Institutional Leadership

Please note that there is intended overlap between the following three recommendations, which are mutually-related but refer to three distinct needs.

- Establish centralized Faculty of Medicine **leadership** (i.e. within a specific position) with the authority and resources to develop, implement and evaluate common principles and practices regarding the management of learner mistreatment.
- Establish a Faculty-level **advisory council** that can provide advice and recommendations regarding learner mistreatment policies, procedures, practices, and pathways as well as with respect to individual and systemic (e.g. at the level of a course or site) learner mistreatment cases.
- Provide learners with multiple, dedicated points of contact through a **student-centric mistreatment portal** and access to **advisors/advocates** who:
  - are trusted individuals with subject matter expertise
  - are non-instructive/evaluative and, for residents and fellows, ideally not from the same department
  - can listen and help clarify learner concerns
  - provide information and advice regarding pathway(s) available to address concerns
  - act as third party to help address concerns, 'informally' through facilitated discussions with relevant parties and/or through 'formal' reporting/investigation/hearing procedures
  - navigate/direct learners to counselling or other supports
  - act as consultants to staff/faculty

Accountability

- Establish Faculty-wide **templates and practices** for receiving, discussing, recording, acting upon and storing records regarding learner concerns regarding mistreatment. These templates and practices should be informed by principles including but not limited to:
  - multiple points of trusted contact, thus enabling a 'no door is the wrong door' philosophy
  - ensure pathways and processes enable and support learner agency, including with respect to decision-making about next steps
  - recognition of power imbalances in medical education and the practice of medicine
  - recognition (i.e. an 'equity lens') of factors that have and continue to contribute to the underrepresentation in medical education and the practice of medicine of individuals from equity seeking groups
  - option for learners to provide information about an incident without providing their name, with the understanding that there are limits to what can be done in such cases
  - clear distinction between 'discussion', 'disclosure' and 'reporting', including the role of the learner in providing consent to share information and initiate 'formal' reporting processes
  - opportunity for learners to discuss/disclose incidents in a safe, confidential environment in order to make an informed decision about how to proceed
  - that learners' psychological, social and physical safety are ensured in the event that an incident is discussed, disclosed or reported
  - consideration of multiple data sources, including teacher and course evaluations
  - collaborative involvement of appropriate university- and hospital-based reporting units
  - respect for due process, including process transparency, timeliness, administrative fairness and confidentiality, for both learners and faculty or other respondents
  - supportive and restorative approaches to address concerns, including clarity that any intimidation or retaliation to disclosures, reports or investigations of mistreatment are considered a form of mistreatment and are subject to action as such
- Develop Faculty-level processes and supports to enable and **manage the collection, analysis and reporting (both internal and public) of learner mistreatment data**, including clarity regarding responsibility for the identification of 'trends' as well as how they will be/have been addressed and reported. Communication to learners of steps taken to address (de-identified) instances of learner mistreatment is important to addressing a barrier to reporting identified in the 'Voice of' surveys and other reports.

Clarity

- Provide learners, faculty and other stakeholders with as much clarity as possible regarding types or categories of mistreatment, including general definitions, references to relevant 'foundational' or reference documents, and representative examples.
- Provide learners, faculty and other stakeholders with as much clarity as possible regarding procedures to determine 'jurisdiction' in cases that involve multiple Faculty, University and/or hospital stakeholders.
- Consistency, collaboration, continuity, and common language around principles, pathways, and initiatives, including with respect to how disclosure/reports based on or informed by social identity are addressed.

Awareness

- Provide learners, faculty and other stakeholders with easily accessible information regarding mistreatment policies, procedures and supports that is unambiguously identified as such and easily accessible. Participatory design thinking approach is recommended.
- Provide learners with multiple and timely education and awareness opportunities (e.g. e-modules, workshops) about mistreatment policies, procedures and supports, and initiatives for improvement. Such opportunities should not be burdensome for learners (i.e. just another task that needs to be completed) and should be catalogued and evaluated for impact.
- Provide tailored education/training/development opportunities to learners, faculty and other stakeholders that are aligned with the Faculty's "We All Belong" campaign to create a more inclusive and welcoming environment for all learners, faculty and staff. Examples of opportunities for cohort-specific, mandatory training may be coupled as follows:

Cohort	**Mandatory Event Location**
Medical students	Curriculum
Residents, Fellows, Faculty	Annual re/appointment process
Non-MD Health Professionals and staff	Annual review