University of Calgary

Cumming School of Medicine

Mini-DCI

Status Report

Due March 16, 2018 (review May-June 2018)

1.4 AFFILIATION AGREEMENTS (U)

In the relationship between a medical school and its clinical affiliates, the educational program for all medical students remains under the control of the medical school's faculty, as specified in written affiliation agreements that define the responsibilities of each party related to the medical education program. Written agreements are necessary with clinical affiliates that are used regularly for required clinical learning experiences; such agreements may also be warranted with other clinical facilities that have a significant role in the clinical education program. Such agreements provide for, at a minimum:

- ***a) the assurance of medical student and faculty access to appropriate resources for medical student education***
- ***b) the primacy of the medical school's authority over academic affairs and the education/ assessment of medical students***
- ***c) the role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching***
- ***d) specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury***
- ***e) the shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment that is conducive to learning and to the professional development of medical students***

Definition taken from CACMS lexicon

- *Required clinical learning experience: A subset of required learning experiences that take place in a health care setting involving patient care that are required of a student in order to complete the medical education program. These required clinical learning experiences may occur any time during the medical educational program.*

Finding: There is no affiliation agreement applicable to medical students for Stanton Territorial Health Authority and Yellowknife.

SUPPORTING DATA

Table 1.4-1 | Affiliation Agreements — Source: School-Reported

For the Stanton Territorial Authority and for Yellowknife, provide the page number in the current affiliation agreement and highlight the passages containing the following information:

a. assurance of medical student and faculty access to appropriate resources for medical student education
b. primacy of the medical school's authority over academic affairs and the education/ assessment of medical students
c. role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching
d. specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury
e. shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment that is conducive to learning and to the professional development of medical students

Campus	Clinical teaching site or regional health authority	Date agreement signed	Page number(s)				
			(a) Access to resources	(b) Primacy of program	(c) Faculty appointments	(d) Environmental hazard	(e) Learning environment
N/A	NTHSSA (subsumes Yellowknife and Stanton)	March 2018	Pages 8 & 9	Page 1	Pages 4 & 10	Pages 13 & 14	Pages 1 & 10

The affiliation agreement has been negotiated, and signed by Dr. Dru Marshall, Provost of the University of Calgary (this version attached as an appendix). At the time of submission of the mini-DCI, it is awaiting signature by the Northwest Territories Health and Social Services Authority (NTHSSA).

SUPPORTING DOCUMENTATION

a. The signed/executed affiliation agreement for Stanton Territorial Health and for Yellowknife. (***Appendix 1.4 a***)

Appendix_1.4_a1_NTHSSAUMEaffiliationagreement

3.2 COMMUNITY OF SCHOLARS/RESEARCH OPPORTUNITIES (SM)

A medical education program is conducted in an environment that fosters the intellectual challenge and spirit of inquiry appropriate to a community of scholars and provides sufficient opportunities, encouragement, and support for medical student participation in research and other scholarly activities of its faculty.

Finding: A repository of research opportunities was recently created. There are no data on the effectiveness of the repository at improving first and second-year student awareness of research opportunities.

SUPPORTING DATA

Table 3.2-1 | Student/Faculty Collaborative Research — SOURCE: school-reported

Provide internal data on the percentage of respondents reporting participation, no opportunity or no interest in research or other scholarly activities with a faculty member. Add rows as needed for each campus.				
Campus		School %		
		Year 1 (class 2020) (n=149)	Year 2 (class 2019) (n=128)	Year 3 (class 2018) (n=119)
SOURCE: additional survey sent to our current classes in January 2018 (question now added to our year-end surveys). There are 160 students per year.	Participated	32.2	55.5	60.5
	No opportunity	12.1	18.0	10.0
	No interest	10.7	7.8	12.6
	No, I plan to participate later	36.2	9.4	12.6
	No, other reason	8.7	9.4	4.2

NOTE: This was presumed to be activities outside of curriculum, as 100% of students participate in scholarly activities as part of our MED 440 course and Population Health community correlation project.

Table 3.2-2 | Student/Faculty Collaborative Research — Source: AFMC GQ

Provide the data from the AFMC Graduation Questionnaire (AFMC GQ) on the percentage of respondents reporting participation, no opportunity or no interest in research or other scholarly activities with a faculty member. Add rows as needed for each campus.				
Campus		School %		
		2015(80% response rate)	2016 (80% response rate)	2017(72% response rate)
	Participated	58.1	65.6	70.3
	No opportunity	11.0	10.2	5.1
	No interest	30.9	22.7	18.6

Table 3.2-3 | Research Opportunities — Source: School-Reported

Provide the total number of medical students involved in each type of research opportunity for the indicated academic years. Add rows as needed for each campus.				
Campus		AY 2014-15	AY 2015-16	AY 2016-17
	MD/PhD program	35	43	47
	Summer research program	0	0	0 (no summers off)
	Leave for research	0	1	1
	Research elective	6	3	7

	Other: (see narrative re: LIM program)			

NARRATIVE RESPONSE

a. Describe the opportunities for medical students to participate in research and other scholarly activities of the faculty.

Our data is showing (see Table 3.2-2) a steady increase (70% in 2017 CGQ) of students choosing to do research outside of structured curricular time. These numbers are showing to be steady re: Table 3.2-1, showing that 60.5% of students in their final year have completed research, and close to a third of our first-year students (six months into school) are involved in research.

The numbers presented in the preceding tables were presumed to be activities outside of the formal curriculum. 100% of our students participate in three curricular-related research activities:

- Applied Evidence Based Medicine (MED 440) provides an opportunity to explore in depth an area of particular interest to each student. Students under the supervision of a preceptor may complete a research project. Others may pursue a clinical experience utilizing critical appraisal skills to address questions related to prognosis, investigation and/or treatment. Alternatively, students may pursue supervised electives in such areas as History of Medicine, Pathology, Health Economics, Community Health, Palliative Care, Rehabilitation Medicine, etc. For the last class who did MED 440 (our current second years, class of 2019), there were 37 research electives done and 36 "directed study" electives. Directed study electives are an in-depth study of a particular area, which can lead to research in the area. For example, 11 students this year did and presented research in the area of quality improvement/patient safety, under the supervision of Dr. Ward Flemons, as part of this course
- Family Medicine clerkship critical appraisal project
- Research as part of the Population Health community correlations project. This includes preparation and submission of a formal abstract, that is reviewed with a faculty prior to and after submission

There are 2 main "internal" drivers (CaRMS may be an important "external" driver) of increased interest in research:

1. Leaders in Medicine (LIM) is a flagship program within the school. It is a combined MD with a Graduate studies program. Currently we have 73 students that are formally part of LIM, either doing a MD MSc or MD PhD. We also have 83 LIM affiliates. All students have opportunity to be affiliate members even if they don't pursue a joint degree. Affiliate students are enrolled solely in the MD program and but have a strong interest in research, and are eligible for many of the benefits of the program, including mentoring, travel awards and attendance at symposia, journal clubs and social events. Every year, student research is presented at a very well attended LIM symposium. The entire LIM program had close to 300 peer-reviewed publications in the past three years, as is presented below.

This is a detailed table that outlines the productivity of LIM members: (DATA source: students' LIM annual reports). The first table is the productivity of LIM affiliates, the second table is the MD/MSc/MBA/MA students, the third MD/PhD, and the fourth the total of all these students.

	AcademicYear 2014-15	AcademicYear 2015-16	AcademicYear 2016-17
# affiliates	70	113	83
# publications (published)	24 (9 students)	26 (17 students)	36 (16 students)
# publications (submitted/in press)	10 (7 students)	29 (20 students)	16 (9 students)
# books/book chapters	1 chapter (1 student)	0	1 chapter (1 student)
Intellectual property	0	0	1 (1 student)

patents			
# presentations, local conferences (poster or talk)	3 (2 students)	19 (14 students)	20 (14 students)
# presentations, national/international conference (poster or talk)	11 (8 students)	29 (17 students)	18 (12 students)
Funding supporting research	7 awards	16 awards	12 awards

	AcademicYear 2014-15	AcademicYear 2015-16	AcademicYear 2016-17
# MD/MSc/MBA/MA	26	26	30
# publications (published)	14 (5 students)	10 (6 students)	20 (11 students)
# publications (submitted/in press)	5 (5 students)	14 (6 students)	16 (9 students)
# books/book chapters	0	0	0
Intellectual property patents	0	0	0
# presentations, local conferences (poster or talk)	9 (6 students)	5 (3 students)	13 (8 students)
# presentations, national/international conference (poster or talk)	15 (11 students)	12 (5 students)	13 (10 students)
Funding supporting research	20 awards	15 awards	20 awards

	AcademicYear 2014-15	AcademicYear 2015-16	AcademicYear 2016-17
# MD PhD	35	43	47
# publications (published)	67 (23 students)	54 (21 students)	42 (18 students)
# publications (submitted/in press)	43 (22 students)	41 (22 students)	33 (17 students)
# books/book chapters	2 manuals 4 chapters (3 students)	4 chapters (3 students)	1 manual 4 chapters (3 students)
Intellectual property patents	0	1 (1 student)	1 (1 student)
# presentations, local conferences (poster or talk)	40 (22 students)	41 (20 students)	28 (14 students)

# presentations, national/international conference (poster or talk)	61 (24 students)	51 (21 students)	39 (19 students)
Funding supporting research	65 awards	63 awards	35 awards

	AcademicYear 2014-15	AcademicYear 2015-16	AcademicYear 2016-17
# TOTAL LIM members	131	182	160
# publications (published)	105 (37 students)	90 (44 students)	98 (45 students)
# publications (submitted/in press)	58 (34 students)	84 (48 students)	65 (35 students)
# books/book chapters	2 manuals 5 chapters (4 students)	4 chapters (3 students)	1 manual 5 chapters (4 students)
Intellectual property patents	0	1 (1 student)	2 (2 students)
# presentations, local conferences (poster or talk)	52 (30 students)	65 (37 students)	61 (36 students)
# presentations, national/international conference (poster or talk)	87 (43 students)	92 (43 students)	70 (41 students)
Funding supporting research	92 awards	94 awards	67 awards

2. Recent initiatives since accreditation. Two particular ones of note. As part of the 2016 accreditation ISA, it became apparent that a subgroup of our students were not aware of research opportunities. Two major changes occurred because of this. Firstly, a yearly seminar on research has taken place, involving LIM students, LIM faculty, Dr. Kevin McLaughlin (UME Assistant Dean Research) and Dr. Gerald Zamponi (Senior Associate Dean Research). In 2017, for the class of 2020, this was moved to the orientation week, thus increasing attendance from a previous maximum of 60 to the entire class. In addition to this, as mentioned in the "findings" above, a repository has been created with a list of faculty members keen on accepting our students for research projects. The repository lists the faculty member's name, then the following information: email address, department, website information, general area of research, specific area of research, basic science/computer/clinical/statistical areas. The repository has 84 interested faculty members listed, has been distributed to all the classes, and the ume_research.html document has been accessed 1412 times since being put online.

Table 3.2-1 shows that only 10% of our final-year students felt there was "no opportunity" for research. This was the first class to benefit from the increased attention to communication of research opportunities, including the repository. Very encouraging to us is that only 12% of the first-year class felt that there were no opportunities for research. One of the limitations from the survey is that it is difficult to know what percentage of these mean "no opportunity due to competing time pressures" as opposed to "no opportunity provided by faculty".

b. Describe how students are encouraged to participate in and informed about research and other scholarly activities in the medical school.

Two main activities "set the tone" for a culture of research and inquiry:

- Three of the school's "big 10" exit objectives, which are presented during orientation, include relevant research statements such as "apply an evidence-based approach", "demonstrate self-directed life-long learning skills" and "describe the basic principles of clinical and translational research, including how such research is conducted, evaluated, explained to patients and applied to patient care"
- The LIM program provides an amazing "collateral energy" for research at the school. The LIM program is described during the application process. About 1/3 of our students are either full-time or affiliate LIM members. The LIM group encourage and inform students about research during orientation, and the annual LIM symposium

In addition, many of our students come from our Bachelor of Health Sciences program, which is heavily invested in research. As well, the information provided in the repository is extremely useful for encouraging student research, by providing detailed information on a large number of interested faculty.

Funding is in place for students wishing to enroll in the Leaders in Medicine program. Other than that, funding for research projects is available through researchers' operating grants, Lydia Sikora fund for all students, LIM research awards, CIHR vouchers (for undergrad students), AIHS scholarships, and the Mach-Gaensslen Foundation of Canada Research Funding.

Small grants ($1000) are available to send students to conferences where they are presenting. Students are eligible for this funding once during the three-year program. In the past four years, an average of 40 students per year have taken advantage of this funding.

Students are given excused absences to present their research at conferences.

3.3 DIVERSITY/PIPELINE PROGRAMS AND PARTNERSHIPS (U)

A medical school in accordance with its social accountability mission has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior academic and educational leadership, and other relevant members of its academic community. These activities include the appropriate use of effective policies and practices, programs or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of policies and practices, program or partnership outcomes.

Definition taken from CACMS lexicon

- *Senior academic and educational leadership: Individuals in high-level positions who are leaders of academic units e.g., department chairs, or leaders of the medical education program e.g., vice-dean, associate dean, curriculum chair, and directors of required learning experiences.*

Finding: There is no evidence of ongoing, systematic and focused recruitment and retention activities at the faculty and senior leadership level of Aboriginal, visible minorities and persons with disabilities. The Committee notes that the Cumming School of Medicine is however doing excellent work with regards to student diversity.

SUPPORTING DATA

Table 3.3-1 | Diversity Categories and Definitions — Source: School-Reported

Provide definitions for the diversity categories identified in medical school policies that guide recruitment and retention activities for medical students, faculty, and academic and educational leadership. Note that the medical school may use different diversity categories for each of these groups. If different diversity categories apply to any of these groups, provide each relevant definition. Add rows as needed for each diversity category.

Cumming School of Medicine (CSM)

Historically, the four designated groups – Women, Indigenous Peoples, Visible Minorities, Persons with Disabilities – have been under-represented in the CSM. Recent strategies introduced to increase these numbers include recruiting and retention activities that are transparent, inclusive and mindful of the strength in diversity. *Equity Guidelines for Search and Selection Committees* have been introduced to raise awareness, broaden the applicant pool, standardize candidate selection methods, structure interviews, and create a review process. New recruitment advertising emphasizes that the CSM is committed to fostering diversity through cultivating an environment where people with a variety of backgrounds, genders, interests, and talents feel welcome. Putting the right structures (policies and practices) in place under the umbrella of a new Office of Professionalism, Equity, and Diversity whose mission it is to advance diversity for each department and institute moves our school to greater inclusion and diversity. In 2018, the new office will also start to track metrics to determine the percentage of self-identifying applicants who are invited to an interview.

41% of our faculty is now women. A new funding opportunity through the University of Calgary Provost's Office enabled the CSM to fill 9 new positions with women. Indigenous Peoples represent 3% of Calgary's general population according to the 2016 Federal Government Census. In a recent voluntary *Self-Identification Census* taken in the CSM, 2.9% of respondents reported being Indigenous. The *CSM Indigenous Health Program* and the *CSM Indigenous Health Dialogue* complement the University of Calgary's *ii'taa'poh'to'p* Indigenous Strategy launched in December 2017 to achieve greater inclusion with Indigenous Peoples.

While we recognize the importance of the four designated groups, the CSM also recognizes that other factors may currently contribute to a broader definition of diversity. As a starting point, the CSM conducted a voluntary *Self-Identification Census* in the Fall of 2017 with departments to understand our Faculty's diversity and to what extent the composition of departments reflect the current demographics of Southern Alberta – the area in which the school's faculty and students work and train.

A new website (cumming.ucalgary.ca/professionalism-equity-diversity) reflects the CSM's commitment to inclusion and diversity, and outlines policies and practices to achieve mission appropriate outcomes.

In 2018, the Office of Professionalism, Equity, and Diversity plans a policy review. This will be implemented through its Advisory Committee. The committee comprising Department

and Institute diversity representatives reports to the Associate Dean, Professionalism, Equity, and Diversity, and is also responsible for creating and implementing innovative strategies to align with the CSM mission-appropriate outcomes. Mission-appropriate outcomes are defined by the CSM as fulfilling our social responsibility to the diverse populations we serve across Southern Alberta in which the common goal of improved health guides service, education, and research.

School-identified diversity category	Faculty	Academic and Educational Leadership
Women	As of February 2018, 41% of our faculty is women.	Academic and Educational Leadership in the CSM comprise the following: Dean, Vice-Dean, Senior Associate Dean (Education), Associate Deans, Assistant Deans, Department Heads. See Table 3.3-2 for details.
Indigenous Peoples	The CSM uses the 2016 Federal Government Census definition of Indigenous Peoples as: First Nations, Inuit, and Métis.	
Visible Minorities	Members of a Visible Minority mean persons other than Indigenous Peoples who are non-white in colour. The top three Visible Minorities in the Calgary metropolitan area are: South Asian (26.5%); Chinese (19.3%); Filipino (15.3%).	
Persons with Disabilities	The University of Calgary considers Persons with a Disability to mean those who have a long-term or recurring physical, mental, sensory, psychiatric, or learning impairment. In the CSM those who self-identify as having a disability are further defined as those with accommodation and those without accommodation.	

Source: School-Reported

Table 3.3-2 | Students, Faculty and Academic and Educational Leadership

Provide the requested information on the percentage of enrolled students, employed faculty, and senior academic and educational leadership in each of the school-identified diversity categories (as defined in table 3.3-1 above).

School-identified diversity category	Faculty (%)*	Academic and Educational Leadership (%)			
		Department Heads	Education Associate Deans	Education Assistant Deans	Dean, Vice-Dean, Senior Associate Dean (Education)
Women	41%	10%	50%	75%	66%
Indigenous Peoples	2.9%	0%	0%	0%	0%
Visible Minorities	18%	10%	0%	0%	0%
Persons with Disabilities:					
a) with accommodation	2.6%	0%	0%	0%	0%
b) without accommodation	3.6%	0%	0%	0%	0%

*Data on 'women' was provided by CSM Office of Analytics (extracted from the University of Calgary database). The remaining data was provided by the voluntary *2017 CSM Self-Identification Census* (28% response rate), and whether the response rate reflects the entire Faculty population or whether the results are the best indicator of the CSM population cannot be determined at this time. Comparative data does not yet exist, either in the University of Calgary database or within the Cumming School of Medicine. A longitudinal study with greater in-depth analysis will be needed.

NARRATIVE RESPONSE

a. Describe the policies and practices in place to achieve mission-appropriate diversity outcomes, for each of the following groups:

1. faculty

1. The Cumming School of Medicine (CSM) is currently guided by the following policies and practices. A policy review is underway, as noted above.
   1.1. *University of Calgary Employment Equity Policy* defines the designated groups listed in Tables 3.3.1 and 3.3.2. This policy requires that measures be taken by all faculty and staff for the identification and removal of artificial barriers to the selection, hiring, promotion and training of the designated groups.
   1.2. *CSM's Professional Standards for Faculty Members and Learners* require that all faculty members and students treat everyone with respect and without discrimination in any interactions with others, on protected grounds such as (but not restricted to) age, race, colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or mental disability, sex, sexual orientation.
   1.3. *CSM's Diversity Vision and Mission Statement* was created in 2017, and establishes the need to foster a culture of inclusion, respectful of differences in perspective and life experience, along with ensuring that equitable processes be taken by redefining recruitment and retention processes to ensure diversity in ideas, curricula, and merit practices.
   1.4. *CSM's Mentorship Policy/Program* was created in 2009 in response to the need to mentor junior faculty to ensure career development and success. Department Heads have been key to establishing mentor/protégé relationships, and while the policy does not specifically identify the school-identified diversity categories, this is being addressed under the policy review.
   1.5. *CAUT Equity Policy* is committed to securing equity for members of marginalized groups disproportionately excluded from full participation in the academy. All CSM faculty are members of CAUT.
2. Since its inception in 2008, the *Indigenous Health Program* has been working to train both medical students and faculty. In 2015, the CSM launched an *Indigenous Health Dialogue* (IHD) to create new opportunities, new programs, develop best practices, and to facilitate the development of critical institutional policies and processes within the school. These initiatives align with *ii'taa'poh'to'p*, the University of Calgary's Indigenous Strategy, launched in December 2017 to promote awareness, education, and understanding between Indigenous and non-Indigenous peoples.

2. senior academic and educational leadership

1. Senior academic and educational leadership are also guided by the same policies as those listed for faculty.
2. Women in Leadership. Eligible applicants are fully funded by the Dean's Office to attend an executive development program – *Executive Leaders in Academic Medicine (ELAM)* – which trains and supports current and future women faculty members for leadership roles.
3. CSM Leadership Development Program is an innovative dual-faculty program developed in partnership between the CSM and Haskayne Executive Education at the University of Calgary that provides participants with diverse leadership learning experiences for the purpose of initiating change in CSM units and to build leadership capacity.
4. Senior leadership has appointed an Associate Dean of Professionalism, Equity, and Diversity with a mandate to help departments move towards achieving more equitable and diverse outcomes by establishing new equity guidelines for search and selection committees, adjust hiring advertisements to reflect greater inclusion and diversity, and propose ways to recruit and retain faculty for greater inclusion and diversity.
5. The CSM's 2015-2020 Strategic Plan (p.42) specifies the need to develop ways to measure our school's performance. Under the leadership of the Associate Dean of the Office of Professionalism, Equity, and Diversity, the office has developed key performance indicators (KPI's) as a way to measure and support diversity initiatives. The Office will also work with and report data to the CSM Office of Analytics for the purpose of strategic planning.

b. Describe the recruitment and retention activities in place to achieve mission-appropriate diversity outcomes, for each of the following groups:

1. faculty

Recruitment and Retention

1. The CSM *Equity Guidelines for Search and Selection Committees* (approved by Department Heads) includes: raising awareness by taking an online version of the implicit association test on unconscious bias; broadening the applicant pool; creating inclusive search procedures that require input from underrepresented groups; selecting a diverse search committee to ensure equity; structuring interviews; and creating a review process. The guidelines are being implemented by CSM Institutes to develop equity recruitment plans as required by the University of Calgary CRC Equity Diversity and Inclusion Action Plan.
2. Recent recommendations by the Office of Professionalism, Equity, and Diversity include:
    2.1. Recruit for greater diversity during CaRMS and from within the CSM graduate student and postdoctoral fellow pool.
    2.2. Build religious and cultural inclusion into the workplace in order to attract and support a diverse faculty; such as respecting religious holidays, accommodating dietary restrictions at meetings, and developing appropriate prayer spaces.
    2.3. Select a diversity advocate from each department, at least two women and one other representative from a designated group to serve on Search and Selection Committees.
    2.4. Consider support mechanisms required for a diverse hire, including those who are uniquely abled.
    2.5. Don't penalize candidates for "resume gaps" that coincide with child-bearing and child-rearing years.
    2.6. Support families by developing a process for maternity/paternity leave, a care-giver network for children and elderly parents, adjust meeting times and Faculty Retreat locations to support families' needs and school schedules.
3. Faculty recruitment advertisements are being streamlined for faculty-wide use to promote inclusion and diversity. Refer to attached *CSM Recruitment Advertisement.*
4. University of Calgary Provost (P25) hires. Funded by the Provost, the CSM is striving for greater diversity within this new funding opportunity. As of January 31, 2018, 17 positions have been filled with 9 of those being women.
5. Alberta Indigenous Mentorship in Health Innovation (AIM-HI) Network aims to support Indigenous health researchers and is part of a nationwide initiative to recruit and retain First Nation, Inuit and Métis scholars in health research. An evaluation component will track success rates and will inform a longer-term recruitment and retention strategy.
6. Network of Women in Medicine (NOW) is a collaboration of academic and clinical women faculty in the CSM that seeks to provide support at all stages of their careers.
7. The Vice-Chair, Mentorship, Equity and Diversity from the University of Toronto (academic/researcher & equity/diversity advocate) will lead a summit in the CSM (April 27, 2018) on strategies to achieve greater inclusion and diversity.
8. The CSM Associate Dean, Professionalism, Equity, and Diversity has established an Advisory Committee with representatives from departments and institutes. Committee objectives: advance diversity for each department and institute; establish metrics that align with the Office of Professionalism, Equity, and Diversity KPI's; establish a Visiting Scholar Program from one of the designated groups for the purpose of developing a pipeline to cultivate faculty from under-represented groups; and develop an internal distinguished achievement award for outstanding contributions to inclusion and diversity.
9. The Office of Professionalism, Equity, and Diversity will work to build awareness within CSM Departments around seminars and other workshops for the purpose of sending diverse faculty members for training, such as: *AAMC Mid-Career Minority Faculty Leadership Seminar*; and *AAMC Early Career Women Faculty Leadership Development Seminar*.

2. senior academic and educational leadership

Recruitment and Retention

1. To date, the CSM's senior academic and educational leadership consists of the Dean, Vice-Dean and Senior Associate Dean (Education). Of these three positions, two are held by women.

2. For the position of dean, the CSM is guided by the University of Calgary's Policy on *Appointment and Reappointment of Deans.* The accompanying *Procedure for Appointment and Reappointment of Deans Appendix 1* specifies that the composition of the Advisory Committee be gender representative and gender inclusive.
3. The Academic Leadership Academy (ALA) at the University of Calgary provides opportunities for new and experienced academic leaders (deans, department heads, associate deans, program directors, committee chairs) to advance their leadership expertise. Developed by the Provost's Office, the ALA aims to develop, attract, and retain highly competent and effective senior academic leaders.

SUPPORTING DOCUMENTATION

Policies aimed at achieving mission-appropriate diversity in faculty, and senior academic and educational leadership. (***Appendix 3.3 a***)

Appendix 3.3a1 - University of Calgary Employment Equity Policy
Appendix 3.3a2 - University of Calgary Appointment and Reappointment of Deans: Procedure for Appointment and Reappointment of Deans Appendix 1
Appendix 3.3a3 - Professional Standards for Faculty Members and Learners in the Faculty of Medicine at the University of Calgary
Appendix 3.3a4 - CSM Diversity Vision and Mission Statement
Appendix 3.3a5 - Faculty of Medicine Mentorship Policy & Program Workbook
Appendix 3.3a6 - CSM Equity Guidelines for Search and Selection Committees
Appendix 3.3a7 - CSM Faculty Recruitment Advertisement
Appendix 3.3a8 - CAUT Equity Policy

3.6 STUDENT MISTREATMENT (SM)

A medical school defines and publicizes its code of conduct for faculty-student relationship in its medical education program, develops effective written policies that address violations of the code, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing inappropriate behaviors. Mechanisms for reporting violations of the code of conduct (e.g., incidents of harassment or abuse) are understood by students and ensure that any violations can be registered and investigated without fear of retaliation.

Finding: Recommendations of the Student Mistreatment Task Force have been largely adopted and implementation is underway. The student body views these efforts positively. Data on delivery and impact is not yet available.

Table 3.6-5 | Student Mistreatment Experiences Source: AFMC GQ

Provide the data from the AFMC GQ on the percentage of respondents that reported one or more of the following experiences for the listed academic year. Add rows as needed for each campus.

Campus		School %											
		Never			Once			Occasionally			Frequently		
		2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
	Publicly humiliated	69.9	65.6	56.8	9.6	13.0	17.8	17.6	15.3	22.0	5.9	7.6	3.4
	Threatened with physical harm	97.8	99.2	97.5	1.5	0.8	1.7	0.7	0	0.8	0	0	0
	Physically harmed	98.5	99.2	99.2	1.5	0.8	0	0	0	0.8	0	0	0
	Required to perform personal services	88.2	80.0	94.9	3.7	8.5	2.5	6.6	10.8	2.5	1.5	0.8	0
	Subjected to unwanted sexual advances	94.9	94.7	92.4	1.5	3.8	5.9	2.2	1.5	0.8	1.5	0	0.8
	Asked to exchange sexual favors for grades or other rewards	99.3	100	100	0	0	0	0.7	0	0	0	0	0
	Denied opportunities for training or rewards based on gender	86.7	82.4	91.5	5.9	7.6	3.4	4.4	5.3	4.2	3.0	4.6	0.8
	Subjected to offensive, sexist remarks/names	82.4	75.6	69.2	8.8	13.0	16.2	8.1	7.6	9.4	0.7	3.8	5.1
	Received lower evaluations /grades based on gender	97.1	94.6	94.9	0.7	1.5	4.3	0.7	3.1	0.9	1.5	0.8	0
	Denied opportunities for training or rewards based on race or ethnicity	97.1	95.4	98.3	0	1.5	0	0.7	2.3	0.8	2.2	0.8	0.8
	Subjected to racially or ethnically offensive remarks/names	94.9	87.8	89.0	1.5	4.6	1.7	2.2	4.6	6.8	1.5	3.1	2.5
	Received lower evaluations or grades solely because of race or ethnicity rather than performance	98.5	96.2	98.3	0	3.1	0.8	0	0.8	0.8	1.5	0	0

	Denied opportunities for training or rewards based on sexual orientation	98.5	99.2	100	0	0	0	0.7	0.8	0	0.7	0	0
	Subjected to offensive remarks / names related to sexual orientation	96.3	93.9	95.7	1.5	2.3	1.7	0.7	2.3	1.7	1.5	1.5	0.9
	Received lower evaluations or grades solely because of sexual orientation rather than performance	99.3	100	100	0	0	0	0	0	0	0.7	0	0

Table 3.6-6 | Student Mistreatment Experiences by Curriculum Year Source: School-Reported

Provide internal data on the percentage of respondents that personally experienced student mistreatment by curriculum year. Add rows as needed for each campus.					
		School %			
Campus		Year 1	Year 2	Year 3	Year 4
SOURCE: additional survey sent to our current classes in January 2018 (question now added to our year-end surveys) Each class has 160 students.	I personally experienced mistreatment	10.1% 149 responses	21.1% 128 responses	26.1% 119 responses	No fourth year class

NARRATIVE RESPONSE

a. Summarize the procedures used by medical students to report personally experienced incidents of mistreatment in the learning environment. Describe how reports are made and identify the individuals to whom reports can be directed. Describe the way in which the medical school ensures that allegations of mistreatment can be made and investigated without fear of retaliation. Describe the process(es) used for follow-up when reports of mistreatment have been made.

There is no question this standard was the main internal focus leading up to our accreditation site visit in 2016, and the one that we are most proud of from a "quality improvement" perspective post accreditation.

To answer the questions, we must go back to the "mistreatment task force" recommendations. This task force was led by both students and faculty. The task force met several times in 2015 and 2016, made six major recommendations, all of which have been achieved. The task force met one year after our site visit (meeting April 13, 2017) to revisit the recommendations and confirm their achievement.

Recommendation	Action taken
creation of an on-line "safe zone" for reporting	The website, mistreatment.ucalgary.ca, has been created since early 2016. The website has been extensively used. As of August 31, 2017, the site had: - 2660 Page Views - 1962 Unique Page Views - 494 views of the "I need help" area - 390 views of the "what is mistreatment" area - 341 views of the "the reporting process" area - 591 views of the "report card" area (see below for example report card)

	Feedback has been excellent from the students regarding the website. This is reflected in the end-of-year surveys (see "additional data" in appendices). The year-end surveys ask the following 3 questions: 1. You are familiar with the school's mistreatment reporting process 2. You know how to access the schools mistreatment advisors 3. You are satisfied with how the school deals with student mistreatment
Appointment of 2 faculty members, to act as advocates for students in mistreatment situations	Two Student Advisors for Mistreatment or SAMs, were appointed in early 2016. Dr. Deirdre Jenkins continues in her role, but recently Dr. Sarah Weeks replaced Dr. Reg Sauve (who retired) in that role. Three faculty members competed for this recent posting. The SAMs are the first point of contact for a student who has a mistreatment concern. The SAMs are there to: - support the students - validate the concerns - decide if a student wishes to pursue the concern - at times, discuss with the involved faculty member - at times, take the concern to UME to follow the process outlined in the next page The following is a summary from Dr. Deirdre Jenkins regarding the SAMs meetings with students (time period January 2016-2018) - 39 students met with a SAM for 41 incidents - 36 of the 41 incidents were student to faculty, 3 student-student, 1 resident-student, 1 student-staff - 14 of the 41 incidents were resolved with initial discussion with the SAMs, 13 led to the SAMs discussing with the involved faculty member (with resolution), 10 led to the SAMs taking the concern to UME (with resolution, via the process outlined on the next page), 2 were taken to the student professionalism committee, and 2 are in progress
Creation of an on-line module	The UME hired professional actors (total budget $4084.67) to create 3 on-line videos. The topics from the videos had been prepared by a large group of faculty and students, under the leadership of the former Associate Dean of Professionalism, Equity, and Diversity (OPED). These topics had been presented to Department Heads and educational leaders at the December 5, 2016 Leadership Forum meeting. The videos highlight one instance of racism, one instance of public humiliation, and one instance of mistreatment in the setting of preceptor fatigue. More discussion about these is presented in the last question below.
Create a session for new students during Orientation week	This has been implemented since 2016, and explains the process of reporting to the new class.
Development of curriculum that focuses on positive behaviors and communication between students and preceptors.	This has also been done, through the work of the modules but also as part of our Well Physician course in the pre-clerkship.

Further evaluation of mistreatment and its place in the culture of medicine	The incredible work of this task force, as well as the Dean of Medicine, the Associate Dean of OPED, has led to significant discussions about mistreatment in our faculty. As well, our students and faculty were leaders in a national forum on mistreatment, as part of CCME 2017. While mistreatment issues unfortunately still occur, we are happy to report that the culture and learning environment in our school is very favorable, as indicated by the results of our end-of-year surveys, particularly scores of 4 to 4.5/5 on question c and d (see "additional data" in appendices.

The following summarizes our procedure for dealing with student reports of mistreatment. Highlights of the procedure are:

- Students can seek the help of our Student Advisors for mistreatment
- Student can report anonymously (via website, end-of-course surveys, end-of-clerkship surveys) which has no possibility of retaliation, as well as non-anonymously directly to faculty leaders, UME administration (this has occurred, as indicated in the report card below, with no instances of retaliation ever reported)
- End-of-course and end-of-clerkship surveys are consistently and regularly reviewed by our UME management team (includes Associate Dean and 3 Assistant Deans), from a presentation by our Program Evaluation Consultant, Dr. Wayne Woloschuk

A) Procedure for Undergraduate Medical Education (UME) Faculty to Student Mistreatment investigation

There are four broad ways student can report mistreatment/professionalism concerns related to faculty.

1) Anonymously through end-of-course or end-of-clerkship survey and/or preceptor ratings (these will flag to Assistant Dean and UME Director of program evaluation) , or directly to associatedean.ume@ucalgary.ca via the http://mistreatment.ucalgary.ca/ website)

PROCESS:

- The UME Program Evaluation Consultant presents regularly to UME management
    - If possible, the Associate Dean of OPED is invited to attend if a concern is being flagged
- Teaching concerns are discussed (by Assistant Deans) with course/clerkship leaders
- Mistreatment/professionalism concerns proceed in the following manner:
    - Five years of evaluations and comments are screened
    - One single "minor" concern (example of "minor": future student physical/emotional well-being not jeopardized by this preceptor continuing to teach) would lead to:
        - the concern brought to the attention of course/clerkship leaders
            - In most instances, they would discuss with preceptor involved (a formal meeting may not take place if this is a minor concern in the setting of very positive comments)
            - At their discretion/wish could involve Assistant/Associate Dean and/or divisional/departmental leadership
    - repeated "minor" concerns or a "major" concern (example of "major": future student physical/emotional well-being jeopardized by this preceptor continuing to teach) would lead to immediate meetings involving:
        - course/clerkship leadership (who could excuse themselves if they wished)
        - the preceptor involved
        - Assistant and/or Associate Dean
        - Division/Departmental leadership (who could be notified and defer to UME if they wished)
- At any time, Associate Dean can ask for advice from OPED or main campus office of protected disclosure (+/- professionalism consultation advisory group)

2) Directly to UME, non-anonymously
    a. Can be through a direct report or the mistreatment.ucalgary.ca website
    b. Process would be identical to above except Associate Dean would provide feedback directly to student

3) Reporting to the Student Advisors for Mistreatment (SAM)
    a. The SAM will discuss, support and validate
    b. Options include:
        i. Not reporting to UME
        ii. Reporting to the respective Assistant Dean, which would trigger:
            1. A five-year review of feedback
            2. If minor and non repetitive
                a. Involvement of the course/clerkship chair, and/or program director PGME, and/or allied health professionals
            3. If major or repetitive
                a. Involvement of Associate Dean and Department Head
            4. Feedback to student (if identity known)

4) Directly to main campus
    a. Students can go directly to the main campus Student Ombuds, or the Office of Protected Disclosure

NOTES:
- Department Heads will be involved for repeated minor concerns or a major concern
- Department Heads will not be involved for a single minor concern, unless:
    - The concern raises the possibility of problems in another area (PGME, clinical)
    - The concern is not met with a favorable interaction from the preceptor
    - The course chair, clerkship director or the Student Advocate for Mistreatment feel that it should be reported
- The Office of Protected Disclosure will be notified for concerns involving faculty members in TUCFA
- Depending on the offense, students can also involve the police
- Students can also report directly to the College of Physicians and Surgeons of Alberta (as any member of the public can)
- in each case, incidents/individuals who are investigated are then anonymously described on the report card on OSLER, which is updated yearly

A) Procedure for UME Student to Student Mistreatment investigation
    a. Student discusses with SAM, or any UME faculty, who will support and validate
        i. The SAM (or faculty member) will engage, when appropriate:
            1. the Student Professionalism Committee, and/or
            2. Main campus Student Non-Academic Misconduct office
        ii. Depending on nature of office, the UME (and potentially Student Academic Review Committee) will get involved

APPROVED: UME management, April 11, 2017

B) Follow-up of mistreatment concerns: via report card, which is produced yearly and posted on the mistreatment website (591 views as of August 2017)

"report card" for faculty concerns, time period May 18, 2016-July 14 2017

NOTES:

- The report has removed detailed information, to protect both the student and faculty involved
- The report does not include matters that have ongoing investigations

Setting	Issue	Method of Complaint	Outcome
Small group environment	Unprofessional behavior	Anonymous: on-line reporting	Meeting with Associate Dean UME and Department leadership: monitoring closely
Clinical environment: 3 resident teachers	Unprofessional behavior	Anonymous end-of-clerkship survey, 1 via SAM	Data from one45 evaluations sent to relevant program director. Meeting between program director and resident. Assistant Dean clerkship discussed with program directors
Lecture	Unprofessional comments	Anonymous: end-of-course survey	Assistant Dean pre-clerkship has discussed with preceptor: monitoring
Small group environment	Unprofessional comments	Anonymous: end-of-course survey	Assistant Dean pre-clerkship has discussed with preceptor, second offense: monitoring very closely
Clinical environment	Unprofessional comments	Directly from student to Assistant Dean	Assistant Dean, SAW, SAM and preceptor have had discussions. Monitoring closely. Debrief with student occurred
Small group environment	Unprofessional comments	Anonymous: end-of-course survey	Course chair spoke to faculty member, second offense, monitoring very closely
Small group environment	Unprofessional comments	Anonymous end-of-course feedback	Course chair spoke with faculty member: monitoring
Clinical environment	Concerns about preceptor teaching and interactions	Directly from student	Discussion between student, Assistant Dean, Course chair: preceptor removed from teaching
Clinical environment	Difficult interaction with preceptor	Reported directly from students to Clerkship Director then to Assistant Dean	Faculty member met with preceptor for general discussion. Preceptor did not meet the "three evaluation" threshold required to feedback specific concerns (to protect students who are reporting). Monitoring
Clinical environment: clerkship site	Concerns about student safety at a clinical site	Anonymous end-of-course feedback	Site leaders and Department Head have been involved and corrected the situation
Clinical environment: clerkship rotation	Concerns about student safety at a clinical site	Directly from student	Site leaders and Department Head have been involved and corrected the situation. Students reassigned and site not currently used for mandatory clerkship. Feedback given to student
Small group environment	Unprofessional comments	Directly to course chair and	Meeting with Associate and Assistant Dean. Repeated offense. Teacher suspended, remediation plan in place

		anonymous on-line reporting	
Small group environment	Unprofessional comments	Anonymous on-line reporting	Meeting with Associate and Assistant Dean. Second offense. Monitoring very closely
Small group environment	Unprofessional behavior	Anonymous: end-of-course survey	Faculty member resigned from teaching
Clinical environment	Unprofessional behavior	To UME via SAM	Clerkship Director met with faculty member: monitoring
Small group environment	Unprofessional behavior	Anonymous: on-line reporting	Course chair spoke to faculty member: monitoring
Clinical environment	Unprofessional behavior	Anonymous end-of-clerkship	Has not reached the 3 student evaluations threshold: being monitored
Clinical environment	Unprofessional behavior	Direct feedback to OPED office	Meeting with faculty member, division and department head: monitoring
Lecture	Unprofessional behavior	Anonymous: end-of-course feedback and anonymously on website	Meeting with faculty member and Assistant Dean pre-clerkship: monitoring
Lecture	Unprofessional comments	Directly from website	Meeting with Assistant Dean pre-clerkship and course chair, then to faculty member: monitoring, process fed back to student
Small group environment	Unprofessional comments	Directly from website, non-anonymously	Meetings occurred with faculty member and Department Head, second offense, being closely monitored. Student informed of plan
Clinical environment	Difficult interaction with preceptor	To UME via SAM	Discussion with SAM and preceptor: monitoring
Clinical environment	Unprofessional behavior	To UME via SAM	Meeting with Assistant Dean pre-clerkship and course chair, then to faculty member: monitoring
Clinical environment	Unprofessional behavior	Directly from student	No prior evaluations concerns (fed back to student). More of a college issue: situation reported to college by student
Clinical environment	Unprofessional behavior	Directly from student	Repeated concerns, faculty member removed from teaching

The following are our currents statistics regarding the percentage of our faculty that have been flagged for professionalism in the past 3 years:

- 34 unique faculty members have been flagged over the past 3 years (mostly via anonymous surveys). This represents 34/1523=2.2% of our faculty
- In that time, UME has received 239,947 individual responses for feedback from students. Most unprofessional behaviors are flagged by one student, though at times can be 5-10 (e.g. lecture). Thus overall, at most 300 (0.1%) of all student responses on anonymous surveys flag professionalism

b. How, by whom, and how often are data regarding the frequency of medical student mistreatment collected? How, by whom, and how often are the data on medical student mistreatment reviewed? How are these data used in efforts to reduce medical student mistreatment? Note any actions that have been taken in response to the data from the AFMC GQ or the independent student analysis related to the incidence of mistreatment.

The primary location for this data resides from student feedback, and thus initially our Program Evaluation Consultant, Dr. Wayne Woloschuk. Dr. Woloschuk presents to the UME management team at least monthly. From there, the process outlined in section a. above is triggered. The Associate Dean, Dr. Sylvain Coderre, keeps track of the instances and produces the yearly report card. The public presentation of the report card is anonymized, but Dr. Coderre also holds a non-anonymized version (for future reference in case of repeat offenses) safely in an electronic record. The general data (CGQ, end-of-year surveys) are presented to UME management but also yearly to the curriculum committee (UMEC) and, on an ad hoc basis, to the subcommittees. In 2015 and 2016, during our accreditation process, this data was widely presented and publicized, and lead to the multitude of very positive and favorable changes outlined above.

c. Describe recent educational activities aimed at preventing student mistreatment in the learning environment. Include a description of the target audience.

Dr. Janet de Groot, and now Dr. Beverly Adams, are Associate Deans of the Office of Professionalism, Equity, and Diversity (OPED). OPED has been a leader in the education around mistreatment, and fostering an appreciative, inclusive culture of respect and professionalism. The following is a summary of its activities in 2016-2018:

1. Video scenarios Student, faculty and staff committee: with out-takes for distribution to promote reflection on what mistreatment is, presentations to:
    a. Leadership Forum – endorsed need to distribute widely, all educators
    b. Master Teachers
    c. Grand Rounds for Department of Ophthalmology
    d. Surgery PGY1 Academic Half Days
    e. Psychiatry PGY2 and 3 half days

2. The videos have now been finalized (discussions above were the paper scenarios). They were presented to all the clerkship leaders at clerkship committee in October 2017. They have now been rolled out to Departmental Grand rounds (Psychiatry January 23, 2018, Neurology being finalized, with a plan for all departments and rural medicine meeting called Cabin Fever). The team involved in the grand round sessions is large, and includes: Dr. Janet de Groot (former OPED Associate Dean), Dr. Beverly Adams (current OPED Associate Dean), Dr. Sylvain Coderre (Associate Dean UME), Dr. Kevin Busche (Assistant Dean UME), Dr. Lara Cooke (former Associate Dean CME), Dr. Jason Waechter (faculty member, Department of Critical Care).

3. Humanism and professionalism faculty development series for clinician educators known for their excellence in education
    a. Extremely well rated course
    b. Participants experience transformation e.g. take course to enhance capacity to educate for humanism and professionalism, and learn more about self in relation to humanism
    c. Faculty support of the importance of the course evident as there is no cost to take the course
    d. Aim: develop a cohort of educators known for humanism, who have a certificate in humanistic medicine
    e. Find ways to support this group through regular meetings

4. Annual retreat on professionalism
    a. June 2013 Catherine Lucey – feedback to supervisors
    b. December 2014 Richard Frankel – Appreciative Inquiry approach to professionalism
    c. November 2015 Nitya Iyer – Digital Professionalism
    d. April 2017 (rescheduled from November) – Bill Branch – transformational outcomes with humanism and professionalism courses, and use of reflection

5. For students: in 2017, for class of 2020: orientations sessions (two) on sexual consent, and completion of "respect in the workplace" on-line modules

See Appendix 3.6 for Additional data:

Appendix 3.6a1 - End of year feedback re: knowledge of mistreatment processes
Appendix 3.6a2 - End of year survey data re: respectful treatment (question 'd')

6.3 SELF-DIRECTED AND LIFE-LONG LEARNING (SM)

The faculty of a medical school ensure that the medical curriculum includes self-directed learning experiences and time for independent study to allow medical students to develop the skills of lifelong learning. Self-directed learning involves medical students' self-assessment of learning needs; independent identification, analysis, and synthesis of relevant information; and appraisal of the credibility of information sources.

Finding: Students expressed a high level of dissatisfaction with the amount of study time available for self-directed learning.

a. Referring to the sample schedules requested below, describe for the first two years of the program, the amount of scheduled time and the amount of study time available for self-directed learning sessions.

A. INDEPENDENT STUDY TIME

The Undergraduate Medical Education (UME) program was developed with sufficient unscheduled curricular time to allow for the consolidation of learned material through independent study and also to allow students to prepare for interactive small group learning sessions. This time is labeled as Independent Study Time (IST) in the timetable. Our MD program philosophy document has long stated that 30% (equivalent to 3 half-days per week) will be IST. This target is self-imposed, and by way of a national survey led by our Associate Dean, exceeds the percentage of IST of all except two other Canadian medical schools.

The philosophy document reads as 30%, and not 3 half-days per week, in order to allow some flexibility in the scheduling of the IST over the extent of a course or pre-clerkship year. This is important for many reasons, including scheduling modifications brought on by long weekends. This flexibility allows for repositioning of IST hours. One example is the 'review weeks' leading up to exams, where students have no new material presented. This is a "compacted" form of IST, with study time (as IST) mixed in with optional review sessions run by course leaders.

School days are eight hours long (Monday to Friday, 0830-1230; 1330-1730; one hour at lunch not counted as IST or scheduled curricular time); 'curricular time' includes all hours in these time periods for each instructional day.

Year 1

29 weeks with 5 days = 1160 hours

5 weeks with 4 days = 160 hours

1 week with 3 days = 24 hours

total = 1344 hours curricular time in year 1

time labeled as IST in schedule = 480 hours

Year 1 IST hours = 36% of scheduled curricular time (480/1344).

In addition to formally labelled IST hours, there are a number of sessions that are optional, that were not counted in the calculations presented above.

- Review sessions in review weeks (in class, optional) = 48 hours
- Intro to Basic Sciences and Humanities (in class, optional) = 12 hours
- 'fun' orientation activities = 18 hours (38 hours of orientation activities are mandatory for all students)

Year 2
33 weeks with 5 days = 1320 hours

5 weeks with 4 days = 160 hours

total = 1480 hours of curricular time in year 2

time labeled as IST in schedule = 342 hours

Year 2 IST hours = 26% of scheduled curricular time (342/1320).

Again, as in Year 1, there are sessions not labelled as IST that could be considered as such:

- Review sessions in review weeks (in class, optional) = 32 hours

Within the Year 2 calculations, we have not included the four-week Summer Electives course. Within this time, students are doing full-time pre-clerkship electives. Like clerkships, these days do not include independent study time and as such are not counted in the hours described above.

Overall pre-clerkship

822 hours of IST

2664 hours of curricular time

Overall pre-clerkship IST hours = 31% IST (822/2664)

It should be noted that we are using a conservative calculation by not including any of the above sessions (review, fun orientation activities, etc) as IST.
Hours of IST are a prime consideration whenever any discussions are undertaken regarding potential curricular changes. The Pre-Clerkship Committee and the Assistant Dean, Pre-Clerkship are very much aware of the need to maintain IST hours.

Student satisfaction data from ISA prepared for 2016 accreditation and recent end of year surveys:
"there is an appropriate balance between IST and scheduled class time"

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree	% SA and A
2019 (year 1)	15 (12.3%)	19 (15.6%)	27 (22.1%)	45 (36.9%)	16 (13.1%)	50
2018 (year 2)	3 (3.1%)	22 (22.4%)	18 (18.4%)	45 (45.9%)	10 (10.2%)	56
2017	17 (10.3%)	61 (36.97%)	29 (17.58%)	48 (29.09%)	10 (6.06%)	43
2016	13 (12.26%)	42 (39.62%)	18 (16.98%)	28 (26.42%)	5 (4.72%)	38
2015	3 (2.46%)	21 (17.21%)	13 (10.66%)	62 (50.82%)	23 (18.85%)	78

See Appendix 6.3a for the actual schedules.

B. OTHER SELF-DIRECTED LEARNING
In addition to IST, there are other sessions in the curriculum that are specifically designed to promote self-directed and life-long learning.

Integrative Course
Within the Integrative course (offered at the end of year two, immediately before clerkship begins) students work in small groups to approach patient cases. Part of the process of this course is to develop self-directed learning skills. The students are evaluated and provided feedback by their small group preceptor.

During the two-weeks of Integrative, students spend a total of 30 hours in the small group sessions. This is the only course scheduled during this two-week period and thus there is considerable time available for the students to prepare. The schedule for this two-week period is included in the Core Document for the Integrative course.

As per the core document for the Integrative course:
The Integrative Course consists of a series of standardized patient cases designed to reflect actual patient-physician interactions. You will interact with the standardized patients and discuss the cases in small group sessions facilitated by a preceptor. In addition to reinforcing your prior knowledge in a clinical setting, the standardized patient problems will give you an opportunity to:

- ☐ Apply problem solving in the more realistic context of interaction with a standardized patient
- ☐ Reinforce clinical skills presented in your Medical Skills Course
- ☐ Integrate your clinical skills with medical knowledge acquired in the Clinical Presentation Curriculum
- ☐ Develop counseling and communication skills not presented elsewhere in the curriculum
- ☐ Explore information resources applicable to clinical problems, including the application of evidence-based medicine to the clinical problems
- ☐ Practice writing orders, admission histories and physicals
- ☐ Practice case presentations to your preceptor

Within each small group, the process is as follows:
Each group will complete 6 cases during the course. Each case will have several components:

a) Clinical encounter 1 (1.5 hours in length)
b) An educational prescription identified by each student for presentation to the group
c) Clinical encounter 2 (1.5 hours in length to include time for above presentation)
d) A clerkship preparation task to be completed in student groups (approx. 1 hour)
e) Presentation and discussion of clerkship preparation task with preceptor (1 hour)

The clinical encounter should be divided roughly into four parts. This sequence may vary somewhat depending on your group's particular learning needs and the nature of the case.

1. Initial interview (history-taking and physical examination)
2. Preliminary counseling (explanation of preliminary findings, lab tests, other diagnostic procedures, etc.)
3. Definitive counseling (discussion of findings, diagnosis, treatment alternatives, giving support, etc.)
4. Follow-up visit

Clinical Encounter 1 - Initial interview
This will normally be carried out by a single student observed by the rest of the group. Other group members will usually be given specific observation tasks such as notekeeping for the clerkship preparation task, or being responsible for providing peer feedback. A more acute case may require 2 students or the whole group to be in the room with the SP, or for the initial interview and physical examination to be combined.
After the initial interview most groups like to have a brief discussion of the differential diagnosis before proceeding to a focused relevant clinical examination.

Clinical Encounter 1 - Physical examination
Some patients will simulate or have physical findings that fit the case, some will not. Your group should examine the standardized patient as appropriate for the case. You will not be expected to perform intimate examinations (breast examination, pelvic examination, rectal examination). Your preceptor must be in the same examination room as the student, thus most preceptors prefer the entire student group be present in the examination room. In the absence of specific physical findings (most of the standardized patients will have normal examinations) your group will be provided with the relevant examination findings by your preceptor.
Following the physical examination you will need to consider the diagnosis and negotiate the next steps with the patient.

Educational prescription
It is likely that the history and physical examination will raise questions that should be identified as learning issues. An educational prescription based upon the identified learning issues should be assigned to each student in the group. Each person should spend approximately 1-2 hours researching learning issues and should prepare to present to the group a 5 minute summary at the beginning of Clinical Encounter 2.

Clinical Encounter 2
The second encounter with each patient will occur 2 days later in real time, but in scripted time may represent a continuation of the same day or be weeks later, dependent upon the case. Clinical encounter 2 will start with the presentation of your learning points to your group and preceptor. Clinical encounter 2 will usually involve the student providing definitive counseling to the patient, such as discussion of investigation findings, diagnosis, treatment alternatives, giving support, etc.

Clerkship Preparation Task
For each of the 6 cases there will be allocated a clerkship preparation task. This is designed to allow you to practice skills that will be useful when you start in clerkship. The tasks are outlined in Section 6 of this document. For some tasks you may need additional information from your preceptor so please ensure you have read the individual task descriptions for details.

AEBM Course
The Applied Evidence Based Medicine (AEBM) course runs from April to December of Year 2. The first half of the course consists of a series of lectures/small groups where the foundational principles of evidence-based medicine are presented to the students. This totals eight half-days of curriculum time. These include not only sessions presenting content around evidence-based medicine but also the requirement for students to perform self-directed learning by preparing CATs with a group.

The second half of the course consists of two 30 hour blocks of time spent with a preceptor in a one-to-one relationship in a clinical environment, research or directed study project. Within the elective time, students are provided with six hours in each 30 hour block for the development and preparation of their own critically appraised topic assignments.

As per the AEBM Core Document:

Overview**:**
The Introductory Lecture on Tuesday, April 8 will be followed by a series of 5 weekly lectures and seminars, involving mandatory breakout sessions. There is a deliberate effort to align the topics of these sessions with the topics addressed in the Year 1 Courses , including Physical Exam, in order to enable “background” context for the

"foreground" discussion of the evidence based literature. It is expected that students will draw on subject matter from Hematology, GI, MSK, Dermatology, Cardiology, and Respiratory - particularly in the "Educational Prescriptions" and "Critically Appraised Topics", but also in the selection of articles to be discussed. It is expected that the learning paradigm provided during these sessions will form the basis of the ongoing learning experience in the elective experience of EBM 440 (see below).

The weekly lectures will be directed at acquiring EBM skills in diagnosis, prognosis, therapeutic interventions, assessing harm, systematic reviews, and utilizing guidelines. To complement the lectures there will be group sessions in the week following. The class will be divided into three sections and team based learning approaches will be employed for these sessions. The independent and group rating techniques for learning will be employed. Attendance will be kept and 1 percent assigned for each week of attendance. Each of the weekly series will begin with answering 10 formative questions. This will be followed by critiquing selected articles using a guided approach directed by the study group's preceptor, utilizing concepts related to validity, reliability, and relevance. At the end of each session, students will be assigned an "educational prescription" related to their weekly topic, and will be provided an opportunity to seek clarification about what is required in fulfilling the "prescription". Each student will be expected to review their own response with their clinical core group during the following week using a self-appraisal guide.

GROUP CAT ASSIGNMENT OVERVIEW:
Finally, each clinical core group will submit a topic on May 14 to be presented on May 27 to their entire class. This topic will consist of a 20 minute presentation, using a Critically Appraised Topic (CAT) format, followed by up to 10 minutes of questions and discussions from the audience and review panel. Each group will be responsible for their style of presentation but a recommended format is to have 3 students present (each with a different component of the CAT, with the remaining members of the group prepared to answer questions regarding the paper and its appraisal).

On May 27 (3:10 to 5PM) each of the clinical core groups will have an opportunity to present on a topic using an Evidence Based Medicine approach described as the Critically Appraised Topic, or CAT. Each small group's presentation will be based on one of the following clinical situations; diagnosis, prognosis, therapy or harm. The CAT will include a statement of the presenting patient problem, the PICO expression of the question to be answered, an explanation of the literature search and its results, an analysis of the selected paper(s) for validity, an interpretation of the results along with their applicability to the patient problem, and finally a summary of the general experience of completing the CAT with respect to its educational value. Twenty minutes will be allotted to the presentation, and ten minutes for questions and response. The presentation must be provided in PowerPoint format, with no more than 20 slides in total, including title and references. Ten percent (10%) of the total course mark will be awarded on the basis of this assignment – 3% for the peer evaluation and 7% for the CAT presentation. All members of the group will receive the same mark assigned to the CAT presentation but peer evaluation marks will be on an individual basis.

Important – due dates
Each of the groups will prepare a single case by May 23, including the completion of a CAT on that patient problem. The presentation must use a clinical encounter of a patient seen in clinical core sessions in the preceding 6 months. The case should be a real patient (though anonymized) and not a conglomerate of several patients. The leader of each group must submit both the case and the CAT pertaining to the group's case via email to the AEBM Course Coordinator by May 23, NB: The collection of 32 CATs will be made available to class members upon request for educational purposes.

Selection of the presenter(s) will also be the responsibility of the AEBM Group. It is recommended that the presenter(s) give at least one practice presentation to their AEBM group, for feedback and discussion. One or two presenters can be selected to manage the actual presentation material of the CAT, from the description of the patient problem and PICO, to search approach and results, and then the applicability and relevance to the patient.

The presentation will follow the general format of a "Critically Appraised Topic (CAT)". Scores will be assigned by a panel of reviewers taking into account:

a) The clarity of the overall presentation.
b) The nature of the clinical problem identified in terms of uniqueness and importance.
c) The comprehensiveness and effectiveness of the search strategy.
d) The selected results of the search strategy (1 to 2 papers only).
e) The evaluation of validity factors related to the selected study or studies.

f) Assessment of the results, in relation to precision, accuracy, and items relevant to the problem such as NNT.
g) The interpretation of the information with respect to the original patient problem.
h) The overall summary.
i) Responses by members of the presenting group, to questions from the audience and the panel.

During the second half of the course (August to January of Year 2) the students undertake 60 hours of clinical, research, quality improvement or directed study time. During this time, the students individually identify clinical questions and perform literature searches to answer these questions. Their projects (CATs and EPs) are presented to the student's preceptor for discussion but are also handed in to be marked by the course leaders as a part of the student's overall mark in the AEBM course.

Students are evaluated and given feedback on their CATs and by the evaluation panel in the group presentation and by their preceptors and course leaders for the individual CATs and EPs.

Clerkship
During clerkship, self-directed learning activities are reinforced by the requirement to complete an evidence-based medicine project in two of the mandatory clerkship rotations (Family Medicine and Obstetrics/Gynecology).

Other
Students are provided with resources to support their self-directed learning.

A new Anatomy and simulation lab was opened in 2014; this is used for both structured teaching sessions as well as open lab time for student study.

Podcasts are available for the majority of lectures within the pre-clerkship. Students can access these (in most cases) by the end of the day on which the lecture occurs. This allows students to control the content and control their own cognitive load while learning.

Cards are series of re-playable patient cases using online formatting developed within the Cumming School of Medicine; this project has harnessed the skills of our Academic Technologies team and the knowledge of dedicated teachers. Many decks of Cards are now available for a wide variety of clinical disciplines.

The online '*Core'* project has produced a series of short videos documenting the physical examinations taught within the Physical Exam unit of the Medical Skills course. These videos are used for independent learning by the students and for standardization of approach by preceptors.

Within Course 8 (longitudinal Comprehensive Clinical Skills course in clerkship) students have access to virtual patients to complement the clinical presentations that are seen on the wards and in clinic.

SUPPORTING DOCUMENTATION

a. Schedules that illustrate the amount of time in the first and second years of the curriculum that medical students spend in self-directed learning sessions and the amount of study time available. (***Appendix 6.3 a***)

Appendix 6.3a - Class of 2020 - Year 1 Timetable & Class of 2019 – Year 2 Timetable

9.4 ASSESSMENT SYSTEM (SM)

A medical school ensures that, throughout its medical education program, there is a centralized system in place that employs a variety of measures (including direct observation) for the assessment of student achievement, including students' acquisition of the knowledge, core clinical skills (e.g., medical history-taking, physical examination), behaviors, and attitudes specified in medical education program objectives, and that ensures that all medical students achieve the same medical education program objectives.

Definition taken from CACMS lexicon

- *Medical education program objectives: Statements of what medical students are expected to be able to do at the end of the educational program i.e., exit or graduate level competencies.*

Finding: There has been improvement in the direct observation of students taking history and performing physical examinations during the Surgery clerkship, as evidenced by mid-year end-of-rotation evaluations form the Class of 2016. This needs to be monitored for sustainability.

SUPPORTING DATA

Table 9.4-1 | Observation of Clinical Skills Source: AFMC GQ

Provide data from the AFMC Graduation Questionnaire (AFMC GQ) on the percentage of respondents that *agree/strongly agree* (aggregated) that they were observed by a faculty member or a resident in all required clinical learning experiences. Provide data from other sources for required clinical learning experiences that are not evaluated in the GQ. Add rows as needed for each campus.

Year 3 Clerkship – all sites	Required clinical learning experiences	School %					
		History			Physical exam (Mental status – Psych)		
		2015	2016	2017	2015	2016	2017
AFMC GQ response rates: - 80% for class of 2015 and 2016 - 72% for class of 2017	Emergency medicine	63.5	66.1	75.0	73.5	74.9	83.6
	Family medicine	74.5	81.6	79.3	81.7	87.7	91.4
	Internal medicine	66.9	74.0	81.3	85.3	89.1	91.6
	Obstetrics gynecology	84.5	92.2	88.0	94.1	96.1	94.9
	Pediatrics	76.1	83.7	77.7	82.8	90.0	87.3
	Psychiatry	92.5	93.8	94.0	74.3	89.9	93.7
	Surgery	58.5	66.7	62.4	68.2	78.3	72.9
	Other (list) Anesthesia	73.1	87.4	NA	80.8	88.2	NA

Table 9.4-2| Observation of Clinical Skills Source: School-Reported

Provide internal data for the percentage of respondents in year 3 and year 4 that agreed (responded Yes) that they were observed by a faculty member or a resident at some point during the time they were taking a patient's history and performing a physical examination (for psychiatry- a mental status examination) in each of the following required clinical learning experiences.					
Year 3 Clerkship – all sites	Required clinical learning experiences	School %			
		History		Physical exam	
		Year 3 Class of 2017	Year 3 Class of 2018 (blocks 1-4)	Year 3 Class of 2017	Year 3 Class of 2018 (blocks 1-4)
An attending/resident physician observed your physical exam skills An attending/resident physician observed your history taking skills **% Agreed or Strongly Agreed[1]**	Emergency Medicine	60.0	73.2	60.0	82.1
	Family Medicine	85.2	92.5	88.6	94.3
	Internal Medicine	65.7	75.0	88.6	75.0
	Obstetrics and Gynecology	71.7	94.0	85.9	98.0
	Pediatrics	65.2	79.1	86.5	93.8
	Psychiatry	95.9	100	95.9	97.6
	Surgery	65.4	81.4	71.6	79.1
	Anesthesia	81.3	77.8	90.0	81.5
Staff critiqued your history taking skills and physical exam skills	UCLIC	100	Not available	100	Not available

NARRATIVE RESPONSE

a. Identify the required learning experiences that include a formal assessment (either for formative or summative purposes) of the following areas:

1. history taking

and

2. physical examination

There are multiple opportunities for formal assessment of history and physical examination skills throughout the clerkship. The survey numbers in the tables above are lower than anticipated given that many of these opportunities are required rotation components and/or are formally scheduled for each student. Leadership from each mandatory clerkship rotation report annually to the Clerkship Committee regarding the process used to ensure that all students have had their history taking and physical examination skills observed during that rotation.

Further, beginning with the Class of 2018, we have changed our ITER (In-Training Evaluation Report) to ask each preceptor whether he/she directly observed the student. The data from the first half of the 2017/2018 academic year is shown in the table below.

Mandatory Rotation	Percentage of students with preceptor ITER indicating history taking was observed	Percentage of students with preceptor ITER indicating physical examination was observed
Emergency Medicine	100	100
Family Medicine	98	98
Internal Medicine	96	98
Obstetrics and Gynecology	92	99
Pediatrics	93	96
Psychiatry	99	n/a

[1] Data source – end of rotation surveys

Surgery	96	93
Anesthesia	100	100
UCLIC	100	100

In addition to activities incorporated in daily patient care, other structured opportunities for formal observation and/or assessment of history taking and physical examination include:

Course 8
Students participate in mandatory small group sessions (5 students per group) throughout the clerkship year that include interaction with standardised or simulated patients. They receive direct feedback from peers and preceptors following these interactions. Over the course of the year, each group completes:
11 history taking sessions
2 physical examination sessions
11 combined history taking and physical examination sessions
3 procedure skills sessions
6 simulation sessions

The course 8 examination is a summative "clerkship OSCE" that directly observes history taking and physical examination across all of the mandatory clerkships.

Internal Medicine
The Internal Medicine rotation provides a formative OSCE for all students. All students are also required to complete the History and Physical Examination (HAPE) Passport. Students must have 6 histories and 6 physical examinations directly observed and documented on the HAPE pass. In addition, all students participate in formal Bedside Teaching sessions which focus on clinical skills.

Obstetrics and Gynecology
All students are required to complete a workbook while on the Obstetrics and Gynecology rotation. This includes the requirement for students to receive feedback regarding an observed history and physical examination.

Pediatrics
The rotation requires completion of the "Peds Passport" – a clinical encounter card. Students must have this card signed by their preceptor. Items include direct observation of 3 focused histories and 4 physical examinations (of newborn, infant, child and adolescent patients). In addition, students must be observed communicating with patients and families regarding management plans. The encounter card also includes an item requiring students to "identify a sick child" – this includes history and physical examination components that would identify a potentially unstable patient.

Psychiatry
All students are scheduled to complete a directly observed history and mental status examination. This is graded and must be satisfactory in order for students to pass the rotation.

Surgery
All students complete a week on the Acute Care Emergent Surgical Services (ACESS) Team. This is a General Surgery call service at each site. Beginning with the Class of 2018, a formal curriculum was implemented during that week that includes 4 case presentations and physical examination of the abdomen that are reviewed by resident or preceptor with each clerk. This includes completion of a mini-CEX.

Anesthesia
Students on this rotation are scheduled with different preceptors each day and thus utilize an encounter card that includes observation of preoperative history and physical examination as well as several key procedures. These are signed by the supervising preceptors.

University of Calgary Longitudinal Integrated Clerkship (UCLIC)
One-on-one longitudinal interaction with attending physician allows for multiple interactions whereby history and physician examination is observed throughout the entire UCLIC experience.

SUPPORTING DOCUMENTATION

a. Data from internal data sources (administrative data e.g., completion of MiniCEX forms, confirmation by the preceptor or resident, or student perceptions) regarding observation of history taking and performance of a physician examination. (***Appendix 9.4 a***)

Appendix 9.4a1 – Encounter cards from Internal Medicine rotations
Appendix 9.4a2 – Encounter cards from Obstetrics and Gynecology rotations
Appendix 9.4a3 – Encounter cards from Pediatrics rotations
Appendix 9.4a4 – Encounter cards from Anesthesia rotations
Appendix 9.4a5 – Marking form for Psychiatry observed history and mental status examination

9.7 TIMELY FORMATIVE ASSESSMENT AND FEEDBACK (SM)

A medical school ensures that the medical education program provides timely formative assessment consisting of appropriate measures by which a medical student can measure his or her progress in learning. Each medical student is assessed and provided with formal formative feedback early enough during each required learning experience four or more weeks in length to allow sufficient time for remediation. Formal feedback occurs at least at the midpoint of the learning experience. In medical education programs with longer educational experiences (e.g., longitudinal integrated clerkship, year-long courses) formal feedback occurs approximately every six weeks. For required learning experiences less than four weeks in length alternate means are provided by which a medical student can measure his or her progress in learning.

Definition taken from CACMS lexicon

- *Required learning experience: An educational unit (e.g., course, block, clerkship rotation or longitudinal integrated clerkship) that is required of a student in order to complete the medical education program. These educational units are usually associated with a university course code and appear on the student's transcript. Required learning experiences are in contradistinction to electives, which are learning experiences of the student's choosing.*

Finding: Surveys (GQ, ISA and end-of-rotation) indicate that students were not consistently receiving formal mid-rotation feedback in the Surgery clerkships. Strategies to improve this were implemented in 2015.

SUPPORTING DATA

Table 9.7-3 | Mid-Point Feedback Source: AFMC GQ

Provide data from the AFMC Graduation Questionnaire (AFMC GQ) on the percentage of respondents that *agree/strongly agree* (aggregated) with the following statement: "I received feedback early enough in this experience to allow me to improve my performance". Add rows as needed for each campus.

Year 3 Clerkship – all sites	Required clinical learning experiences	School %		
		2015	2016	2017
AFMC GQ response rates: - 80% for class of 2015 and 2016 - 72% for class of 2017	Emergency Medicine	83.1	85.4	89.7
	Family Medicine	85.4	88.5	94.0
	Internal Medicine	83.8	86.9	93.3
	Obstetrics and Gynecology	86.5	95.3	93.2
	Pediatrics	78.0	90.0	83.9
	Psychiatry	85.7	90.7	93.0
	Surgery	74.9	76.1	78.8
	Anesthesia	82.2	89.9	NA

Table 9.7-4 | Mid-Point Feedback Source: School-Reported

Provide internal data on the percentage of respondents that agreed (responded Yes) that they received mid-point feedback for each listed required clinical learning experience. Provide administrative data if available, documenting the provision of mid-point feedback for each required clinical learning experience. Specify the data source. Add rows as needed for each campus.			
Year 3 Clerkship – all sites	Required clinical learning experiences	Year 3 Class of 2017	Year 3 Class of 2018 (blocks 1-4)
Mid-rotation feedback to discuss your performance was provided **% answering "yes"**[2]	Emergency Medicine (daily)	91.3	91.1
	Family Medicine	97.7	100
	Internal Medicine	94.3	94.4
	Obstetrics and Gynecology	97.8	98.0
	Pediatrics	75.3	83.3
	Psychiatry	98.6	97.6
	Surgery	82.7	76.7
	Other (list) Anesthesia (daily)	92.5	81.5
	UCLIC	91.7	Not available

NARRATIVE RESPONSE

a. Describe how and by whom the provision of formative assessment in required learning experiences, including clinical, is monitored:

1. within each learning experience

The end-of-rotation student surveys are reviewed twice per year (data shown in table 9.7-4). The survey numbers for some rotations are lower than anticipated given that there are structured opportunities for feedback in each rotation as outlined below.

Emergency Medicine (2 weeks)
Students are scheduled 1:1 with preceptors thus facilitating active discussion and feedback to students. A daily preceptor ITER (In-Training Evaluation Report) is completed and this serves to supplement in-person feedback from preceptors to students.

Family Medicine (6 weeks)
Students are scheduled 1:1 with preceptors thus facilitating active discussion and feedback to students. A mid-point formative ITER is completed by preceptors at week 3 of the 6 week rotation. Expectations of preceptors are clearly outlined in a document describing roles and responsibilities of preceptors. This emphasizes the importance of providing feedback to students.

Internal Medicine (10 weeks)
Feedback is provided every 2 weeks – at the end of the two-week selectives and at the middle of the 4 week Medical Teaching Unit component. Students that complete an ICU selective receive weekly preceptor feedback during that rotation component.

[2] Data source – end of rotation surveys

Obstetrics and Gynecology (6 weeks)
The student workbook includes a checkbox reminding students to meet with their evaluator at mid-rotation (week 3). A midpoint formative ITER is completed by preceptors at week 3 of the six-week rotation.

Pediatrics (6 weeks)
Student encounter cards include a checkbox for weekly feedback.

The rotation is divided into various components. An ITER is completed at the end of each rotation component (1 to 3 weeks in duration). In addition, students on the Pediatric Emergency Selective receive daily feedback. Written feedback is provided at the end of the week of night shifts on the Clinical Teaching Unit at the Alberta Children's Hospital.

Psychiatry (6 weeks)
Feedback is provided every 2 weeks – at the end of the two-week Child and Adolescent component and at the middle of the four-week Adult component.

Surgery (6 weeks)
Written mid-rotation feedback is sent to each student by email at the beginning of week 4 of the six-week rotation.

Preceptors continue to be encouraged to provide feedback directly to students.

The rotation is divided into General Surgery and Surgery Selective components. An ITER is completed at the end of each rotation component (1 to 3 weeks in duration).

Anesthesia (2 weeks)
This rotation uses daily encounter cards to guide discussion and to track activities during the rotation. Students are scheduled 1:1 with preceptors thus facilitating active discussion and feedback to students. A daily preceptor ITER is completed and this serves to supplement in-person feedback from preceptors to students.

University of Calgary Longitudinal Integrated Clerkship (UCLIC)
One-on-one longitudinal interaction with attending physician creates a unique mentorship opportunity whereby the student is able to receive appropriate and constructive feedback throughout the UCLIC experience.

Online Formative Examinations
Online formative examinations must be completed by week 4 of the six-week rotations and by week 6 of the Internal Medicine rotation. These are required educational activities that must be completed for satisfactory rotation evaluations.

2. at the curriculum management level

Leadership from each mandatory clerkship rotation report annually to the Clerkship Committee regarding the process used to ensure that all students receive feedback during each rotation according to the Clerkship Student Feedback Policy.

b. For required learning experiences of less than four weeks duration, describe how students are provided with timely feedback on their knowledge and skills related to the required learning experiences objectives.

The Emergency Medicine and Anesthesia rotations are each 2 weeks in duration. Both of these utilize daily preceptor ITERS.

SUPPORTING DOCUMENTATION **(Appendix 9.7a)**

Appendix 9.7a - *Clerkship Student Feedback Policy*

11.2 CAREER ADVISING (SM)

A medical school has an effective and where appropriate confidential career advising system in place that integrates the efforts of faculty members, directors of required clinical learning experiences, and student affairs staff to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs.

Definition taken from CACMS lexicon

- *Required clinical learning experience: A subset of required learning experiences that take place in a health care setting involving patient care that are required of a student in order to complete the medical education program. These required clinical learning experiences may occur any time during the medical educational program.*

Finding: Additional activities addressing student satisfaction with guidance when choosing electives have recently been implemented. Data on the effectiveness of these activities are needed. This has been a recurrent concern.

SUPPORTING DATA

Table 11.2-3 | Electives Advising — Source: AFMC GQ

Provide school data from the AFMC Graduation Questionnaire (AFMC GQ) on the percentage of respondents that were *satisfied/very satisfied* (aggregated) in the following area. Add rows as needed for each campus.

Campus		School %		
		2015	2016	2017
AFMC GQ response rates: - 80% for class of 2015 and 2016 - 72% for class of 2017	Guidance when choosing electives	42.4	40.6	46.5

Table 11.2-4 | Electives Advising by Curriculum Year — Source: School-Reported

Provide internal data, by curriculum year, on the percentage of respondents that were *satisfied/very satisfied* (aggregated) with the following area. Add rows as needed for each campus.

Campus		School %			
		Year 1 2019	Year 2 2018	Year 3 2017	Year 4
Poor, Fair, Good, Very Good, Excellent (reporting the % rated Good, Very Good, Excellent)	Guidance when choosing electives	46.6	58.5	36.8	NA

NARRATIVE RESPONSE

a. Identify the individual(s) who are primarily responsible for providing guidance to medical students on their choice of intramural and extramural electives during each year of the curriculum. Note the role(s) or title(s) (e.g., student affairs dean, faculty advisor) of the individual(s) who are responsible for the formal approval of medical students' elective choices. Describe any formal (required) sessions where counseling on electives occurs.

The Student Advising and Wellness (SAW) team is comprised of (in addition to student reps from each year):

- Dr. Ron Cusano: SAW Director (0.6 FTE)
- Dr. Carol Hutchison: SAW Associate Director (0.4 FTE)

- Ms. Johanna Holm: Student Guidance and Wellness Specialist (1.0 FTE)
- Ms. Zainy Abdy: SAW Administrative Assistant (1.0 FTE)

The SAW team is supported by the entire UME team (including Associate Dean UME, Dr. Sylvain Coderre), but in particular:

- Dr. Laurie-Ann Baker, Elective Chair
- Ms. Kristy Ward (UME Electives Coordinator)
- Ms. Tania Pander (UME Electives Coordinator)
- Ms. Mandy Dale (Rural Program Electives Coordinator)
- Ms. Valerie Matwick, Dr. Gwen Hollaar (Global Health team)

Dr. Laurie-Ann Baker is responsible for formal approval of electives, and ensuring adherence to our elective diversification policy.

The Student Advising and Wellness office (SAW) is a vibrant office that has the central oversight of electives counselling. Prior to and since accreditation, the SAW team has teamed up with our student leaders to revamp the entire career counselling portfolio (including electives counselling), a strategy that is well summarized in Appendix 11.2a, and entitled "Roadmap to CaRMS".

As it pertains specifically to electives counselling, these are the six major events that deal with this topic in the first two years:

Event (**mandatory are bolded**)	Date last held	Presenter(s)	Number Attendees	Feedback
1st Year: Pre-Clerkship Summer Electives/CaRMS Orientation	Dec 5/17	Dr. Ron Cusano Ms. Mandy Dale Ms. Valerie Matwick Ms. Kristy Ward	160	17 = very satisfied 48 = satisfied 17 = neutral 3 = dissatisfied 0 = very dissatisfied (n=85)
1st Year: Careers in Medicine	Jan26/17	Dr. Ron Cusano Dr. Carol Hutchison UME Master Teachers	160	5 = very satisfied 12 = satisfied 15 = neutral 10 = dissatisfied (n=42)
2nd Year: Clerkship Elective Process Orientation	Jun 13/17	Dr. Ron Cusano Dr. Laurie-Ann Baker	160	9 = very satisfied 28 = satisfied 5 = neutral 3 = dissatisfied 1 = very dissatisfied (n=46)
2nd Year: Myth Busters	Jun 26/17	Dr. Sylvain Coderre Dr. Ron Cusano	100	8 = very satisfied 16 = satisfied 9 = neutral 2 = dissatisfied 0 = very dissatisfied (n=35)

2nd Year: Clerkship Orientation/Discussion Panel	Jan 8/17	Dr. Ron Cusano Dr. Carol Hutchison 8 clerks	100	13 = satisfied 2 = dissatisfied (n=15)
3rd Year: CV and Personal Letter	Jun 27/17	Dr. Ron Cusano Dr. Carol Hutchison	160	2 = very satisfied 3 = satisfied 1 = neutral 0 = dissatisfied (n=6)

In addition to these large group events, the SAW team meets individually with students for career/electives counselling. This includes access to a vocational specialist from main campus. From July 1st 2016 through January 22, 2018: 256 elective counselling appointments were booked with SAW (195 unique students).

Students also have access, from day one of medical school, to a faculty mentor, and thus have the opportunity from the beginning of medical school to discuss all aspects of career counselling with this faculty mentor.

As it pertains specifically to electives counselling, Dr. Cusano and his team have produced an "electives vision" document, which includes the above-listed events, and the following statements:

Electives – Vision

Ron Cusano, Director of SAW

Electives play an important role in all medical schools but are particularly important in a 3 year program.

1) Exposure to multiple disciplines to enable the student to make an informed choice.
2) Exposure to preceptors to obtain reference letters.
3) Exposure to different programs.
4) Display or prove the interest they have in a program.

The philosophy of the SAW office is to maximize exposure to the different disciplines or interests in order to help the student make the right choice and maximize their chance at obtaining interviews.

1st year:

1) We encourage the students to focus on academics in the first six months. Learning what it takes to pass a medical school exam and to perfect their study routines.
2) In the next 6 months we do encourage some shadowing. While these are not electives, the hope is the student will get some exposure to the different kinds of disciplines in medicine. Academics however are emphasized.

2nd year

1) In second year the students have two 2 week electives in the summer prior to starting classes. Although these are more formal than shadowing, it is emphasized that these are used to help decide their future goals. They are told that they have little to do with CaRMS and are meant to inform.
2) AEBM (Applied Evidence Based Medicine) – two are completed which can consist of either a small research project or clinical hours with a preceptor. Again

this can be used to explore a discipline to get a better idea of what the student may want to do.

3rd Year

1) Third year electives should be more geared towards the discipline you have chosen and less towards deciding. We understand that in a three program this may be difficult. So there is certainly some wiggle room. Our habit has been for students to do electives in at least 2 disciplines (plan A and plan B). The goals being to demonstrate interest, make contacts and possibly get references. If students feel that only one specialty is the only discipline they would be happy doing, then certainly a plan A alone would be supported.

It should be noted that as important as electives are, a strong performance in clerkship will go a lot further in assuring a successful CaRMS.

Overall summary of 11.2

We believe that in response to student feedback over the years, the SAW team has designed frequent, innovative and varied ways to present the material on electives. This includes a large number of one-one sessions in this area. However, it must be noted that CGQ data does not match our perception of the quality of this electives counselling program, a program that has been co-designed by the medical students themselves. This is puzzling to us, but the CGQ numbers may simply represent that "nothing is ever enough" when it comes to the extremely high-stakes and stressful CaRMS match process, particularly for a "time pressured" three-year program. Comparison of our numbers, with national numbers, we believe supports this assertion:

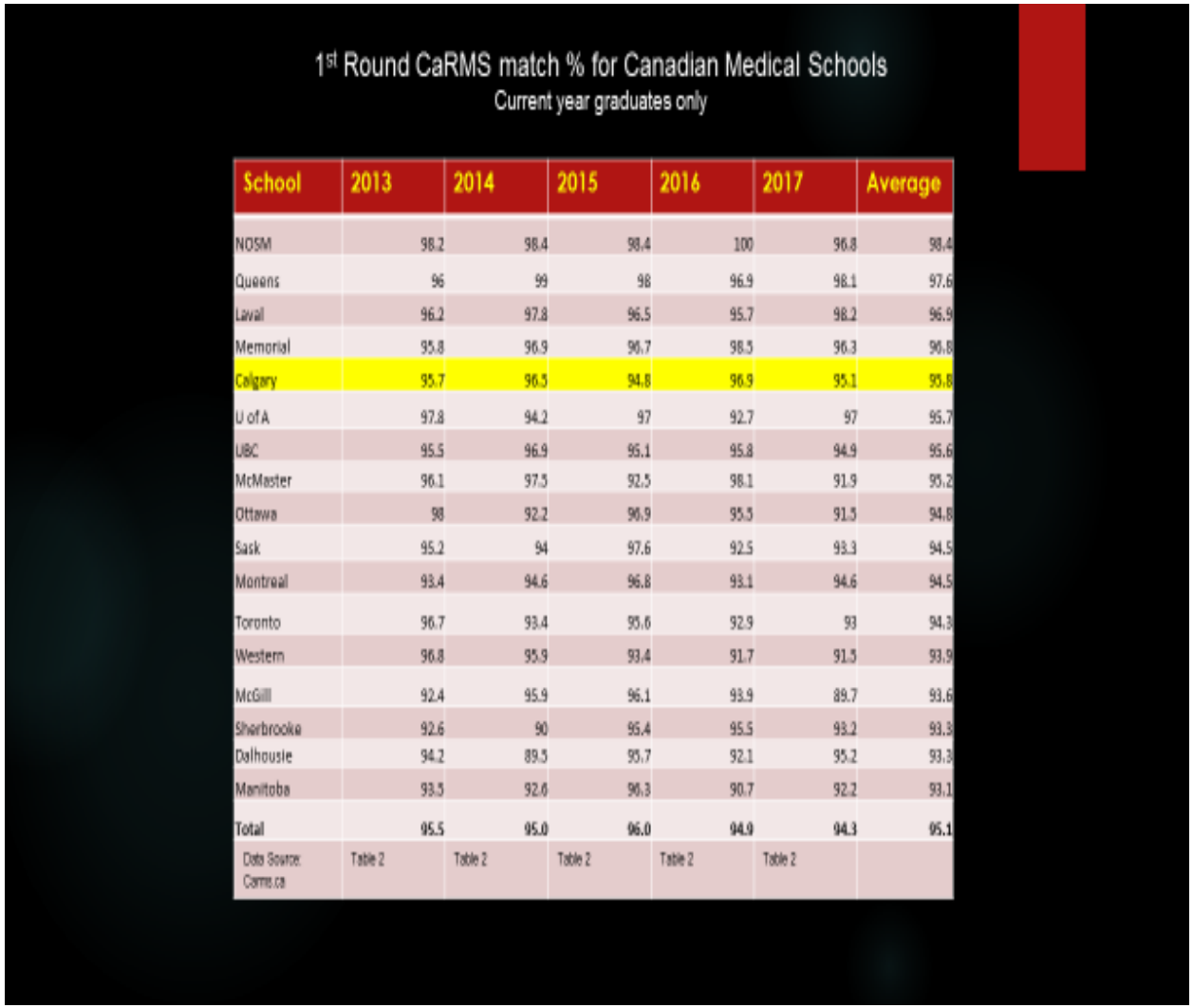
Calgary numbers, CGQ 2016 and 2017 (ratings expressed as percentages)

Class		Very Dissatisfied	Dissatisfied	Neither Satisfied nor dissatisfied	Satisfied	Very Satisfied	Count	Mean
2016	Guidance when choosing electives	14.1	22.7	22.7	32.0	8.6	128	2.98
2017	Guidance when choosing electives	10.3	20.7	22.4	33.6	12.9	116	3.18

National numbers, CGQ 2016 and 2017 (ratings expressed as percentages)

Class		Very Dissatisfied	Dissatisfied	Neither Satisfied nor dissatisfied	Satisfied	Very Satisfied	Count	Mean
2016	Guidance when choosing electives	7.2	22.9	25.2	35.2	9.5	1669	3.17
2017	Guidance when choosing electives	8.7	22.2	25.7	32.9	10.5	1840	3.14

There is also a source of administrative data that is relevant to this standard. Our match rates have consistently placed us in the top third of the country, with matching in all available disciplines, including highly competitive ones:



1st Round CaRMS match % for Canadian Medical Schools

Current year graduates only

School	2013	2014	2015	2016	2017	Average
NOSM	98.2	98.4	98.4	100	96.8	98.4
Queens	96	99	98	96.9	98.1	97.6
Laval	96.2	97.8	96.5	95.7	98.2	96.9
Memorial	95.8	96.9	96.7	98.5	96.3	96.8
Calgary	95.7	96.5	94.8	96.9	95.1	95.8
U of A	97.8	94.2	97	92.7	97	95.7
UBC	95.5	96.9	95.1	95.8	94.9	95.6
McMaster	96.1	97.5	92.5	98.1	91.9	95.2
Ottawa	98	92.2	96.9	95.5	91.5	94.8
Sask	95.2	94	97.6	92.5	93.3	94.5
Montreal	93.4	94.6	96.8	93.1	94.6	94.5
Toronto	96.7	93.4	95.6	92.9	93	94.3
Western	96.8	95.9	93.4	91.7	91.5	93.9
McGill	92.4	95.9	96.1	93.9	89.7	93.6
Sherbrooke	92.6	90	95.4	95.5	93.2	93.3
Dalhousie	94.2	89.5	95.7	92.1	95.2	93.3
Manitoba	93.5	92.6	96.3	90.7	92.2	93.1
Total	95.5	95.0	96.0	94.9	94.3	95.1
Data Source: Carms.ca	Table 2	Table 2	Table 2	Table 2	Table 2	

SUPPORTING DOCUMENTATION **(Appendix 11.2a)**

Appendix 11.2a A Roadmap to CaRMS

12.1 FINANCIAL AID / DEBT MANAGEMENT COUNSELING/ STUDENT EDUCATIONAL DEBT (SM)

A medical school provides its medical students with effective financial aid and debt management counseling and has mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) on medical student indebtedness.

Finding: Debt is higher than the national average. A Financial Literacy curriculum was implemented in October 2015 and is being further developed. This needs to be monitored for effectiveness.

SUPPORTING DATA

PLEASE NOTE: The teaching sessions below have been designed and delivered "internally" by the MD program itself. The primary individual responsible for these sessions is Ms. Karen Chadbolt, our UME Finance Manager, working with Dr. Ian Walker (Admissions Director), Dr. Ron Cusano (Student Advising and Wellness Director), in collaboration with Ms. Chadbolt's counterpart at the University of British Columbia.

Table 12.1-1 | Financial Aid/ Debt Management Activities — Source: School-Reported

Describe financial aid and debt management counseling/advising activities (including one-on-one sessions) that were available for medical students in each year of the curriculum during the most recently completed academic year. Note whether they were required (R) or optional (O). Add rows as needed for each campus if the information differs across campuses.				
	Financial aid/ debt management activities (R/O)			
Campus (if applicable)	Year 1	Year 2	Year 3	Year 4
Foothills Campus (Note: all sessions are recorded for students to podcast on their own time)	One-on-one sessions begin as soon as acceptance letters are received. Budgeting and debt/financial counseling begin and personal budgets are created. Many one-on-one meetings include partners or parents. Financial Literacy 101 (R) is a mandatory session held in July during Orientation. These sessions are evaluated (see Table 12.1-8 below) with ratings trending up as the talk is adjusted/improved. In the recent iteration, there were many positive remarks on feedback, with an overall rating of 4.62/5. The Insurance Panel presentation (O) is held in September/October for Year 1 and Year 2 students. This is not mandatory. Both events are evaluated by students in attendance. (see Table 12.1-8 below) A tax clinic is offered in March to all students. Appointments are set up with Haskayne School of Business students who travel to the Foothills Campus to meet with UME students. They will prepare and file their taxes.	Finance Manager available for budgeting and debt/financial counselling as requested by students. The majority of these meetings result in the creation of a personal budget. Financial topics discussed include insurance, RRSPs, TFSAs, investing, etc. Many one-on-one meetings include partners. Financial Literacy 201 (O) Insurance Panel (O) is held in September for Year 1 and Year 2 students. Both events are evaluated by students in attendance. (see Table 12.1-8 below)	Finance Manager available for budgeting and debt/financial counselling as requested by students. The majority of these meetings result in the creation of a personal budget. Financial topics discussed include insurance, RRSPs, TFSAs, investing, etc. Many one-on-one meetings include partners. Transition to Residency (O) is held during the LMCC review month in the spring. This is a presentation given in conjunction with the Professional Association of Residents of Alberta (PARA). This event is evaluated by students in attendance.	N/A

Table 12.1-2 | Financial Aid Management Services at Geographically Distributed Campuses and Sites Away from the Medical School, where Students Spend Six or More Consecutive Months

Source: School-Reported

Indicate how the financial aid management services are made available to students at each distributed campus by placing "Y" for Yes in the appropriate column(s). Add rows as needed for each campus. ***Note: This question also applies to schools where students are away from the medical school for a six-month or more consecutive period (e.g., longitudinal integrated clerkships or distributed rotation-based clerkships).***			
	Financial aid management services available to students via		
Campus	Personnel located on campus	Visits from central campus personnel	E-mail or tele/videoconference
Foothills campus Year 3 students (including longitudinal clerkship, ie. UCLIC) return to Calgary for the LMCC review. This gives us the opportunity to include these students in the Transition to Residency session. This session is podcasted for students to review on their own time.	Finance Manager, UME		

Table 12.1-3 | Financial Aid and Debt Counseling Services

Source: AFMC GQ

Provide data from the AFMC Graduation Questionnaire (AFMC GQ) on the percentage of respondents that were *satisfied/very satisfied* (aggregated) in the areas listed in the table. Add rows as needed for each campus.				
Campus		School %		
		2015 (response rate 80%)	2016 (response rate 80%)	2017 (response rate 72%)
	Financial aid administrative services	74.5	74.7	73.6
	Overall educational debt management counseling	70.6	69.9	72.4

Table 12.1-4 | Financial Aid and Debt Counseling Services

Source: School-Reported

Provide internal data, by curriculum year, on the percentage of respondents that were *satisfied/very satisfied* (aggregated) with financial aid services and counseling. Add rows as needed for each campus.					
Campus		Year 1	Year 2	Year 3	Year 4
Foothills Campus. Financial aid services and counseling are part of the overall debt management meetings. These topics are included within financial literacy presentations, so evaluated as part of the overall presentation or end-of-year survey. The Finance Manager answers the majority of student questions with regard to student loans and lines of credit. In certain situations where special situations exist or	Financial aid services and counseling	Included in "debt management counseling numbers" below	Included in "debt management counseling numbers" below	Included in "debt management counseling numbers" below	
	Debt management counseling	58.9	67.1	37.5 *	

students need to have adjustments or corrections made to their application, the Finance Manager refers the student to the Financial Aid department on main campus. The one-on-one financial services and debt counseling sessions are not individually evaluated, but are included as part of the overall end-of-year evaluation. The end-of-year evaluation has been updated to ask specific questions about debt management counselling and financial aid services counseling. Financial literacy and other presentations are evaluated, and copies of feedback reports are appended. Please see narrative section for additional information. * Note: Only 50% of the class of 2017 completed the AFMC GQ and one-third of the respondents did not answer this question. The Class of 2017 only had one session with the Finance Manager and was just leaving as the Financial Literacy program was beginning.					

Table 12.1-7 | Average Medical School Educational Debt

Source: AFMC GQ

Provide school and national benchmark data from the AFMC Graduation Questionnaire (AFMC GQ) on the average reported medical school educational indebtedness of all medical student graduates with medical school debt and the percentage of graduates with indebtedness in excess of $200,000. Add rows as needed for each campus.							
Campus		%					
		2015 (response rate 80%)		2016 (response rate 80%)		2017 (response rate 72%)	
		School	National	School	National	School	National
	Average medical school debt	NA	NA	$100,000	$80,000	$117,500	$94,000
	Percentage of graduates with debt greater than or equal to $200,000	NA	NA	19.0	9.9	14	11.6

Table 12.1-8: ratings of last six financial presentations

Date	Duration (minutes)	Event Title	Mean Rating (out of 5)	n
7/19/2016	90	Finance 101	3.8	64
9/21/2016	60	Insurance Presentation	3.93	45
11/30/2016	60	Financial Literacy 201	3.73	11
4/19/2017	90	Finance: Transition to Residency	Not rated	0
5/18/2017	60	Financial Literacy 201	4	16
7/18/2017	60	Financial presentation 101	4.62	117
9/21/2017	60	Insurance Presentation	3.6	31

NARRATIVE RESPONSE

a. If the medical school has one or more geographically distributed campuses, describe which of the required and optional sessions were available at each campus during the most recently completed academic year.

Not applicable.

b. Describe other mechanisms that are being used by the medical school and the university to limit medical student debt, such as limiting tuition increases.

University of Calgary Cumming School of Medicine students continue to report higher debt compared to the national average. The U of C program is 3 years in length and does not afford students the time to work on a part-time basis. Many students that apply to this program are mature and have accumulated a large debt load prior to admission to the program.

Tuition ($15,000) has not increased since 2014-2015. The tuition freeze will be ending in 2018, but at this point, we have not received notice that the tuition will increase.

An additional mechanism for assisting students with large debt is the $150,000 of differential tuition funds that have been designated for the Special Bursary. The Special Bursary was created to provide assistance to students in financial distress. Applications have been held yearly since 2015, with two application rounds in 2016-17. The total funding from 2015-2017 is $297,500. (Please refer to Appendix 12.1a, Special Bursary Statistics document).

Further, it has been proposed that there is a relationship between the increase in students accessing one-on-one financial/debt counselling sessions and the decrease in the applications for the Special Bursary. While this cannot be concluded statistically, it is reasonable to suggest there may be a correlation that increased financial presentations and meetings with the Finance Manager has made students more aware of the risk of debt and the costs (including hidden costs) associated with medical school. (Please refer to Appendix 12.1b, summary prepared by Dr. Kevin McLaughlin).

The Clerkship Bursary is another tool provided by the CSM and is included in the UME budget. We provide clerks with a one-time access to $350 per month for 12 months, ($4,200 total) to help students in clerkship pay for parking, meals etc. as they travel throughout the city and the province on their mandatory rotations.

Other assistance includes emergency funding and the opportunity to apply for memorial awards that are specific to UME students.

The Financial Literacy program
Financial Literacy 101, Insurance Panel, Financial Literacy 201, Transition to Residency

Topics covered in Financial Literacy 101:

- Costs of medical school for all three years, including hidden costs students face (electives, Ice Bowl, AFMC portal application, CaRMS, LMCC application, etc.)
- Budgeting scenarios for typical students (single, with a partner, married and supporting spouse and children) – budgets are an important tool
- How to determine net worth, cash on hand
- Credit report, credit score, credit rating as well as information on Credit Bureaus in Canada
- Student loans, student line of credit (Financial Awards from Main Campus joins in at this point)
- Brief overview of the Prime Rate in Canada (as this will affect their LOC interest payments)
- Answers to common questions
- Discussion of student bursaries and awards (emphasis on Special Bursary)

Topics Covered in Insurance Panel

- Three different insurance companies participate in this event. It allows the students to ask each company specific questions and decide for themselves the type of company and insurance they wish to obtain.
- Insurance basics
- A faculty perspective on the importance of insurance (particularly Disability Insurance)
- When do I need insurance? How much do I need?
- Overview of insurance terminology (exclusion period, "own occupation")

Topics Covered in Financial Literacy 201:

- Reiterate budgeting and debt discussion (students at this point are becoming very aware of their own debt situation, emotional responses to debt)
- Reiterate importance of developing and maintaining a budget
- Hidden costs of Clerkship
- Answers to questions (Finance Manager works with CMSA VP of Finance who polls the class for common questions and concerns. The presentation is structured around these questions: e.g. should I buy a house with my line of credit? Should I invest with my line of credit, should I buy a car for clerkship? How much does the CaRMS tour actually cost?)
- Overview of the Clerkship Bursary – how it works, when students can expect to receive the funds
- Overview of memorial awards available for students
- Review of insurance concepts

Topics Covered in Transition to Residency:

- Professional Association of Residents of Alberta (PARA) is a joint presenter with Finance Manager
- Managing debt after medical school
- Answers to questions (should I buy a home during residency, when to start investing etc.)
- Continued discussion about insurance (PARA covers a lot of this)
- Tax Planning and investing – when and how to start
- Paying off debt vs. investing/saving – how to manage both
- How long it will take to pay off debt
- Paying back student loan debt
- Discussion of Prime Rate (reminder of concepts)

SUPPORTING DOCUMENTATION **(Appendix 12.1a)**

Appendix 12.1a – Special Bursary Statistics
Appendix 12.1b – Changes in Special Bursary Awards

12.5 PROVIDERS OF STUDENT HEALTH SERVICES / LOCATION OF STUDENT HEALTH RECORDS (U)

The health professionals who provide health services, including psychiatric/psychological counseling, to a medical student have no involvement in the academic assessment or advancement of the medical student receiving those services. A medical school ensures that medical student health records are maintained in accordance with legal requirements for security, privacy, confidentiality, and accessibility.

Finding: The Cumming School of Medicine has a policy to address the non-involvement of providers of Student Health Services in student assessment. The policy does not delineate the responsibility of the faculty and the school, and leaves the onus on the student. Discussions with faculty during the site visit indicated a lack of awareness of this policy.

NARRATIVE RESPONSE

a. Describe how the medical school ensures that a provider of health and/or psychiatric/psychological services to a medical student has no current or future involvement in the academic assessment of, or in decisions about, the advancement of that student. Describe how medical students, residents, and faculty are informed of this requirement.

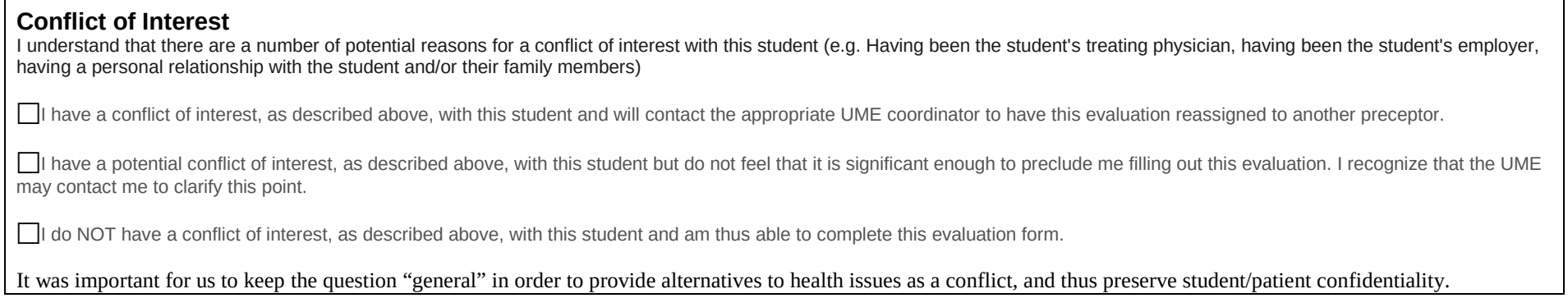
The two main concerns outlined by the visiting team have been addressed.

Firstly, we realized that the policy we had in place did not clearly delineate the role of the faculty in this process. We sought ways to improve this, while keeping in mind student (patient in this case) confidentiality. The importance of maintaining student confidentiality eliminated certain possible mechanisms, such as sending a class composite and asking all the faculty to identify, in a "blanket" fashion, students they had treated in the past (and thus breaching confidentiality for a situation which may never have arisen).

To reach the current policy found in Appendix 12.5a (revised by curriculum committee June 29, 2017), we put together a policy that included input from other schools. In this policy, the faculty has 3 key responsibilities:

- Identification beforehand (or during) by student or faculty, and notification to UME leadership, with subsequent organization of an alternate placement
- Identification during an emergency situation, in which the onus will be managing the conflict (policy states clearly that in this and all situations, such faculty will recuse themselves of assessment/promotion decisions)
- Identification later in the rotation, and inclusion of a conflict of interest question in the in-training-evaluation report or ITER (see below)

The second concern was awareness of the policy, and we believe this has been solved by both general means (posting on website, distribution to clerkship leaders) but perhaps more effectively by inclusion of the following question on the ITER (faculty can select one of three boxes, and a link to the policy in Appendix 12.5a is provided):



Conflict of Interest

I understand that there are a number of potential reasons for a conflict of interest with this student (e.g. Having been the student's treating physician, having been the student's employer, having a personal relationship with the student and/or their family members)

☐ I have a conflict of interest, as described above, with this student and will contact the appropriate UME coordinator to have this evaluation reassigned to another preceptor.

☐ I have a potential conflict of interest, as described above, with this student but do not feel that it is significant enough to preclude me filling out this evaluation. I recognize that the UME may contact me to clarify this point.

☐ I do NOT have a conflict of interest, as described above, with this student and am thus able to complete this evaluation form.

It was important for us to keep the question "general" in order to provide alternatives to health issues as a conflict, and thus preserve student/patient confidentiality.

The distribution of this conflict question, which has occurred for one year now (2157 ITERs), via the ITER has helped raise awareness of the issue and policy with all our faculty, residents and students. In addition, it has helped us gain some data on the magnitude of the problem. Since its inception a year ago:

- 2151 (out of 2157) faculty "ticked" the third box, meaning no conflict of interest and able to complete the form
- No faculty has "ticked" the first box (thus no conflict, including being student's treating physician, precluding evaluation)
- Six faculty members (out 2157 ITERs) "ticked" the second box and were contacted by our Assistant Dean, Clerkship (Dr. Pam Veale) with the following details:

Explanation	Response
Met at wedding of mutual friend, acquaintance of student's parent via volleyball team	No concern. Second preceptor contributed and agreed to evaluation.
Neighbor. Did not feel impacted on evaluation – good performance	No concern. Second preceptor contributed and agreed to evaluation.
Cousin of colleague in EM. No direct conflict	No concern. Daily rotation evaluations in EM so will be combined.
My potential conflict of interest is from participating in the same research project several years ago. However, I do not think it interferes with my objective evaluation of her very good performance.	No concern. Appropriate continuity of preceptor for project.
Preceptor is Medical Director at SHC. Student was project manager at that site for ~1 year prior to medical school. She did not report directly to but they did work together on projects.	Discussed with student – from her perspective felt no conflict
Student and I were in some of the same classes in undergrad and we were friends. We haven't been in contact for several years now. It didn't influence my assessment or our shift together.	Daily evaluation combined with other preceptors.

Thus out of those six faculty members, none of them had a conflict pertaining to providing health services.

The policy is also communicated to the students during the "Orientation to Clerkship/Site Selection" session and is present in the Clerkship student handbook.

SUPPORTING DOCUMENTATION

a. Policies and/or procedures that specify that providers of health and psychiatric/psychological services to a medical student will have no involvement in the academic assessment of or in decisions about the advancement of that student. (***Appendix 12.5 a***)

Appendix 12.5a – *Providers of Health and Psychiatric/Psychological Services to Medical Student*