by the *Act respecting health services and social services* (ARHSSS), a health institution is comprised of various facilities and provides health care services to the population of a territory. These facilities are grouped into integrated health and social services centres (centres intégrés de santé et de services sociaux – CISSS) and integrated university health and social services centres (centres intégrés universitaires de santé et de services sociaux – CIUSSS). They also include institutes and university hospital centres (CHU). This reorganization of the network, with the abolition of health and social services agencies, came into force on April 1, 2015 following the adoption of Bill 10, the definition of which is now part of the *Act respecting health services and social services*, CQLR, c. S-4.2. The services provided in institutions encompass not only inpatient but also outpatient care, including some types of specialized care and primary care, such as home care.

HIDDEN CURRICULUM

Non-official curriculum that refers to the transmission of practice standards, principles, values or beliefs that are parallel or contradictory to the official curriculum or in contravention of the *Code*.

INCIDENT

"Action or situation that does not have consequences for the state of health or welfare of a user, a personnel member, a professional involved or a third person, but the outcome of which is unusual and could have had consequences under different circumstances."

Source: *Act respecting health services and social services.*

INCIDENT OR ACCIDENT REPORTING

"Action of bringing to the attention of the organization (institution or health care facility), using the AH-223 form and in accordance with the procedure established by the institution, any accident or incident witnessed by an employee, a professional who engages in their profession in the institution, any intern or any other person who, pursuant to a contract, provides services to the users of the institution."

Source: Ministère de la Santé et des Services sociaux [Translated from the French].

LEGAL REPRESENTATIVE

Person who is authorized by law to perform an act on behalf of, in place of and for another person.

With respect to consent to care, the following persons may be representatives, to the extent provided for by the *Civil Code of Québec*.[2]

- The person having parental authority or tutor of a minor under 14 years of age (a minor 14 years of age and over may give their consent alone, subject to certain exceptions);
- The mandatary, tutor or curator of a person of full age who is incapable of giving consent;
- If the person of full age who is incapable of giving consent is not so represented, consent is given by their spouse or, if the person has no spouse or their spouse is prevented from giving consent, it is given by a close relative or a person who shows special interest in the person of full age.

It should be noted that a person of full age who is under protective supervision (tutorship or curatorship) is not necessarily unable to give consent to care.

LEVEL OF MEDICAL INTERVENTION (LMI) (LEVEL OF CARE)

"Expression of the values and wishes of a patient in the form of goals of care resulting from discussion between the patient or his/her representative and the physician concerning the anticipated evolution of health status as well as medically appropriate care options and their consequences in order to orient care and guide the choice of diagnostic and therapeutic interventions."

Source: Institut national d'excellence en santé et en services sociaux (INESSS).[19]

MEDICAL STUDENT

Person enrolled in a program of studies leading to a medical degree and any person enrolled in such a program as part of a host or exchange program approved by the faculty of medicine or the government authorities. The student must have a certificate of registration issued by the Collège des médecins du Québec (CMQ).

ORGANIZATIONAL STRUCTURE

Hierarchical organizational chart that defines the levels of responsibility, mandates and tasks required to operate a health care institution. All institutions have a similar organizational structure, including a board of directors, management personnel (which includes a chief executive officer and a director of professional services), a council of physicians, dentists and pharmacists, a council of nurses, a multidisciplinary council, a users' committee and a council of midwives, if need be, as well as the departments, services and various specific subcommittees. Each of these bodies performs its functions in all centres operated by the institution.

Source: ALDO-Québec.

PARTNER IN CARE

"The term 'patient as partner in care' refers to a person who is gradually empowered, in the course of their clinical trajectory, to make free and informed health choices. Their experiential knowledge is recognized and their self-care skills are developed by the members of the clinical team. Respected in all aspects of their humanity, they are a full-fledged member of the health care delivery team. While recognizing the team members' expertise, the partner in care centres the team's concerns around their life plan and in this way participates in decisions that concern them."

"In a partnership approach, the care and services provided by the health care provider and the clinical team are built around the patient's life plan. The provider partner recognizes the patient's experiential knowledge and shares their own knowledge to enable the patient to develop their self-care skills and gradually empower them to make free and informed health choices. The provider partner respects all aspects of the patient's humanity and considers them a full-fledged member of the team, encouraging their active participation in decisions that concern them."

Source: Faculty of Medicine, Université de Montréal [Translated from the French].

PHYSICAL SAFETY

Includes protection against biological risks, such as immunization, radiation protection, respiratory protection, protection against exposure to body fluids; it also includes protection against risks associated with physical spaces, in particular during home care, risks associated with travel and encounters with violent patients.

Source: Faculty of Medicine, Université de Montréal.

PROFESSIONAL SAFETY

Includes protection from allegations of malpractice, insurance against medical malpractice suits, disclosure assistance, academic and professional record confidentiality, as well as reporting procedures where confidentiality is assured and there are no reprisals.

Source: Faculty of Medicine, Université de Montréal.

PSYCHOLOGICAL SAFETY

Includes prevention, protection and access to resources to counter the risks of psychological distress, alcohol or drug dependence, intimidation and harassment.

Source: Faculty of Medicine, Université de Montréal.

RECORD KEEPING

Process involved in compiling the information needed for a person's medical follow-up. It is governed by regulations defined by the CMQ as well as by an institution's or training site's archives regulations. Record keeping includes compliance with requirements relating to the organization of the record, its content, elements relevant to the physician's clinical approach and the legibility of the information, as stipulated in the *Regulation respecting records, places of practice and cessation of practice by a physician*[8] and by other legislative and regulatory standards in institutions or training sites. The learner and the supervisor are invited to consult three CMQ practice guidelines on the subject: *Record keeping by physicians in non-hospital settings,*[10] *La tenue des dossiers par le médecin en centre hospitalier de soins généraux et spécialisés,*[9a] and *The physician, telemedicine and information and communications technologies.*[9b, 9c]

RESIDENT

Person who holds a medical degree or who is recognized by the Collège des médecins du Québec as having an equivalent degree. A resident is enrolled in a postgraduate university program and completes training periods as part of this program. A resident must have a certificate of registration and a training card issued by the CMQ.

ROLE MODEL

Person who, through their attitude and behaviour, influences a learner, in particular in the development of their competence, the expression of their professionalism and their approach to medical practice in the different specialities in Quebec.

TRAINING CARD

Issued by the CMQ, a training card authorizes a resident or fellow to perform professional activities that correspond to their level of training at sites that are accredited or approved by the CMQ.

TRAINING SITE

Place where clinical and teaching activities are provided for learners. All training sites must be either affiliated with or authorized by a university, and must be accredited by the CMQ and meet the standards of the different accreditation bodies, i.e., the CMQ, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the Committee on Accreditation of Canadian Medical Schools.

Hyperlinks

1. *Code of ethics of physicians*
2. *Civil Code of Québec*
3. Royal College of Physicians and Surgeons of Canada: *Creating a Positive Work Environment*
4. **a)** *Le médecin et le consentement aux soins* (CMQ) [available in French only]

   b) ALDO-Québec - Professional secrecy
5. Canadian Medical Protective Association (CMPA): "Disclosing harm from healthcare delivery: Open and honest communication with patients"
6. Canadian Patient Safety Institute (CPSI)
7. Ministère de la Santé et des Services sociaux (MSSS)
8. *Regulation respecting records, places of practice and cessation of practice by a physician* (CMQ)
9. **a)** *La tenue des dossiers par le médecin en centre hospitalier de soins généraux et spécialisés* (CMQ) [Record keeping by physicians in general and specialized hospital centres; available in French only]

   b) *The physician, telemedicine and information and communication technologies* (CMQ)

   c) Telemedicine (CMQ) [available in French only]
10. *Record keeping by physicians in non-hospital settings* (CMQ)
11. *How to file a complaint against a physician* (CMQ)
12. *Regulation respecting the standards relating to prescriptions made by a physician* (CMQ)
13. National Steering Committee on Resident Duty Hours, RCPSC
14. *Regulation respecting the procedures for supervising persons performing a period of professional training in medicine* (CMQ)
15. *Regulation respecting the terms and conditions for the issuance of the permit and specialist's certificates by the Collège des médecins du Québec*
16. *Regulation respecting professional activities that may be engaged in by persons other than physicians* (CMQ)
17. **a)** CanMEDS – Leader

    b) CanMEDS – Collaborator
18. CMQ position statements
19. Institut national d'excellence en santé et en services sociaux (INESSS): *Levels of care: Norms and quality standards*
20. Health Risks of Cannabis Use
21. **a)** Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec

    b) Joyce's Principle

ARBELAEZ, C. (Ed.), et al. (2011). *The Chief Resident Survival Guide*, 2nd ed., *Emergency Medicine Residents' Association (EMRA)*, 96 p.

ASGHARI, F., N. N. FARD and A. ATABAKI (2011). "Are we proper role models for students? Interns' perception of faculty and residents' professional behaviour", *Postgraduate Medical Journal*, vol. 87, nº 1030, pp. 519-523.

AUSTRALIAN MEDICAL ASSOCIATION (2019). *A guide to social media and medical professionalism: the tips and traps every doctor and medical student should know*, 23 p.

BACK, A. L., et al. (2003). "Teaching Communication Skills to Medical Oncology Fellows", *Journal of Clinical Oncology*, Vol. 21, Issue 12, June 15, pp. 2433-2436.

BALMER, D. F., A. P. GIARDINO and B. F. RICHARDS (2012). "The Dance Between Attending Physicians and Senior Residents as Teachers and Supervisors", *Pediatrics*, Vol. 129, No. 5, pp. 910-915.

BESTAWROS, A. (2004). "La responsabilité civile des résidents en médecine et de leurs commettants", *Revue du Barreau*, Vol. 64, Spring.

BHAGIA, J. and J. A. TINSLEY (2000). "The Mentoring Partnership", *Mayo Clinic Proceedings*, Vol. 75, Issue 5, May, pp. 535–537.

BREEN, K. J., et al. (2010). "Ethical and legal responsibilities of medical students", *Good Medical Practice: Professionalism, Ethics and Law*, Cambridge University Press, pp. 18-32.

BUSARI, J. O., et al. (2003). "The perceptions of attending doctors of the role of residents as teachers of undergraduate clinical students", *Medical Education*, Vol. 37, No. 3, March, pp. 241-247.

BYSZEWSKI, A., et al. (2012). "Wanted: role models - medical students' perceptions of professionalism", *BMC Medical Education*, Vol. 12, No. 115.

CANADIAN MEDICAL PROTECTIVE ASSOCIATION (CMPA) (2018). *The physician as teacher – What are the responsibilities?*.

CANADIAN MEDICAL PROTECTIVE ASSOCIATION (CMPA) (2020). *When physicians feel bullied or threatened*, October.

CANADIAN MEDICAL PROTECTIVE ASSOCIATION (CMPA). *Good Practices Guide. Safe care – reducing medical-legal risk*.

CHAMBERLAND, M. and R. HIVON (2005). "Les compétences de l'enseignant clinicien et le modèle de rôle en formation clinique", *Pédagogie médicale*, Vol. 6, No. 2, May, pp. 98-111.

CHEN, X., et al. (2012). "How do supervising surgeons evaluate guidance provided in the operating room?", *The American Journal of Surgery*, Vol. 203, Issue 1, pp. 44-48.

CHRISTAKIS, D. A. and C. FEUDTNER (1993). "Ethics in a short white coat: the ethical dilemmas that medical students confront", *Academic Medicine*, Vol. 68, Issue 4, April, pp. 249-254.

COHEN, J. S. and S. PATTEN (2005). "Well-being in residency training: a survey examining resident physician satisfaction both within and outside of residency training and mental health in Alberta", *BMC Medical Education*, Vol. 5, No. 21, June.

COLLÈGE DES MÉDECINS DU QUÉBEC (2008). *Pour des soins appropriés au début, tout au long et en fin de vie*, 43 p.

COLLÈGE DES MÉDECINS DU QUÉBEC (2015). "De la page à l'écran", *Revue Le Collège*, Vol. 55, No. 2, Spring, 32 p.

COLLÈGE DES MÉDECINS DU QUÉBEC (2018). *Le médecin et le consentement aux soins*, 79 p.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO (2007). *The Practice Guide*, September.

COTTRELL, D., J. GRANT and B. C. JOLLY (2007). "AMEE Guide No. 27: Effective educational and clinical supervision", *Medical Teacher*, Vol. 29, Issue 1, pp. 2-19.

COTTRELL, E. (2007). "Talking with patients and colleagues", *The Medical Student's Survival Guide 2: Going Clinical*, Radcliffe Publishing, Oxford, New York, pp. 25-36.

DAUGHERTY, S. R., et al. (1998). "Learning, Satisfaction, and Mistreatment during Medical Internship", *The Journal of the American Medical Association (JAMA)*, Vol. 279, No. 15, pp. 1194-1199.

DOUGHTY R. A., P. D. WILLIAMS and C. N. SEASHORE (1991). "Chief resident training. Developing leadership skills for future medical leaders", *American Journal of Diseases of Children*, June, Vol. 145, No. 6, pp. 639-642.

ECRI INSTITUTE (2019). *Top 10 Patient Safety Concerns for 2019. Executive Brief*, 19 p.

FÉDÉRATION DES MÉDECINS RÉSIDENTS DU QUÉBEC (FMRQ) (2009). "Medical residents' health: your rights and obligations – Resources and alternatives", *Le Bulletin*, Vol. 31, No. 3, March.

FÉDÉRATION DES MÉDECINS RÉSIDENTS DU QUÉBEC (FMRQ) (2013). "Professionnalism", *Le Bulletin*, Vol. 35, No. 3, Spring.

FÉDÉRATION DES MÉDECINS RÉSIDENTS DU QUÉBEC (FMRQ) (2014). *Code of Ethics for Quebec Medical Residents*, June.

GEURTS, S., C. RUTTE and M. PEETERS (1999). "Antecedents and consequences of work-home interference among medical residents", *Social Science & Medicine*, Vol. 48, Issue 9, May, pp. 1135-1148.

GOOLD, S. D. and STERN D. T. (2006). "Ethics and Professionalism: What Does a Resident Need to Learn?", *The American Journal of Bioethics*, Vol. 6, Issue 4, pp. 9-17.

GOULET, F., et al. (2013). "Effects of continuing professional development on clinical performance. Results of a study involving family practitioners in Quebec. Results of a study involving family practitioners in Quebec". *Canadian Family Physician*, Vol. 59, May, pp. 518-525.

HAGGERTY, J. L., et al. (2003). "Continuity of care: a multidisciplinary review", *BMJ*, Vol. 327, pp. 1219-1221.

HENRY, B. W., J. G. HAWORTH and P. HERING (2006). "Perceptions of medical school graduates and students regarding their academic preparation to teach", *Postgraduate Medical Journal*, Vol. 82, No. 971, September, pp. 607–612.

HICKS, P. (2011). "The Role of Supervision in Creating Responsible and Competent Physicians", *Academic Pediatrics*, Vol. 11, No. 1, pp. 9-10.

HUDDLE, T. S. (2013). "The Limits of Social Justice as an Aspect of Medical Professionalism". *Journal of Medicine and Philosophy*, Vol. 38, Issue 4, pp. 369-387.

JASWAL, J. (2013). "Mentorship in Canadian Residency Programs", Canadian Conference on Medical Education, April 22.

JULIAN, K. A., et al. (2007). "Teaching Residents to Teach: The Impact of a Multi-Disciplinary Longitudinal Curriculum to Improve Teaching Skills", *Medical Education Online*, Vol. 12, No. 12.

KIKUKAWA, M. (2013). "The characteristics of a good clinical teacher as perceived by resident physicians in Japan: a qualitative study", *BMC Medical Education*, Vol. 13, No. 100.

KRAVETZ, A. J., et al. (2011). "Patient Misunderstanding of The Academic Hierarchy is Prevalent and Predictable", *Journal of Surgical Research*, Vol. 171, Issue 2, pp. 467-472.

LANDAU, C., et al. (1986). "Stress in social and family relationships during the medical residency", *Journal of Medical Education*, Vol. 61, No. 8, August, pp. 654-660.

LAURIN, S., M.-C. AUDÉTAT and G. SANCHE (2005). "Comment planifier une intervention correctrice quand un stagiaire manque de professionnalisme?", *Le médecin du Québec*, October 22.

LINGARD, L., et al. (2002). "Team Communications in the Operating Room: Talk Patterns, Sites of Tension, and Implications for Novices", *Academic Medicine*, Vol. 77, Issue 3, March.

MACDONALD, C. (2000). "Clinical Standards and the Structure of Professional Obligation", *Professional Ethics, A Multidisciplinary Journal*, Vol. 8, No. 1, Spring, pp. 7-17.

MAULDON, E., J. RADFORD and A. TODD (2014). "Expanding capacity for supervision in general practice through student-engaged clinical audit", *Quality in Primary Care*, Vol. 22, No. 1, pp. 35-41.

MCALISTER, C. (2015). "Breaking the Silence of the Switch — Increasing Transparency about Trainee Participation in Surgery", *The New England Journal of Medicine*, Vol. 372, June, pp. 2477-2479.

MEDICAL PROFESSIONALISM PROJECT: AMERICAN BOARD OF INTERNAL MEDICINE FOUNDATION (2004). "Le professionnalisme médical pour le nouveau millénaire : une charte pour les praticiens", *Pédagogie médicale*, Vol. 5, No. 1, pp. 43-45.

MÉNARD, J.-P. (2012). "Droit et pratique: le statut légal du résident", *L'actualité médicale*, November 27.

MORROW, G., et al. (2012). "Does specialty training prepare doctors for senior roles? A questionnaire study of new UK consultants", *Postgraduate Medical Journal*, Vol. 88, No. 1044, pp. 558-565.

NOLS, J. (2002). "Responsabilité des médecins-patrons, des centres universitaires et des résidents en médecine", *Devoir de sécurité et la responsabilité des établissements de santé (Colloque)*, Éditions Yvon Blais, Cowansville, Québec, pp. 31-59.

NOVACK, D. H., R. M. EPSTEIN and R. H. PAULSEN (1999). "Toward creating physician-healers: fostering medical students' self-awareness, personal growth, and well-being", *Academic Medicine*, Vol. 74, Issue 5, May, pp. 516-620.

OGLE, K., W. SULLIVAN and M. YEO (2012). "Teaching ethics in family medicine: Introducing a faculty handbook", *College of Family Physicians of Canada*, 154 p.

OLIVER, D. (2011). "Teaching medical learners to appreciate 'difficult' patients", *Canadian Family Physician*, Vol. 57, No. 4, April, pp. 148-150.

PALLIN, D. J., et al. (2008). "Is Consent 'Informed' When Patients Receive Care from Medical Trainees?", *Academic Emergency Medicine*, Vol. 15, No. 12, pp. 1304-1308.

PELLEGRINI Jr, V. D. (2012). Perspective: "Ten Thousand Hours to Patient Safety, Sooner or Later". *Academic Medicine*, Vol. 87, Issue 2, pp. 164-167.

PETERKIN, A. D. (2008). "Staying Human during Residency Training: How to Survive and Thrive after Medical School", *University of Toronto Press*, July 5.

PORTA, C. R., et al. (2012). "Training Surgeons and the Informed Consent Process: Routine Disclosure of Trainee Participation and Its Effect on Patient Willingness and Consent Rates", *The Journal of the American Medical Association (JAMA)*, Vol. 147, Issue 1, pp. 57-62.

ROSSIGNOL, M. and L. BOOTHROYD (2016). "Les niveaux de soins: normes et standards de qualité", *Institut national d'excellence en santé et en services sociaux*, January, Gouvernement du Québec, 47 p.

ROTH, C. G., et al. (2019). "Twelve tips for the introduction of emotional intelligence in medical education", *Medical Teacher*, Vol. 441, No. 7, pp. 746-749.

ROUGAS, S., et al. (2015). "Twelve tips for addressing medical student and resident physician lapses in professionalism", *Medical Teacher*, Vol. 37, No. 10, pp. 901-907.

SAMBUNJAK, D., S. E. STRAUS and A. MARUŠIĆ (2006). "Mentoring in Academic Medicine: A Systematic Review", *The Journal of the American Medical Association (JAMA)*, Vol. 296, No. 9, pp. 1103-1115.

SANTEN, S. A. et al. (2019). "Factors Affecting Entrustment and Autonomy in Emergency Medicine: 'How much rope do I give them?", *Western Journal of Emergency Medicine*, Vol. 20, No. 1, pp. 58-63.

SANTEN, S. A., et al. (2004). "Patients' willingness to allow residents to learn to practice medical procedures", *Academic Medicine*, Vol. 79, No. 2, pp. 144-147.

SIMERJIT, S. et al. (2013). "Qualities of an effective teacher: what do medical teachers think?", *BMC Medical Education*, Vol. 13, No. 128.

STERNSZUS R., M. E. MACDONALD and Y. STEINERT (2015). "Resident Role Modeling: 'It Just Happens'", *Academic Medicine*, November 17, Vol. 91, Issue 3, pp. 427-432.

SWICK, H. M., et al. (1999). "Teaching Professionalism in Undergraduate Medical education", *The Journal of the American Medical Association (JAMA)*, Vol. 282, No. 9, September, pp. 830-832.

TAIT, A. R. (2019). "Consent Obtained by Residents: Informed by the Uninformed?", *The Journal of Clinical Ethics*, Vol. 30, No. 2, pp. 163-166.

TARDIF, J. (2006). *L'évaluation des compétences: documenter le parcours de développement*, Chenelière Éducation, Montreal, 363 p.

VAN DER LEEUW, J., et al. (2013). "The Attributes of the Clinical Trainer as a Role Model: A Systematic Review", *Academic Medicine*, Vol. 88, Issue 1, pp. 26-34.

VAN ROERMUND, T. C. M., et al. (2011). "Teachers' ideas versus experts' descriptions of 'the good teacher' in postgraduate medical education: implications for implementation. A qualitative study", *BMC Medical Education*, Vol. 11, No. 42.

VEASEY, S., et al. (2002). "Sleep Loss and Fatigue in Residency Training: A Reappraisal", *The Journal of the American Medical Association (JAMA)*, Vol. 288, No. 9, September 4, pp. 1116-1124.

WAGNER, P., et al. (2007). "Defining medical professionalism: a qualitative study", *Medical Education*, Vol. 41, No. 3, pp. 288–294.

WARD, B., G. MOODY and J. F. MAYBERRY (1997). "The views of medical students and junior doctors on pre-graduate clinical teaching", *Postgraduate Medical Journal*, Vol. 73, pp. 723-725.

WEALTHALL, S. and M. HENNING (2012). "What makes a competent clinical teacher?", *Canadian Medical Education Journal*, Vol. 3, No. 2.

WEST, C. P. and T. D. SHANAFELT (2007). "The influence of personal and environmental factors on professionalism in medical education", *BMC Medical Education*, Vol. 7, No. 29.

WETZEL, M. S. (1996). "Developing the role of the tutor/facilitator", *Postgraduate Medical Journal*, Vol. 72, pp. 474-477.

WRIGHT, S. M., et al. (1998). "Attributes of Excellent Attending-Physician Role Models", *The New England Journal of Medicine*, December 31, Vol. 339, No. 27, pp. 1986-1993.

ZENDEJAS, B., et al. (2011). "Handing Over Patient Care: Is it Just the Old Broken Telephone Game?", *Journal of Surgical Education*, Vol. 68, Issue 6, pp. 465-471.

MEMBERS OF THE WORKING GROUP

DR. MARIE ARSENAULT

Associate Dean of Postgraduate Medical Education, Université Laval

DR. SYLVIE BÉLANGER

Pediatrician and Director of the Pediatrics Program, CHU de Québec

DR. KEN DOYLE

Assistant Professor, Department of Emergency Medicine, Faculty of Medicine and Health Sciences, McGill University

DR. JOSÉE DUBOIS

Full Professor, Diagnostic Radiology, Université de Montréal

PROFESSOR ÈVE-REINE GAGNÉ

Associate Dean of Undergraduate Medical Education, Université de Sherbrooke

DR. YVES GERVAIS

Inspector, Professional Inspection Division, Collège des médecins du Québec

MS. CATHERINE LAJOIE

President of the FMEQ

MS. MARIE-ANIK LAPLANTE

Union Affairs Coordinator, FMRQ

DR. LOUISE SAMSON

Assistant Director of the Medical Education Division (in office until May 2021), Collège des médecins du Québec

BACKGROUND

The idea of developing this guide was first proposed by Dr. Anne-Marie MacLellan, Director of Medical Education at the Collège des médecins du Québec (CMQ), who recognized the importance of clearly defining the role and responsibilities of the learner and the supervisor with the objective of promoting quality care and patient safety. A working group, coordinated by Dr. Louise Samson, Assistant Director of Medical Education at the CMQ, who was assisted by Dr. Yves Gervais, Inspector, as joint coordinator, was mandated by the Executive Committee to develop the guide. The members of the working group were selected based on their role as university officers, supervisor representatives or learner representatives. The working group carried out its activities over a two-year period initially. An extensive consultation of key partners and a literature review were conducted in order to validate the working group's reflections.

ACKNOWLEDGEMENTS

The authors would like to thank the following people at the Collège des médecins du Québec for their collaboration in updating the guide: Dr. Anne-Marie MacLellan, Director of Medical Education, Dr. Armand Aalamian, Assistant Director of Medical Education, Dr. Stéphane Ouellet, Medical Adviser to the Medical Education Division, and Dr. Nathalie Saad, pulmonologist and member of the Board of Directors.