

This privileged communication
is the property of the
Committee on Accreditation of Canadian Medical Schools

**TEAM REPORT
OF THE
SURVEY OF**

**UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE**

Calgary, Alberta

February 28 – March 2, 2016

**PREPARED BY AN *AD HOC* SURVEY TEAM
FOR THE
COMMITTEE ON ACCREDITATION OF CANADIAN
MEDICAL SCHOOLS
AND THE
LIAISON COMMITTEE ON MEDICAL EDUCATION**

TABLE OF CONTENTS

	Page
Memorandum.....	1
Site Visit Team Composition.....	2
Acknowledgement	2
Disclaimer	2
Final Site Visit Team Element Rating Summary Table.....	3
Summary of Site Visit Team Findings.....	4
History of the School	5
Accreditation History of the School.....	6
Curriculum Description	7
Key Parameter Overview Summary Table (last full visit vs visit)	13
Evaluation of the DCI.....	13
Evaluation of the MSS	14
Evaluation of the ISA.....	15
Evaluation of the CGQ and AFMC GQ.....	15
Evaluation of Standard 1	17
Evaluation of Standard 2.....	25
Evaluation of Standard 3.....	31
Evaluation of Standard 4.....	43
Evaluation of Standard 5.....	52
Evaluation of Standard 6.....	72
Evaluation of Standard 7.....	85
Evaluation of Standard 8.....	100
Evaluation of Standard 9.....	117
Evaluation of Standard 10.....	131
Evaluation of Standard 11	145
Evaluation of Standard 12.....	158

CORE APPENDICES

Appendix	Element	DCI Document	Title	Appendix page number
C-1			Schedule of the visit	4
C-2			Medical School Self-Study Element Rating Summary Table	16
C-3			Self-Study Taskforce and Subcommittee membership	17
C-4			Independent Student Analysis Summary	20
C-5			Campus maps	19
C-6	1.1	Appendix B	The strategic plan executive summary	30
C-7	1.3	Table 1.3-1	Standing Committees	31
C-8	2.2	Appendix G	Dean's abbreviated curriculum vitae (no more than 4 pages).	32
C-9	2.3	Appendix H	Organizational chart illustrating the relationship of the medical school dean to university administration, to the deans of other schools and colleges, and to the administrators of the health science center and affiliated teaching hospitals (if relevant).	36
C-10	2.3	Appendix I	Dean's position description	37
C-11	2.4	Appendix J	Organizational chart of the dean's office	39
C-12	3.3	Table 3.3-1	Diversity Categories and Definitions	40
C-13	3.3	Table 3.3-2	Students, Faculty and Academic and Educational Leadership	41
C-14	3.6	Table 3.6-1	Awareness of Mistreatment Policies Among Students	42
C-15		Table 3.6-2	Awareness of Mistreatment Procedures Among Students	42
C-16		Table 3.6-3	Student Mistreatment Experiences	43
C-17		Table 3.6-4	Student Mistreatment Experiences by Curriculum Year	44
C-18	4.1	Table 4.1-1	Total Faculty	45
C-19		Table 4.1-6	Protected Faculty Time	46
C-20	4.2	Table 4.2-1	Scholarly Productivity	47
C-21	5.1	Table 5.1	Medical School Revenue Sources	48
C-22	5.1	Appendix Y	An expenditures summary for the fiscal year in which the full survey takes place (based on budget projections) and for each of the prior three fiscal years.	50
C-23	6.1	Table 6.1-1	Competencies, Medical Education Program Objectives, and Outcome Measures	51
C-24	6.2	Table 6.2-1	Required Clinical Learning Experiences (Required Patient Encounters and Procedural Skills)	56
C-25	6.3	Appendix GG	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.	62
C-26	6.4	Table 6.4-1	Percentage Total Required Clinical Learning Experience Time	80
C-27		Table 6.4-2	Inpatient and ambulatory patient experience	80
C-28	6.7	Table 6.7-1	Health Professions Degree Programs Taught by Medical School Faculty	81
C-29		Table 6.7-2	Master's and Doctoral Degree Programs Taught by Medical School Faculty	81
C-30		Table 6.7-3	Residency and Fellowship Programs	82
C-31	7.1	Table 7.1-2	Basic Science Education	84

C-32		Table 7.1-4	General Medical Education – Curricular content social sciences	84
C-33	7.2	Table 7.2-2	General Medical Education	85
C-34		Table 7.2-3	General Medical Education	85
C-35	7.4	Table 7.4-2	Clinical reasoning	86
C-36	7.5	Table 7.5-1	General Medical Education – Common Societal Problems	86
C-37	7.6	Table 7.6-3	General Medical Education - Preparation for Residency	86
C-38	7.7	Table 7.7-2	General Medical Education - Preparation for Residency	87
C-39	7.8	Table 7.8-2	Communication Skills – Preparation for Residency	87
C-40	8.1	Appendix KK	An organizational chart for the management of the curriculum that includes the ‘curriculum committee’ and its subcommittees, other relevant committees, the undergraduate dean or equivalent, and the individuals or groups with involvement in curriculum design, implementation, and evaluation	88
C-41	8.2	Appendix PP	One example from a required learning experience in the first two years and one from a required clinical learning experience illustrating the way in which the learning objectives are linked to the medical education program objectives.	89
C-42	8.4	Table 8.4-1	Monitoring of Medical Education Program Outcomes	92
C-43		Table 8.4-2	LMCCQE Part 1 Results of First-time Takers	94
C-44		Table 8.4-3	LMCCQE Part 2 Results of First-time Takers	97
C-45		Table 8.4-4	Adequacy of Curriculum in Preparation for Residency	98
C-46		Table 8.4-5	Overall Satisfaction	98
C-47	8.6	Table 8.6-1	Patient encounters and procedural skills	99
C-48		Table 8.6-2	Alternative Clinical Experiences	99
C-49	9.1	Table 9.1-1	Provision of Objectives and Orientation	100
C-50		Table 9.1-2	Resident Preparation to Teach	101
C-51	9.4	Table 9.4-1	Observation of Clinical Skills	102
C-52		Table 9.4-2	Methods of Assessment – Year One	103
C-53		Table 9.4-3	Methods of Assessment – Year 2	104
C-54		Table 9.4-4	Methods of Assessment – Year 3	106
C-55		Table 9.4-5	Methods of Assessment - Year 4	107 / NA
C-56	9.7	Table 9.7-2	Mid-point Feedback	108
C-57		Table 9.7-3	Mid-point Feedback	108
C-58		Table 9.7-4 if appropriate	Longitudinal Integrated Clerkship Feedback	109
C-59	9.8	Table 9.8-1	Availability of Final Grades	110
C-60	10.4	Table 10.4-1	Entering Student Mean Performance Data	111
C-61	11.1	Table 11.1-1	Academic Advising/Counseling	111
C-62		Table 11.1-2	Academic Advising/Counseling by Curriculum Year	111
C-63		Table 11.1-3 If applicable	Academic Advising/Counseling at geographically distributed campuses and sites where medical students spend six or more consecutive months	112
C-64		Table 11.1-4	Attrition and Academic Difficulty	112
C-65		Table 11.1-5	Attrition and Academic Difficulty by Curriculum Year	113
C-66		Table 11.1-6	Average Graduation Rates Over Five Years	113
C-67	11.2	Table 11.2-1	Career Planning Services	114

C-68		Table 11.2-2	Career Planning Services by Curriculum Year	114
C-69		Table 11.2-3	Electives Advising	115
C-70		Table 11.2-4	Electives Advising by Curriculum Year	115
C-71		Table 11.2-7	Residency Match Rates	116
C-72	11.6	Appendix DDDD	A sample MSPR for a recent graduate with good overall performance and a sample MSPR for a student who has experienced difficulty.	117
C-73	12.1	Table 12.1-3	Financial Aid and Debt Counseling Services	141
C-74		Table 12.1-4	Financial Aid and Debt Counseling Services	141
C-75		Table 12.1-6	Average Medical School Educational Debt	142
C-76		Table 12.1-7	Average Overall Educational Debt	142 / NA
C-77		Table 12.1-8	Medical School Indebtedness	142 / NA
C-78		Table 12.1-9	Medical School Indebtedness Among Graduates	142 / NA
C-79	12.3	Table 12.3-1	Personal Counseling	142
C-80		Table 12.3-2	Wellbeing Programs	143
C-81		Table 12.3-3	Student Support Services by Curriculum Year	143
C-82	12.8	Table 12.8-1	Student Education on Exposure to and Prevention of Infectious Diseases	143
C-83		Table 12.8-2	Student Knowledge of Post-Exposure Treatment	144
C-84		Table 12.8-3	Protocol for exposure to infectious and environmental hazards	144

SUPPLEMENTAL APPENDICES

S-1	Student Mistreatment Taskforce Recommendations	1
S-2	Undergraduate Medical Education Organizational Chart	4
S-3	Cumming School of Medicine Goals, Objectives and Operating Philosophy.....	5
S-4	Dates for pre-clerkship course reviews 2015-16	8
S-5	Dates for clerkship rotation reviews 2015-16.....	10
S-6	3-year completion data for the “must see” clinical presentations	11
S-7	Overview of the financial literacy curriculum.....	27
S-8	Providers of Health and Psychiatric/Psychological Services to Medical Student policy	29
S-9	CPSA Blood Borne Infections in Health Care Workers.....	31

MEMORANDUM

TO: Committee on the Accreditation of Canadian Medical Schools

FROM: The Secretary of the *ad hoc* Site Visit Team that visited the University of Calgary, Cumming School of Medicine on February 28 – March 2, 2016

RE: Report of the Site Visit Team

On behalf of the *ad hoc* CACMS Site Visit Team that visited the University of Calgary, Cumming School of Medicine on February 28 – March 2, 2016, the following report of the team's findings is provided.

Respectfully,

Shannon Venance, Team Secretary

The schedule of the visit is included in Core Appendix C-1.

SITE VISIT TEAM COMPOSITION

Team Chair:	Dr. John Kelton Dean, Faculty of Health Sciences McMaster University Hamilton, ON	Hematology
Team Secretary:	Dr. Shannon Venance Director, CBME Implementation Schulich School of Medicine & Dentistry Western University London, ON	Neurology
Team Member:	Dr. John Drover Director, Accreditation Quality Improvement Faculty of Medicine Queen's University Kingston, ON	Critical Care Medicine
LCME Team Member:	Dr. Janet Lindemann Dean, Medical Student Education The University of South Dakota Sioux Falls, SD	Family Medicine
Student member:	Ms. Cynthia Min University of British Columbia Vancouver, BC	Medical Student
Faculty Fellow:	Dr. David Musson Associate Dean, Undergraduate Medical Education Northern Ontario School of Medicine Thunder Bay, ON	Family Medicine Psychology

ACKNOWLEDGEMENT

The team expresses its sincere appreciation to Dean Meddings and the staff, faculty, and students of the Cumming School of Medicine for their many courtesies and accommodations during the visit. Dr. Thomas Feasby and Ms. Gretchen Greer merit special recognition and commendation for their thoughtful visit preparations and generous support during the conduct of the visit.

DISCLAIMER: This report summarizes the findings and professional judgments of the *ad hoc* site visit team that visited the University of Calgary, Cumming School of Medicine on February 28 to March 2, 2016, based on the information provided by the school and its representatives before and during the accreditation visit, and by the CACMS. The CACMS may come to differing conclusions when they review the team's report and any related information.

FINAL SITE VISIT TEAM ELEMENT RATING SUMMARY TABLE

Site Visit Team CACMS Element Rating Summary Table
 Cumming School of Medicine
 University of Calgary

Standard	1	2	3	4	5	6	7	8	9	10	11	12
Element	1.1	2.1	3.1	4.1	5.1	6.1	7.1	8.1	9.1	10.1	11.1	12.1
	1.2	2.2	3.2	4.2	5.2	6.2	7.2	8.2	9.2	10.2	11.2	12.2
	1.3	2.3	3.3	4.3	5.3	6.3	7.3	8.3	9.3	10.3	11.3	12.3
	1.4	2.4	3.4	4.4	5.4	6.4	7.4	8.4	9.4	10.4	11.4	12.4
	1.5	2.5	3.5	4.5	5.5	6.5	7.5	8.5	9.5	10.5	11.5	12.5
	1.6	2.6	3.6	4.6	5.6	6.6	7.6	8.6	9.6	10.6	11.6	12.6
					5.7	6.7	7.7	8.7	9.7	10.7		12.7
					5.8	6.8	7.8	8.8	9.8	10.8		12.8
					5.9		7.9		9.9	10.9		
					5.10					10.10		
					5.11					10.11		
					5.12							

SUMMARY OF SITE VISIT TEAM FINDINGS

The following is the Summary of Site Visit Team Findings, linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element. Standards where all elements are rated as satisfactory are not listed. Note that the team's positive observations are not included in the Site Visit Report.

Element Rating: SM, US	Short Title
US	1.4 Affiliation agreements
	Finding: There is no affiliation agreement applicable to medical students for Stanton Territorial Health Authority and Yellowknife.
US	3.3 Diversity/pipeline programs and partnerships
	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.
SM	3.6 Student mistreatment
	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.
SM	9.4 Assessment system
	Finding: The 2015 GQ data revealed a small majority of students indicated they were observed performing a history and physical during the Surgery clerkship. There has been improvement evidenced by mid-year end-of-rotation evaluations from the Class of 2016,
SM	9.7 Timely formative assessment and feedback
	Finding: Surveys (GQ, ISA and end-of-rotation) indicate that students were not consistently receiving formal mid-rotation feedback in the Surgery clerkship. Strategies to improve this were implemented in 2015.
SM	12.1 Financial aid/debt management counseling/student educational debt
	Finding: The school has an optional financial literacy curriculum delivered over the three years with recent changes in 2015. Similarly, significant changes to the bursary program have been made. The impact of these changes is uncertain.
US	12.5 Non-involvement of providers of student health services in student assessment/location of student health records
	Finding: Although the school has a policy to address non-involvement of providers, the policy does not delineate the responsibility of the faculty and the school, but leaves the onus on the student. Discussions with faculty during the site visit indicated a lack of awareness of this policy.

HISTORY OF THE SCHOOL

Note that campus maps are provided in Core Appendix C-5.

The University of Calgary Medical School was founded in 1967 and renamed the Cumming School of Medicine in 2014. Originally created to train family physicians, the school has evolved into educating physicians for a wide spectrum of activities: from primary care to specialty care; to careers in education, management, and research. The School of Medicine is housed in the Health Sciences Centre, adjacent to the Foothills Medical Centre, the largest hospital in Alberta. The introduction of the Alberta Heritage Foundation for Medical Research facilitated the expansion of the research enterprise with the construction of the Heritage Medical Research Building, connected to the Health Sciences Centre.

The Cumming School of Medicine offers a 3-year Doctor of Medicine program committed to patient-centered learning and early hands-on experience. The current annual enrolment of new medical students is 155.

The Cumming School of Medicine comprises 5 basic science departments and 15 clinical departments. All clinical departments are affiliated with the Alberta Health Services - Calgary Zone with department heads jointly appointed by the Cumming School of Medicine and Alberta Health Services. The School offers 3 undergraduate degree programs (Bachelor of Health Sciences, Bachelor of Community Rehabilitation and Doctor of Medicine), 10 graduate programs (Biochemistry & Molecular Biology, Biomedical Technology, Cardiovascular and Respiratory Sciences, Community Health Sciences, Gastrointestinal Sciences, Immunology, Leaders in Medicine (joint MD/graduate degree), Medical Science, Microbiology & Infectious Diseases and Neuroscience) and over 100 postgraduate residency and fellowship medical education programs.

Partnership between the Cumming School of Medicine and Alberta Health Services – Calgary Zone supports 7 institutes (Alberta Children’s Hospital Research Institute for Child and Maternal Health; Arnie Charbonneau Cancer Institute; Calvin, Phoebe and Joan Snyder Institute for Chronic Diseases; Hotchkiss Brain Institute; O’Brien Institute for Public Health; Libin Cardiovascular Institute of Alberta; and the McCaig Institute for Bone and Joint Health) and 3 core facilities (Clinical Research Unit; Calgary Centre for Clinical Research; and the Centre for Advanced Technologies in the Life Sciences). The institutes encompass education, research and service to society activities and serve as the umbrella organizations for research groups.

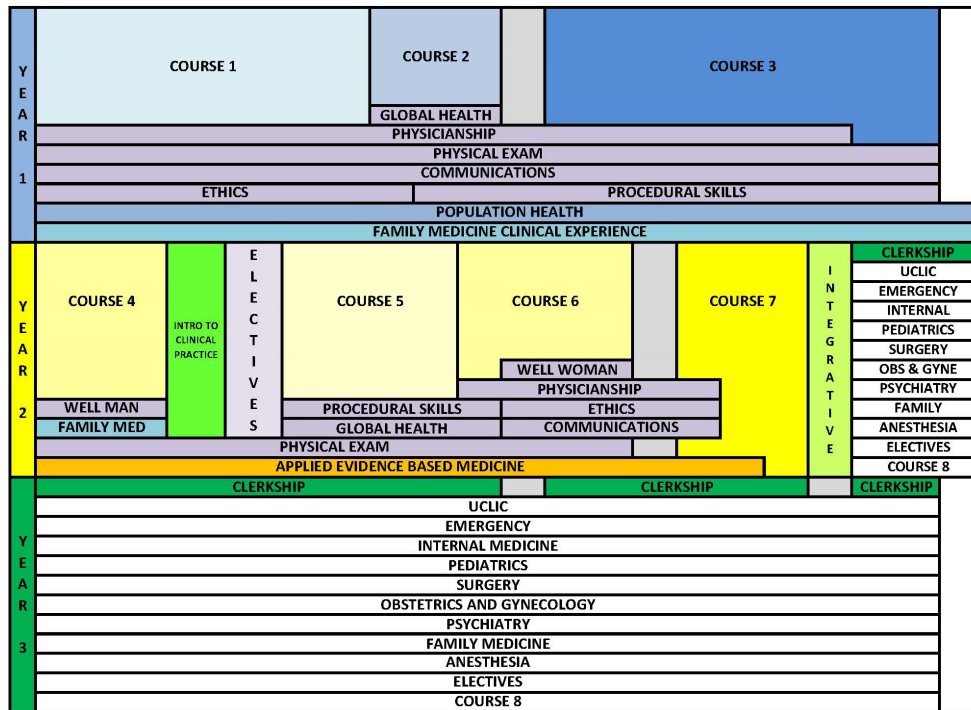
ACCREDITATION HISTORY OF THE SCHOOL

University of Calgary Cumming School of Medicine			Since the last full site visit (March 2-5, 2008)						UPDATED: 15 March 2023			
Standard	15-16 Element	Full site visit June 2008	Class size Oct 2008	Class size Feb. 2009	Sec FF June 2009	Status report June 2010	Status report June 2011	Status report Feb 2012	Status Report Feb 2013	Status Report Feb 2014	Status Report Oct 2014	Status Report Feb 2015
ED-2	8.6	NC				NC	NC	C				
ED-25	9.2	NC				NC	NC	CM	NC	NC	NC	C
ED-32	9.5	NC				NC	NC	C				
MS-19	11.2	NC				NC	NC	CM	CM	CM	CM	CM
FA-13	1.3	NC				C						
ER-1	5.12		NC	C								
Class size ER-3	5.3	T	T	T To 150	T To 180	R						
New curr*		T				R						
Research facilities ER-4	5.4	T				R						
Student feedback ED-47	8.5	T				T	T	CM	CM	CM	CM	C
Follow-up 1		Status report	Template	Report	Status report	Status report	Status report	Status report	Status report	Status report	Status report	Next full site visit
Due date		Apr 1 /10	Jan 2 /09	Apr 15 /10	Apr 15 /10	Apr 15 /11	Dec 15 /11	Dec 15 /12	Dec 15 /13	Aug 1 /14	Dec 1 /14	
Follow-up 2				Sec FF								
Due date				2009								
Action			Defer		Approved							
Accreditation status		Full	Full	Full	Full	Full	Full	Full	Full	Full	Full	Full
Next full site visit		2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16

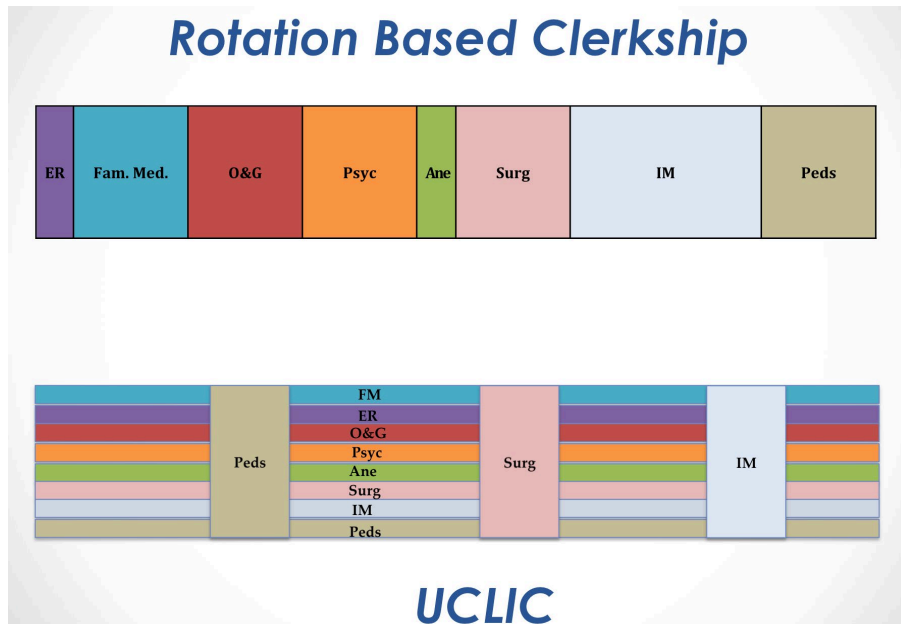
T area in transition. Terminology changed to Compliance with Monitoring in 2012. R refers to an area in transition that has been Resolved*
Finding is not directly linked to an accreditation standard

CURRICULUM DESCRIPTION

Schematic or diagram that illustrates the structure of the curriculum



Structure of any parallel curriculum



OVERVIEW DATA

Table 6.0-1 | Academic Year 1 - Instructional Formats

Source: School-reported

Using the most recently-completed academic year, list each required learning experience from year one of the curriculum and provide the total number of instructional hours for each listed instructional format. Note that "small group" includes case-based and problem-solving sessions. Provide the total number of hours per required learning experience and instructional format. Provide a definition of "other" if selected. Add rows as needed for each campus.								
Campus	Required learning experience	Weeks	Number of Formal Instructional Hours per Required Learning Experience					
			Lecture	Lab	Small Group	Patient Contact	Other (Describe)	Total
HSC	Course 1 (Introduction to Medicine, Blood, Gastrointestinal)	13	143	16	53	12 (CC), 9 (Patient Presentation)	5 (Flip Classroom Workshops), 7 (Flip Classroom IST), 28 (Review Sessions & Exams)	273
HSC	Course 2 (Musculoskeletal, Dermatology)	8	79.5	6 + 2 open lab	9	8 (CC – 4 ortho, 2 rheum, 2 GALS), 6 (Patient presentations)	3 (Hands on physical exam sessions with standardized patients), 10 (TBL), 20 (exams and review sessions)	143.5
HSC	Course 3 (Cardiovascular, Respiratory)	10	116	12	48	12 (CC), 9 (Patient Presentation)	18 (review & exams)	215
HSC	Population Health	longitudinal	46	0	10	12 (Patient Presentation)	4 (Interviews), 20 (Presentation Prep), 4 (Symposium)	96
HSC	Ethics-year 1	longitudinal	7	0	10	0	2 (Theatrical production)	19
HSC	Procedural Skills-year 1	longitudinal	1	8	0	0	0	9
HSC	Physical Exam-year 1	longitudinal	1	0	0	28 (Hands on physical exam sessions with standardized patients)	0	29
HSC	Global Health-year 1	longitudinal	3.5	0	4.5	2	0	10
HSC	Communications-year 1	longitudinal	4	0	0	28 (with standardized patients)	0	32
HSC	Well Physician-year 1	longitudinal	3	0	8	0	0	11

Physician offices	Family Medicine Clinical Experience	4 sessions	0	0	0	16	0	16
TOTAL			404	44	142.5	142	121	853.5

Table 6.0-2 | Academic Year 2 - Instructional Formats

Source: School-reported

Using the most recently-completed academic year, list each required learning experience from year two of the curriculum and provide the total number of instructional hours for each listed instructional format. Note that "small group" includes case-based or problem-solving sessions. Provide the total number of hours per required learning experience and instructional format. Provide a definition of "other" if selected. Add rows as needed for each campus.								
Campus	Required learning experience	Weeks	Number of Formal Instructional Hours per Required Learning Experience					Total
			Lecture	Lab	Small Group	Patient Contact	Other (Describe)	
HSC	Course 4 (Renal, Endocrine and Obesity)	10	133	2	52	6 (CC)	30 (exam and review)	223
HSC	Course 5 (Neurosciences, Aging and Special Senses)	10	100	6	47	12 (CC), 4 (Patient Presentation)	2 (Patient Assignment), 24 (Review Sessions, Exams)	195
HSC	Course 6 (Children and Women's Health)	10	112	0	41.5	10 (CC), 2 (small group), 15.5 (patient presentation)	11.5 (review), 2 (Obs movie night, review midpoint). 2 hours lecture and 2 hours small groups are shared with ethics, and not included in these numbers	194.5
HSC	Course 7 (Psychiatry)	5	52	0	12	6 (CC), 9 (patient presentation)	3 (review) 3(exam)	85
HSC	Ethics-year 2	longitudinal	7	0	7	0	0 (4 hours delivered during course 6)	14
HSC	Procedural Skills- year 2	longitudinal	0	4	0	0	0	4
HSC	Physical Exam-year 2	longitudinal	2	0	0	16 (standardized patients)	0	18
HSC	Global Health-year 2	longitudinal	3	0	5	0	4 (Global health symposium)	12
HSC	Communications-year	longitudinal	4.5	0	0	11.5 (standardized	0	16

	2					patients)		
HSC	Well Physician-year 2	longitudinal	2	0	6	0	0	8
HSC	Well Man	2 sessions	2	0	0	2 (standardized patients)	0	4
HSC	Well Woman	2 sessions	2	0	0	2.5 (standardized patients)	0	4.5
HSC	Evidence-Based Medicine (didactic)	longitudinal	10	0	0	0	10 (team based learning), 2 (student CAT presentations), 2 (Exam), 2 (review session)	26
HSC	Applied EBM	longitudinal	0	0	0	60 (can be research also)	0	60
HSC	Introduction to Clinical Practice	2	21	4	11	2	4 (Sim), 4 (skills), 2 (online AHS med rec module)	48
HSC	Integrative Course	2	0	0	0	30 Small groups with standardized patients	0	30
Physician offices	Family Medicine Clinical Experience	3 sessions	0	0	0	12	0	12
Electives	Summer Electives	4	0	0	0	160	0	160
TOTAL			450.5	16	181.5	360.5	105.5	1114

Table 6.0-3 | Academic Year 3 - Weeks/Formal Instructional Hours

Source: School-reported

Provide data from the most recently-completed academic year on the total number of weeks and formal instructional hours per week (includes lectures, conferences, teaching rounds, clinical and procedural skills teaching/workshops) for each required learning experience in years three-four of the curriculum. Provide a range of hours if there is significant variation across weeks. Note that hours devoted to patient care activities should NOT be included. Add rows as needed for each instructional site if there are differences between sites.

Instructional Site*	Required learning experience	Total Weeks	Typical Hours per Week of Formal Instruction
FMC/PLC/RGH/SHC/Rural/Health Sciences Center	Family Medicine clerkship	6	0-6 hours
FMC/PLC/RGH/SHC/Health Sciences Center	Internal Medicine clerkship	10	5-7 hours
FMC/PLC/RGH/Health Sciences Center	Surgery clerkship	6	4-10.5 hours
FMC/PLC/ACH	Pediatrics clerkship	6	1-4.5 hours
FMC/PLC/RGH/SHC/Rural/ACH	Psychiatry clerkship	6	6-8 hours

FMC/PLC/RGH/SHC/rural	Obstetrics and Gynecology clerkship	6	1-13 hours
Various Canadian sites	Clerkship electives	12	NA
FMC/PLC/RGH	Anesthesia clerkship	2	1-6.25 hours
HSC	Course 8: comprehensive clinical skills curriculum for clerkship	60 hours	5 hours every 4 weeks
FMC/PLC/RGH	Emergency Medicine clerkship	2	3-5 hours

- See narrative below

The Cumming School of Medicine offers a 3-year Doctor of Medicine degree program over 131 weeks (8 months from August - March for year 1; 11 months from April - mid-February for year 2; and 13 months from mid-February - April the following year for year 3). No major curricular revision is underway.

The integrated Clinical Presentation curriculum is organized around the 120+/- 5 ways a patient can present to a physician. The Clinical Presentations can take the form of historical points (e.g. chest pain), physical examination signs (e.g. hypertension), or laboratory abnormalities (e.g. elevated serum lipids). “Schemes” or classification systems, unique to each Clinical Presentation, provide scaffolding onto which basic and clinical sciences knowledge can be both structured and integrated, and support the development of clinical problem solving.

The pre-clerkship curriculum (years 1 and 2) last underwent revision in 2006 resulting in 16 courses (Tables 6.0-1 and 6.0-2 above):

- 7 block courses (MDCN 350 Course 1, MDCN 360 Course 2, MDCN 370 Course 3 in year 1; MDCN 410 Course 4, MDCN 450 Course 5, MDCN 460 Course 6 and MDCN 470 Course 7 in year 2);
- 6 longitudinal courses integrated over the two years (MDCN 320/420 Medical Skills, MDCN 340 Population Health, MDCN 330/430 Family Medicine Clinical Experience and MDCN 440 Applied Evidence Based Medicine). The longitudinal course Medical Skills (MDCN 320/420) is comprised of the Ethics, Procedural Skills, Physical Exam, Global Health, Communications, Well Physician, Well Man and Well Woman modules;
- 1 course of 4 weeks for Summer Electives (MDCN 402) in year 2; and
- 2 preparatory courses for clerkship in year 2 (MDCN 490 Introduction to Clinical Practice and MDCN 480 Integrative Course).

With the exception of the Family Medicine Clinical Experience (7 half-days in a family physician’s office), the teaching takes place at the Health Sciences Centre. The instructional format consists of ~40% lecture, ~25% is small group learning, 13% one-to-one preceptor experiences and other learning strategies such as team-based learning, flipped classrooms and patient presentations. The school targets 30% independent study time.

The year 3 clerkship (Table 6.0-3 above) consists of 44 weeks for the 8 mandatory department based clinical learning experiences (MDCN 502 Family Medicine, MDCN 504 Internal Medicine, MDCN 508 Pediatrics, MDCN 506 Surgery, MDCN 510 Psychiatry, MDCN 512 Obstetrics & Gynecology, MDCN 516 Anesthesia and MDCN 522 Emergency Medicine), 12 weeks for MDCN 514 Clinical Electives and 60 hours of integrated academic half-days (MDCN 520 Course 8). The majority of students complete the traditional rotation-based clerkship at clinical sites in Calgary: Foothills Medical Centre (FMC), Peter Lougheed Centre (PLC), South Health Campus (SHC), Alberta Children’s Hospital (ACH), and the Rockyview General Hospital (RGH). There is the expectation that students will complete 5-10 weeks outside the city of Calgary at affiliated rural sites. In 2009, MDCN 520 (Course 8) was introduced as an academic half day to “improve teaching of clinical skills, simulation, conflict resolution, basic sciences, patient safety, pharmacology and chronic disease management”. Course 8 is also used to ensure all students have satisfactorily achieved the required patient encounters and procedures.

Up to 30 students annually will complete their clerkship in the University of Calgary Longitudinal Integrated Clerkship (UCLIC) stream consisting of 32 weeks of longitudinal rural preceptorship, 12 weeks of urban medicine (4 weeks Internal Medicine, 4 weeks Pediatrics and 4 weeks Surgery in Calgary) and 12 weeks of electives. The School has published results demonstrating the equivalence of the two streams in Academic Medicine (2014).

KEY PARAMETERS OVERVIEW SUMMARY TABLE

(Standard 1, Table 1.0-1 *(compares key parameters between the last full accreditation visit and the current visit).

The following table compares selected data from the time of the last accreditation visit to information provided for the current visit

	Data from the last full Site Visit Report	AY 2014-2015
Entering class size	150	158
Total medical school enrollment	402	501
Number of residents & fellows	611	957
Number of full-time basic science faculty	159	171
Number of full-time clinical faculty	312	292*
(\$ in Millions)		
Visa student and trainee fees	1.5	0.9
University (excluding allied health and other program)	44.5	57.3
Federal government	2.7	1.4
Provincial government	5.4	26.4
Practice plan/Alternate Funding Plan/Billing Group	13.7	24.8
Hospital Health Authority	28.2	39.0
Research awards, grants and contracts	127.1	141.1
Research grant overhead funds	.5	2.4
Gifts, donations and interest earned on endowments/investments	7.4	31.5
Other	6.0	15.2
Total revenues	236.9	340.0

* Does not include 35 full time faculty in the Department of Community Health Sciences which the AFMC does not include in basic or clinical science.

In the interval between full site visits the entering class size has returned to ~ 2008 enrollment, after several years of a provincially mandated increase to a high of 180 in 2011-12 (accounting for differences in the table with respect to enrollment and trainee fees). The increase in residents and fellows result from expanded postgraduate training position availability nation-wide and does not provide a strain on the education and clinical care missions. The number of full-time basic science and clinical faculty is sufficient to deliver the medical education program and a number of vacant positions (due to retirements) will be filled through several new funding sources (provost, AIHS, Ministry of Alberta Health). The School is well funded and has seen an increase in dollars from the majority of sources, including a \$100M philanthropic gift in 2014 matched by the provincial government (\$200M total). There was a decrease in government funding (\$3.6M) with provincially mandated reductions in enrolment, however the operating budget was maintained.

EVALUATION OF THE DCI

The DCI was clear and appropriately cross-referenced appendices (required and any supplemental provided by the school), any relevant overview data as well as the ISA/GQ. Generally, there was internal consistency of the information provided with rare exceptions that did not impact interpretation of the School's documentation. The DCI was detailed and answered the questions asked with some exceptions that reflected differences in the interpretation of the standards, elements and/or necessary documentation.

The School responded in a timely manner to the team's request for additional and clarifying information, providing answers and further documentation as required. There were rare instances (e.g. for elements 8.6; 9.8; 12.5) for which the team had concerns when the original data was validated by the school indicating they were satisfied with the documentation or answers provided; this required the team to probe in greater depth at the time of the site visit.

EVALUATION OF THE MSS

The Medical School Self Study comprised the Accreditation Steering Committee with six sub-committees, all of which included medical students (Core Appendix C-3). Dr. Tom Feasby, the past dean of the medical school chaired the Accreditation Steering Committee. The chairs of the sub-committees served on the Steering Committee. Membership included representation from stakeholders within the academic community. The MSS committee membership was weighted towards senior leadership (decanal leaders, department heads, Alberta Health Services leads, administration), clinical faculty and medical students with the inclusion of administrative support personnel and basic science faculty members on sub-committees. The MSS evaluation of elements was satisfactory and reflected the School's processes and documentation. On occasion, evidence to support the findings or demonstrate effectiveness was implied, requiring the team to request additional information or confirm during the site visit.

The MSS report generally offered a satisfactory evaluation of required elements and where appropriate, provided a more detailed self-assessment integrating the current status, student opinion data including the ISA and any recommendations or future directions reflecting ongoing quality improvement processes (for example, Student Mistreatment 3.6). In some instances, questions asked in the element were not explicitly answered (for example, Non-involvement of providers 12.5) or the team was required to make assumptions explored at the time of the site visit that the self-study team was satisfied with a process or outcome. The MSS report identified several strengths reflecting institutional resources (e.g. funding, administrative staff, program policies, processes and evaluation) in addition to the findings for 8 elements across 6 standards, all identified as Satisfactory with a Need for Monitoring (Core Appendix C-2). All MSS findings have plans to address the elements with varying degrees of implementation at the time of the study visit.

The MSS report reflected on, incorporated and addressed medical student concerns raised in the ISA. Specifically, the dean struck three task forces co-chaired by medical students to address Student Mistreatment, Wellness and Career Advising and has indicated he will accept the recommendations from each of these. After discussion with students, faculty and others during the site visit, it was determined that the MSS Report and the DCI accurately portray the circumstances at the school and the efforts for ongoing improvement. The School has a very supportive decanal team, group of dedicated faculty and highly engaged students committed to their MD program. Discussion with students at the time of the visit suggests there has been significant attention paid to the concerns raised in the ISA.

The team identified 3 elements rated as unsatisfactory (1.4; 3.3 and 12.5) and 4 elements as satisfactory with monitoring (3.6; 9.4; 9.7 and 12.1) - 3.3, 3.6 and 12.1 are common to the MSS. The MSS identified findings for 8 elements, all rated satisfactory with monitoring (3.3; 3.6; 6.6; 8.8; 9.1; 11.2; 12.1; and 12.3). The school did not have an affiliation agreement covering the two medical students involved in the longitudinal integrated clerkship in the Northwest Territories (1.4) and the policy on non-involvement of health providers placed the onus on the student with discussions on site showing a lack of faculty awareness of the policy (12.5). The school identified findings in 3 elements (6.6, 8.8 and 11.2) that after review of documents and onsite discussion the team believes are satisfactory. Element 11.2 was found to be in Noncompliance at the time of the last full visit and in Compliance with Monitoring as of the February 2015 status report.

The school is aware of the areas requiring improvement, and in particular have already taken steps to address those that directly affect the quality and safety of education for their medical students.

EVALUATION OF THE ISA

The ISA documents the commitment and attention to detail of the Cumming School of Medicine (CSM) students for their role in the accreditation process (ISA Executive Summary Core Appendix 4). The ISA reflects the opinion of the majority of students-at-large with an average response rate of ~90% (77-100%) from the Classes of 2015, 2016 and 2017 on the initial independent student survey. The ISA student accreditation working group, in collaboration with the Calgary Medical Students' Association, surveyed the classes of 2015-2018 and reviewed the CACMS Standards and Elements as outlined in the MSS to provide their opinion. The report was organized into four themes with identified strengths, critical areas of improvement and recommendations (Curriculum; Programmatic Design & Management; Wellness & Learner Environment; Career & Academic Advising). All medical students were invited to comment on the penultimate version of the ISA report.

The ISA identified the learning environment, the participation of residents in their education, communication skills and diversity and partnerships as school strengths. The ISA also identified a number of areas for improvement with respect to the competencies and curricular objectives; curricular design, management and monitoring; and student financial aid, academic and career counseling. Qualitative data of a small percentage of students highlighted the top 3 strengths and the top 3 areas for improvement. The team explored the student-identified issues in the majority of sessions, and particularly in meetings with the students. In general, the ISA recommendations were thoughtful and constructive, providing the student perspective.

Review of the ISA and discussions with students during the site visit revealed that students in general are very satisfied with their educational experience, have a very good opinion of the Cumming School of Medicine and would recommend the program to friends and family. Discussions with students on site reinforced that the decanal team is accessible and receptive to student issues, with multiple opportunities for student feedback and representation on committees. A minority of students indicated concerns about accessibility and receptiveness to feedback, and this was largely confined to the Class of 2016. The majority of students the team met with recognized there are challenges in a condensed 3-year program in areas such as electives and career advising, yet acknowledged that the school has taken steps to ensure these are introduced early in their program. Meetings with the year 1 and year 2 students, and discussions with year 3 students, in particular on the tours, indicates a much greater awareness of the program graduation objectives, curriculum policies and procedures, and student mistreatment protocols including the anonymous webpage "mistreatment.ucalgary.ca" as their "safe place to go". The students recognise an increase in student engagement subsequent to the appointment of the current associate dean, undergraduate medical education in July 2014. The team carefully considered the ISA data and comments when collating findings.

EVALUATION OF CGQ and AFMC GQ DATA

The student response for the 2015 AFMC GQ questionnaire was 77% (137 responses of 172 eligible). The relevant data from the CGQ and GQ required for completion of tables or the element rating forms was complete and accurate. The team carefully considered the CGQ and GQ data when evaluating the medical education program, and in particular when policy, procedural or curricular changes occurred at a point in time after the learning experiences of the graduating cohorts of 2015 and 2016. Where it was appropriate, triangulating data was sought from the ISA or documents and data provided by the school.

EVALUATION OF ELEMENTS BY STANDARD

STANDARD 1
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 1: MISSION, PLANNING, ORGANIZATION AND INTEGRITY

A medical school has a written statement of mission and goals for the medical education program, conducts ongoing planning, and has written bylaws that describe an effective organizational structure and governance processes. In the conduct of all internal and external activities, the medical school demonstrates integrity through its consistent and documented adherence to fair, impartial, and effective processes, policies, and practices.

Survey Team
Standard 1 Element Rating Table

Standard 1	Mission, Planning, Organization and Integrity
Element	
1.1	Strategic Planning and Continuous Quality Improvement
1.2	Conflict of Interest Policies
1.3	Mechanisms for Faculty Participation
1.4	Affiliation Agreements
1.5	Bylaws
1.6	Eligibility Requirements

Standard 1 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 1 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 1 Mission, Planning, Organization, and Integrity
US	1.4 Affiliation Agreements
	Finding: There is no affiliation agreement applicable to medical students for Stanton Territorial Health Authority and Yellowknife.

1.1 STRATEGIC PLANNING AND CONTINUOUS QUALITY IMPROVEMENT

A medical school engages in ongoing planning and continuous quality improvement processes that establish short and long-term programmatic goals, result in the achievement of measurable outcomes that are used to improve programmatic quality, and ensure effective monitoring of the medical education program's compliance with accreditation standards.

- 1.1 a The medical school has a written statement of mission and vision for the medical education program.
- 1.1 b The strategic plan is reviewed and revised at appropriate intervals.
- 1.1 c The outcomes of the strategic plan are monitored to ensure that the strategic plan is effective.
- 1.1 d The medical school engages in ongoing planning and continuous quality improvement that establish short and long-term programmatic goals.
- 1.1 e The medical school monitors ongoing compliance with CACMS accreditation Standards and Elements and takes steps to maintain compliance.
- 1.1 f Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has a written statement of mission and vision for the medical education program (2015-2020) (Core Appendix C-6).
- b. The strategic plan is reviewed yearly with review/revision every 5 years.
- c. The outcomes of the strategic plan are monitored by the Planning and Priorities Committee (PPC) to ensure that the strategic plan is effective. The PPC is charged with ongoing monitoring of the plan and evidence was provided. The Office of Faculty Analytics collects data to monitor outcome measures.
- d. The medical school engages in ongoing planning and continuous quality improvement that establish short and long-term programmatic goals. The short- and long-term goals have been established, funded, and monitored by senior associate deans, including undergraduate medical education.
- e. The medical school monitors ongoing compliance with CACMS accreditation Standards and Elements and takes steps to maintain compliance. An AFMC Interim Accreditation Review was completed in 2012. Regular review of accreditation standards is conducted by major committees. The medical school has explicitly focused on the standards found to be in non-compliance since last accreditation.
- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

1.2 CONFLICT OF INTEREST POLICIES

A medical school has in place and follows effective policies and procedures applicable to board members, faculty members, and any individuals with responsibility for the medical education program to avoid the impact of conflicts of interest in the operation of the medical education program, its associated clinical facilities, and any related enterprises.

- 1.2 a There are conflict of interest policies and procedures that apply to the individuals noted in the element.
- 1.2 b The medical school informs the relevant individuals about these policies and procedures.
- 1.2 c These policies and procedures address conflict of interest in each of the following areas:
 - i. research
 - ii. faculty with academic and teaching responsibilities
 - iii. commercial support for continuing professional development
- 1.2 d There are strategies for managing actual or perceived conflicts of interest in the operation of the medical education program, its associated clinical facilities, and any related enterprises.
- 1.2 e Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit, confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Conflict of interest policies and procedures exist for all of the individuals noted including the Board of Governors and all faculty.
- b. The medical school informs the relevant individuals about these policies and procedures. The Board of Governors sign confidentiality agreements and faculty review and sign declarations annually.
- c. These policies and procedures address conflict of interest in research, faculty with academic and teaching responsibilities and commercial support for continuing professional development. Educational activities and research are explicitly defined in the policies.
- d. There are strategies for managing actual or perceived conflicts of interest in the operation of the medical education program and its associated clinical facilities. The team reviewed the University and the Board of Governors Codes of Conduct, the interpretation guide on conflict of interest and the medical school's Conflict of Interest policy.
- e. Review of the documentation related to this element and discussions with relevant key individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

1.3 MECHANISMS FOR FACULTY PARTICIPATION

A medical school ensures that there are effective mechanisms in place for direct faculty participation in decision-making related to the medical education program, including opportunities for faculty participation in discussions about, and the establishment of, policies and procedures for the program, as appropriate.

- 1.3 a Faculty are voting members on the majority of standing committees in the medical school.
- 1.3 b The process used to select faculty members for standing committees takes into account the need to have members whose perspectives are independent of departmental leadership and central administration.
- 1.3 c Faculty are made aware of proposed changes in the medical education program, its policies and procedures, and given an opportunity to provide input.
- 1.3 d There is at least one general faculty meeting each year (in person or virtual) where faculty are notified of the agenda and the outcomes of the meeting.
- 1.3 e The medical school uses an effective system to inform the faculty of important issues at the medical school.
- 1.3 f Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Faculty are voting members on the majority of standing committees in the medical school (Core Appendix C-7).
- b. The process used to select faculty members for standing committees takes into account the need to have members whose perspectives are independent of departmental leadership and central administration. Elected members are elected by a nominating committee and not directly by faculty members. Terms of Reference for the Nominating Committee and the Leadership Forum were reviewed. The Faculty Council votes on the acceptance of the elected members put forward by the Nominating Committee. Faculty Council includes all academic faculty.
- c. Faculty are made aware of proposed changes in the medical education program, its policies and procedures, and given an opportunity to provide input. Faculty may participate in quarterly Faculty Council meetings. Department Heads share information with faculty and represent the views of faculty at monthly meetings and Leadership Forum meetings. Faculty are present on many leadership committees and through the Research Institutes. Social Media is also used. The recent strategic planning process was very inclusive.
- d. There are four general faculty meetings (Faculty Council) each year where faculty are notified of the agenda and the outcomes of the meeting.
- e. The medical school uses an effective system to inform the faculty of important issues at the medical school, including predominantly electronic means and multiple messages from the dean.
- f. Review of the documentation related to this element and discussions with relevant key individuals at

the time of the onsite visit confirm that the requirements listed above are being met by the medical school. This was an area of noncompliance at the time of the last full accreditation visit.

1.4 AFFILIATION AGREEMENTS

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 education program'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.*
- f) Confirmation of the authority of the department heads of the medical school to ensure faculty and medical student access to appropriate resources for medical student education when those department heads are not also the clinical service chiefs at affiliated institutions.*

- 1.4 a The medical school has signed affiliation agreements with all clinical facilities at which medical students complete the inpatient portions of required clinical learning experiences including longitudinal integrated clerkships.
- 1.4 b These agreements have explicit language as indicated in a-f in the element.
- 1.4 c Review of the documentation related to this element confirm that the requirements listed above are being met by the medical school at the time of the onsite survey visit.

RATING

- ☐ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☒ Unsatisfactory

Evidence to support the above rating

- a. The medical school has signed affiliation agreements for the main clinical affiliates – Master Affiliation Agreement Calgary Health Region, Alberta Health Services, and University of Calgary Teaching Clinics although there is no affiliation agreement applicable to medical students for Stanton Territorial Health Authority and Yellowknife. The medical students function under the existing postgraduate affiliation agreement. A revision will be pursued in spring 2016.
- b. The affiliation agreements provided have explicit language as indicated in a-f in the element.
- c. Review of the documentation related to this element confirm that the requirements listed above are met by the medical school at the time of the onsite visit with the exception of the missing agreement applicable to medical students for Stanton Territorial Health Authority and Yellowknife.

1.5 BYLAWS

A medical school has and publicizes bylaws or similar policy documents that describe the responsibilities and privileges of its dean and those to whom he or she delegates authority (e.g., vice, associate, assistant deans), department heads, senior administrative staff, faculty, medical students, and committees.

- 1.5 a There are bylaws or similar policy documents that describe the responsibilities and privileges of the dean and those to whom he or she delegates authority (e.g., vice, associate, assistant deans), department heads, senior administrative staff, faculty, medical students and committees that are made known to faculty members.
- 1.5 b The bylaws or similar policy documents support an effective governance structure for the medical school.
- 1.5 c Review of the documentation related to this element confirm that the requirements listed above are being met by the medical school at the time of the onsite survey visit.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There are documents including the University of Calgary Delegation of Authority and Accountability under the Post Secondary Learning Act that describe the responsibilities and privileges of the dean and those to whom he delegates authority such as department heads, senior administrative staff, faculty, medical students and committees that are made known to faculty members. The terms of reference of the Cumming School of Medicine Faculty Council outlines oversight of educational activities such as “programs of study” and the “granting of degrees”. Other activities such as those related to finance and faculty appointments are not covered in these documents. Relevant sections of the Collective Agreement outline the authority of the dean to approve workload assignments made by department heads.
- b. The bylaws or similar policy documents support an effective governance structure for the medical school. The process for selection of basic science department heads is outlined in the Academic Selection Process. The process for selection of clinical department heads jointly selected by the Cumming School of Medicine and Alberta Health Services is a shared responsibility that works well and follows a clearly outlined selection process. The dean is the chair of the Academic Selection Committee when a department head is to be appointed at the Cumming School of Medicine.
- c. Review of the documentation related to this element confirm that the requirements listed above are being met by the medical school at the time of the onsite visit.

1.6 ELIGIBILITY REQUIREMENTS

A medical school ensures that its medical education program meets all eligibility requirements of the CACMS for initial and continuing accreditation and is either part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine.

- 1.6 a The medical school and its geographically distributed campuses are located in Canada.
- 1.6 b Students complete all required learning experiences in the medical school.
- 1.6 c The medical school is part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine.
- 1.6 d Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school is located in Canada.
- b. Students complete all required learning experiences in the medical school.
- c. The medical school is affiliated with the University of Calgary that has legal authority to grant the degree of Doctor of Medicine.
- d. Review of the documentation related to this element and discussion with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

STANDARD 2
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 2: LEADERSHIP AND ADMINISTRATION

A medical school has a sufficient number of faculty in leadership roles and of senior administrative staff with the skills, time, and administrative support necessary to achieve the goals of the medical education program and to ensure the functional integration of all programmatic components.

**Survey Team
Standard 2 Element Rating Table**

Standard 2	Leadership and Administration
Element	
2.1	Senior Leadership, Senior Administrative Staff and Faculty Appointments
2.2	Dean's Qualifications
2.3	Access and Authority of the Dean
2.4	Sufficiency of the Dean's Administrative Staff
2.5 – N/A	Responsibility of and to the Dean
2.6 – N/A	Functional Integration of Faculty

Standard 2 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 2 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 2 Leadership and Administration

2.1 SENIOR LEADERSHIP, SENIOR ADMINISTRATIVE STAFF AND FACULTY APPOINTMENTS

The dean and those to whom he or she delegates authority (e.g., vice, associate, assistant deans), department heads, and senior administrative staff and faculty of a medical school are appointed by, or on the authority of, the governing board of the university.

- 2.1 a The dean and those to whom he or she delegates authority (e.g., vice, associate, assistant deans), department heads, and senior administrative staff (e.g., CFO), and faculty of the medical school are appointed by the governing board of the university or by other individuals who have been given the authority to make these appointments by the governing body of the university.
- 2.1 b Review of the documentation related to this element confirm that the requirement listed above is being met by the medical school at the time of the onsite survey visit.

RATING

- ☒ Satisfactory
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The dean is appointed by the governing board on the recommendation of the Advisory Selection Committee; the vice dean and senior associate deans are appointed by the provost on recommendation from the dean; associate and assistant deans and department heads are selected by search committees, with approval by the dean and provost. The Academic Selection Process – Proposed Revisions 2015 shows that the dean and/or the committees have the authority delegated by the governing body of the university.
- b. Review of the documentation related to this element and discussion with key individuals during the onsite visit confirm the requirement listed above is being met by the medical school.

2.2 DEAN'S QUALIFICATIONS

The dean of a medical school is qualified by education, training, and experience to provide effective leadership in medical education, scholarly activity, patient care, and other missions of the medical school.

- 2.2 a The dean of the medical school is qualified by education, training, and experience to provide effective leadership in medical education, scholarly activity, patient care, and other missions of the medical school.
- 2.2 b The dean's performance in providing effective leadership in the missions of the medical school is evaluated on a regular basis to enhance performance in those areas.
- 2.2 c Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The dean possesses strong qualifications in education, research and clinical care that clearly qualify him to effectively lead the medical school in medical education, scholarly activity, patient care, and other missions (Core Appendix C-8).
- b. The dean's performance in providing effective leadership in the missions of the medical school is evaluated on a regular basis to enhance performance in those areas. The dean undergoes an evaluation performed by the provost early in the fifth year of appointment. The university also has a midterm 360 evaluation of sitting deans that has been completed.
- c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

2.3 ACCESS AND AUTHORITY OF THE DEAN

The dean of a medical school has sufficient access to the university president or other university official charged with final responsibility for the medical education program and to other university officials in order to fulfill his or her responsibilities. The dean's authority and responsibility for the medical education program are defined in clear terms.

- 2.3 a The dean has appropriate access to the university president or other university official charged with final responsibility for the medical education program in order to fulfill his or her responsibility for the medical education program.
- 2.3 b The dean has appropriate access to other university officials in order to fulfill his or her responsibilities for the medical education program.
- 2.3 c The dean has appropriate access to officials in the hospitals or health authorities in order to fulfill his or her responsibilities for the medical education program.
- 2.3 d The position description of the dean clearly identifies his or her authority and responsibility for the medical education program.
- 2.3 e Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The dean has appropriate access to the university president or other university officials charged with final responsibility for the medical education program in order to fulfill his responsibility for the medical education program. The dean and the president meet on a monthly basis and the dean and the provost and vice-president (academic) meet on a weekly basis.
- b. The dean has appropriate access to other university officials in order to fulfill his responsibilities for the medical education program. The dean or medical school senior leadership interact with individuals from the provost and vice president office daily (Core Appendix C-9).
- c. The dean has appropriate access to officials in the hospitals or health authorities in order to fulfill his responsibilities for the medical education program. The dean attends joint council meetings every two months with senior leaders from the Cumming School of Medicine and Alberta Health Services and meets weekly with the Calgary Zone medical director.
- d. The position description of the dean clearly identifies his authority and responsibility for the medical education program (Core Appendix C-10).
- e. Review of documentation related to this element and discussion with relevant individuals during the onsite visit confirm that the requirements listed above are being met by the medical school.

2.4 SUFFICIENCY OF ADMINISTRATIVE STAFF

A medical school has in place a sufficient number of associate or assistant deans, leaders of organizational units, and senior administrative staff who are able to commit the time necessary to accomplish the missions of the medical school.

- 2.4 a There are a sufficient number of vice, associate or assistant deans; leaders of organizational units and senior administrative staff (e.g. CFO) who have the time necessary to fulfill their responsibility for the mission(s) of the medical school for which they are responsible.
- 2.4 b Vacant positions are filled in a timely manner that ensures appropriate leadership in these areas.
- 2.4 c AAMC CGQ and AFMC GQ data show that the majority of respondents are satisfied/very satisfied with the accessibility and responsiveness of the office of the vice/associate/assistant dean or director of the medical education program (academic) to address their concerns and include them on key medical school committees and working groups.
- 2.4 d AAMC CGQ and AFMC GQ data show that the majority of respondents are satisfied/very satisfied with the accessibility and responsiveness of the office of the vice/associate/assistant dean or director of student affairs to address their concerns and include them on key medical school committees and working groups.
- 2.4 e The performance of the each of the individuals noted in 2.4.a., and the department chairs is evaluated on a regular basis to enhance performance in the area for which they are responsible.
- 2.4 f Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There are a sufficient number of vice, associate or assistant deans, senior leaders and administrative staff who have the time necessary to fulfill their responsibility for the mission(s) of the medical school for which they are responsible (Core Appendix C-11). The majority of senior leaders are at 50% FTE or more, which provides them with enough time to fulfill their responsibilities to the medical school.
- b. Vacant positions are filled in a timely manner that ensures appropriate leadership in these areas. It is noted that there are very few vacancies as search committees are conducted well in advance.
- c. AAMC CGQ and AFMC GQ data (DCI Table 2.4-2) show that the majority of respondents are satisfied/very satisfied with the accessibility and responsiveness of the office of the associate dean of the medical education program (academic) to address their concerns and include them on key medical school committees and working groups. The ISA (DCI Table 2.4-3) shows that there is a small proportion (3-10%) of students who do not feel the deans are accessible, aware or responsive to student concerns. There has been significant improvement in CGQ/GQ data on accessibility and responsiveness from 2013 (69%, 55%) to 2015 (88%, 78%). No concerns were identified when meeting with the students.
- d. AAMC CGQ and AFMC GQ data (DCI Table 2.4-4) shows that the majority of respondents are

satisfied/very satisfied with the accessibility and responsiveness of the office of the director of student affairs to address their concerns and include them on key medical school committees and working groups. There has been improvement in the CGQ/GQ data on accessibility and responsiveness from 2013 (67%, 61%) to 2015 (88%, 81%) with no concerns noted in the ISA (DCI Table 2.4-5).

- e. The performance of each of the individuals noted in 2.4.a. above, and the department heads is evaluated on an annual basis to enhance performance in the area for which they are responsible.
- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

STANDARD 3
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 3: ACADEMIC AND LEARNING ENVIRONMENTS

A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments, recognizes the benefits of diversity, and promotes students' attainment of competencies required of future physicians.

Survey Team
Standard 3 Element Rating Table

Standard 3	Academic and Learning Environments
Element	
3.1	Resident Participation in Medical Student Education
3.2	Community of Scholars/Research Opportunities
3.3	Diversity/Pipeline Programs and Partnerships
3.4	Anti-Discrimination
3.5	Learning Environment/Professionalism
3.6	Student Mistreatment

Standard 3 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 3 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 3 Academic and Learning Environments
US	3.3 Diversity/Pipeline Programs and Partnerships
	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.
SM	3.6 Student Mistreatment
	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.

3.1 RESIDENT PARTICIPATION IN MEDICAL STUDENT EDUCATION

Each medical student in a medical education program participates in at least one required clinical learning experience conducted in a health care setting in which he or she works with a resident currently enrolled in an accredited program of postgraduate medical education.

- 3.1 a Every medical student at each campus in the last three graduating classes worked with a resident in a healthcare setting in a required clinical learning experience of at least a four-week duration.
- 3.1 b The residents who worked with medical students as described above are, or were enrolled in accredited programs of postgraduate medical education.
- 3.1 c Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Every medical student in the last three graduating classes worked with a resident in a healthcare setting in a required clinical learning experience of at least a four-week duration. All medical students enrolled in the undergraduate medical education program at the Cummings School of Medicine have multiple opportunities to work with residents. This includes students enrolled in the longitudinal integrated clerkship and traditional rotation-based clerkship streams.
- b. The residents who worked with medical students are or were enrolled in accredited postgraduate medical education programs.
- c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

3.2 COMMUNITY OF SCHOLARS/RESEARCH OPPORTUNITIES

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.

- 3.2 a The medical school informs medical students about, and encourages them to participate in research and other scholarly activities of the faculty.
- 3.2 b The medical school supports medical student participation in research and other scholarly activities of the faculty (e.g. coordination of student placements, development of opportunities, or provision of financial support).
- 3.2 c AAMC CGQ and AFMC GQ data show that respondents who wanted to participate in a research project with a faculty member had the opportunity to do so.
- 3.2 d Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school informs students about opportunities to participate in research and other scholarly activities, and encourages them to do so.
- b. The medical school supports medical student participation in research and other scholarly activities of the faculty. The school and students highlight the Leader in Medicine (LiM) program in which 10-20% of students are supported in the pursuit of dual degrees as a major strength. The ISA identifies that student awareness of opportunities particularly among year 1 and 2 students could be improved. In response to student concerns, a repository of research opportunities has been created to allow students to identify areas of potential interest. Data supporting the effectiveness has yet to be established.
- c. AAMC CGQ and AFMC GQ data show that respondents who wanted to participate in a research project with a faculty member had the opportunity to do so. Data from the DCI Table 3.2-1 show that a minority of respondents (14% 2013; 13% 2014; and 11% 2015) indicated no opportunity to participate. Students confirmed the availability of student research opportunities and the recent efforts by the school to make a compendium of research activity available to increase student awareness.
- d. Review of the documentation related to this element and discussions with students and faculty at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

3.3 DIVERSITY/PIPELINE PROGRAMS AND PARTNERSHIPS

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.

- 3.3 a The medical school in accordance with its social accountability mission has defined the various categories of diversity it wishes to achieve in its students, faculty and senior academic and educational leadership.
- 3.3 b The medical school engages in ongoing, systematic and focused recruitment activities to achieve mission-appropriate diversity outcomes among its:
 - i. students
 - ii. faculty
 - iii. senior academic and educational leadership
- 3.3 c The medical school engages in ongoing, systematic and focused retention activities to achieve mission-appropriate diversity outcomes among its:
 - i. students
 - ii. faculty
 - iii. senior academic and educational leadership
- 3.3 d The medical school monitors the diversity of enrolled students, employed faculty and senior academic and educational leadership in each of the school-defined diversity categories to measure its progress in achieving the desired diversity in these populations.
- 3.3 e The policies and practices, programs or partnerships used by the medical school aimed at achieving diversity among qualified applicants for medical school admission are appropriate to achieve the expected outcomes.
- 3.3 f The medical school evaluates and monitors the effectiveness of its policies and practices, programs or partnerships in achieving diversity among qualified applicants to the medical school.
- 3.3 g The medical school is moving toward the achievement of mission-appropriate diversity among its students, faculty and senior academic and educational leadership.
- 3.3 h Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☐ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☒ Unsatisfactory

Evidence to support the above rating

a. The Cumming School of Medicine has defined categories of diversity for faculty, staff and students consistent with the federal requirements to include women, Aboriginal peoples, visible minorities and persons with disabilities. Going forward in 2016, the medical school admissions process has also identified rural students and those applicants from a socially and financially disadvantaged background (Core Appendix C- 12).

b.-c. The school engages in ongoing, systematic and focused recruitment activities of Aboriginal students. Current programs have led to an increase in offers to Aboriginal applicants. There is an office of Aboriginal Health to assist with retention activities. Women currently constitute the majority of enrolled students. A pipeline program has recently been launched that will identify and support high school students from rural and socio-economically disadvantaged backgrounds in preparing for application to medicine.

Recruiting efforts have led to an increased number of women faculty members (Core Appendix C-13). Support for female faculty to undertake formal leadership training is provided. 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. Discussion at the time of the visit indicates that the emphasis is on the removal of barriers and the qualifications of the candidates at the time of hiring and/or advancement.

d. The school monitors the diversity of enrolled students through annual census of gender in undergraduate and postgraduate medical education, and through the annual review of CGQ demographic data. The medical school's admission department maintains applicant data records, including self-declared Aboriginal status of both successful and unsuccessful applicants. The school tracks recruitment and academic progression of women faculty (Core Appendix C-13).

e. Current policies have led to increased applications and offers of admissions for Aboriginal students. The Pathways program that will offer early admission to targeted groups out of secondary school and supporting them through undergraduate degree programs is innovative. As this program will begin with the current admissions cycle, data on effectiveness is not yet available.

f. The medical school evaluates and monitors the effectiveness of its' policies and practices, programs or partnerships in achieving diversity in recruitment and retention policies with respect to applicants to the undergraduate medical program. Annual statistics are compiled and retained by the Office of Admissions.

g. The school is making some progress with regard to Aboriginal student admission. The ISA identifies student diversity as a strength. With respect to faculty, success has largely been limited to an increase in the proportion of women faculty members, principally at the Assistant and Associate Professor level, as well as in some key leadership positions within the school and at the University. During onsite discussion, there was limited understanding of the school's diversity policies.

h. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are not being met by the medical school. There was limited evidence of engagement with achieving diversity through recruitment and retention activities during discussion at the time of the visit with department heads.

3.4 ANTI-DISCRIMINATION POLICY

A medical school and its clinical affiliates do not discriminate on any grounds as specified by law including, but not limited to, age, creed, gender identity, national origin, race, sex, or sexual orientation. The medical school and its clinical affiliates foster an environment in which all individuals are treated with respect and take steps to prevent discrimination, including the provision of a safe mechanism for reporting incidents of known or apparent breaches, fair and timely investigation of allegations, and prompt resolution of documented incidents with a view to preventing their repetition.

- 3.4 a The medical school and its clinical affiliates have anti-discrimination policies that are made available to faculty, students and other members of the medical school community.
- 3.4 b The medical school and its clinical affiliates foster an environment in which all individuals are treated with respect and takes steps to prevent discrimination.
- 3.4 c There is a safe mechanism for reporting incidents of known or apparent breaches of the anti-discrimination policy.
- 3.4 d Allegations are investigated in a fair and timely manner.
- 3.4 e There is prompt resolution of documented incidents with a view to preventing their repetition.
- 3.4 f Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <ul style="list-style-type: none">a. The university, the medical school and its clinical affiliates have anti-discrimination policies that are made available to faculty, students and other members of the medical school community. The University of Calgary and Alberta Health Services Codes of Conduct, the Student Non-Academic Misconduct Policy and the university's Accommodations Policy are readily accessible on the school's website. A Cumming School of Medicine Professionalism Guideline drafted in 2015 includes anti-discrimination expectations. A separate Harassment Policy has been drafted by the associate dean, equity and professionalism. Prohibitions on discrimination are set forth in the Province of Alberta Human Rights Act.b. The school and its affiliated clinical sites have practices and policies in place to foster a respectful and non-discriminatory workplace and take steps to prevent discrimination.c. There are safe mechanisms for reporting incidents of known or apparent breaches of the anti-discrimination policies at the university, the school and the clinical affiliates.d. Allegations are investigated in a fair and timely manner as per the policy documents and legislation referenced and provided in the DCI 3.3b.e. There are clear timelines and policies ensuring the prompt resolution of any documented incidents of discrimination. There is evidence that the school and clinical affiliates attend to the inclusiveness of the learning environment and address and prevent repetition of such incidents.f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical |
|---|

school.

3.5 LEARNING ENVIRONMENT/PROFESSIONALISM

A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, implement appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

- 3.5 a The medical school has defined the professional attributes (behaviors and attitudes) that medical students are expected to develop.
- 3.5 b These expected professional attributes are effectively communicated to faculty, residents and others in the medical school and clinical learning environments.
- 3.5 c The medical school and its clinical affiliates collaborate in the periodic evaluation of the learning environment using appropriate methods, and share the results of these evaluations to identify positive and negative influences on the development of medical students' professional attributes, especially in the clinical setting.
- 3.5 d The medical school and its clinical affiliates have implemented appropriate strategies to a) enhance the positive influences and b) mitigate the negative influences on medical students' development of the expected professional attributes.
- 3.5 e The medical school and its clinical affiliates identify and promptly correct violations of professional standards in the learning environment.
- 3.5 f Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has explicitly defined the professional attributes that medical students are expected to develop. These specifically address the behaviours and attitudes of the professional identity expected of a physician.
- b. The expected professional attributes are communicated to the students through a program of delivery beginning with orientation and a welcoming ceremony, and then are revisited in courses and activities throughout the curriculum. The professional attributes expected of students are integrated into all required learning experience assessment forms which faculty and residents complete.
- c. There is a collaborative relationship between the Cumming School of Medicine and Alberta Health Services in striving for a learning environment that reinforces positive influences on the medical students' professionalism. Evaluation of the learning environment is conducted regularly with student feedback, for example on end of course/rotation evaluations with respect to safety of learning and quality of teaching. The feedback is collated and communicated to teaching staff and department heads. This data is monitored by the Clerkship Committee and the Undergraduate Medical Education

Committee. The ISA identifies the learning environment as a strength.

- d. The medical school and its clinical affiliates have implemented appropriate strategies to enhance the positive and mitigate the negative influences on medical students' development of the expected professional attributes. Alberta Health Services has representation on undergraduate and postgraduate medical education committees. Both the Cumming School of Medicine and Alberta Health Services have leadership training programs that specifically address the expectations of professional behavior. Faculty development workshops through the Teaching Scholars in Medicine and Humanism and Professionalism clearly address professionalism.
- e. Clear policies exist to address unprofessional behavior on the part of faculty. Onsite discussion provided examples of prompt correction of identified violations of professional standards in the learning environment.
- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

3.6 STUDENT MISTREATMENT

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.

- 3.6 a There is a defined and published code of conduct addressing the faculty-student relationship and student mistreatment.
- 3.6 b There are formal policies or procedures for responding to allegations of medical student mistreatment including the venues for reporting and mechanisms for investigating reported incidents.
- 3.6 c Medical students, residents, faculty responsible for required learning experiences and those who teach or assess medical students and other individuals who interact with students in the medical school or clinical environment are informed about the medical school's standard of conduct in the faculty-student relationship and about medical student mistreatment policies.
- 3.6 d Mechanisms for reporting and investigating incidents of mistreatment protect students from retaliation.
- 3.6 e Medical students are informed of the procedures for reporting mistreatment and investigating reported incidents in a way that protects them from retaliation.
- 3.6 f Data from the AAMC CGQ, and the AFMC GQ, the ISA or more recent data collected by the medical school show that the majority of respondents agree/strongly agree that they are aware of the school's policies regarding student mistreatment.
- 3.6 g Data from the AAMC CGQ, the AFMC GQ, the ISA or more recent data collected by the medical school show that the majority of respondents agree/strongly agree that they know the procedures for reporting student mistreatment.
- 3.6 h Allegations of student mistreatment are investigated and resolved in a timely manner.
- 3.6 i AAMC CGQ, and AFMC GQ data student mistreatment data and other reports of mistreatment collected by the school are reviewed by individuals/committee(s) in the medical school and clinical learning environments with the authority to take steps to reduce the level of mistreatment.
- 3.6 j The medical school monitors the reasons why students do not report mistreatment and has taken steps to reduce barriers to reporting.
- 3.6 k Since the time of the last full survey, the medical school implemented appropriate educational activities aimed at reducing and preventing student mistreatment at instructional sites where mistreatment has occurred.
- 3.6 l AAMC CGQ, AFMC GQ and ISA data show that levels of physical and sexual mistreatment of medical students are virtually non-existent.

3.6 m AAMC CGQ, AFMC GQ data, ISA and other data collected by the medical school show that the level of student mistreatment is decreasing.

3.6 n Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☐ Satisfactory
- ☒ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The University of Calgary Code of Conduct addresses the faculty-student relationship and student mistreatment. The Alberta Health Services Workplace Policy clearly addresses faculty-learner relationships. The Cumming School of Medicine has developed Guidelines on Professionalism and a Harassment Policy; the drafts reviewed address student mistreatment explicitly.
- b. There are formal policies and procedures (University of Calgary Code of Conduct, Procedures for Protected Disclosure, Student Non-Academic Misconduct Procedures) for responding to reports of student mistreatment. The school has several venues to report concerns related to mistreatment, including a “red button” feature on the home page of the medical program. In response to concerns raised in the ISA and CGQ/GQ (Core Appendix C-14 to C-17), a Student Mistreatment Taskforce, co-chaired by students and the department head Critical Care Medicine, was struck in 2015.
- c. Medical students, residents, and faculty who teach and assess learners or who interact with them in clinical environments are made aware of the school’s standards and policies. The Code of Conduct and related policies and procedures are readily accessible on a variety of websites; orientation is provided to learners, faculty members, and residents. In July 2015, the dean of the Cumming School of Medicine broadly disseminated to all faculty, staff and learners the message that learner mistreatment is unacceptable and will not be tolerated.
- d. The school has clear policies and practices designed to protect the students from retaliation, including mechanisms for protecting students making confidential reports and multiple options for anonymous reporting. Work of the Student Mistreatment Task and the Student Affairs office resulted in the “a safe place” website at www.mistreatment.ucalgary.ca. Discussions during the site visit indicated that students were collectively aware of this website.
- e. Students are informed of the procedures for reporting mistreatment and investigating reported incidents in a way that protects them from retaliation (see d. above). Medical students have access to the university’s Office of Equity and Protected Disclosure.
- f. Data from the AAMC CGQ and the AFMC GQ show that a majority of respondents (92% in 2014; 88% in 2015) agree/strongly agree that they are aware of the school’s policies for reporting student mistreatment (Core Appendix C-14).
- g. Data from the AAMC CGQ and the AFMC GQ show that a majority of respondents (70% in 2014; 71% in 2015) agree/strongly agree that they know the school’s procedures for reporting student mistreatment (Core Appendix C-15).
- h. Allegations of student mistreatment are investigated and resolved in a timely manner. Clear timelines exist for reporting back to the complainant. This has been an area of focused improvement over the past year. A report card demonstrating the nature of complaints and the outcome of those investigations is maintained by the undergraduate medical education program, and as/if appropriate, is shared with

students.

i. AAMC CGQ, and AFMC GQ data on student mistreatment are reviewed regularly by the Undergraduate Medical Education Committee, which has the authority to take steps necessary to address concerns that are identified.

j. The medical school has made clear efforts to understand reasons why student mistreatment may not be reported. These include regular meetings between the program and student leaders, and the establishment of a Student Mistreatment Task Force to help identify and reduce any barriers to reporting.

k. The school acknowledged student mistreatment issues raised in the CGQ/GQ and the ISA (Core Appendix C-14 to C-17), identified addressing these as a priority for the school and established the Student Mistreatment Task Force, which was co-chaired by students. The task force has made a number of recommendations presented to the dean in November 2015 and a number of these have been adopted with implementation underway (Supplemental Appendix S-1). Discussions with students at the time of the site visit indicate that these efforts are viewed positively.

l. AAMC CGQ, AFMC GQ and ISA data (Core Appendix C-16 and C-17) show that physical mistreatment of medical students is virtually non-existent. A minority of respondents (~2%) were subject to unwanted sexual advances.

m. The team considered the efforts of the school as well as the students' acknowledgement of the efforts by the school to mitigate student mistreatment to be a surrogate for any trend in AAMC CGQ, AFMC GQ and ISA data as this data is subjective and open to interpretation in the absence of qualitative data.

n. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school but require ongoing monitoring.

STANDARD 4
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 4: FACULTY PREPARATION, PRODUCTIVITY, PARTICIPATION, AND POLICIES

The faculty members of a medical school are qualified through their education, training, experience, and continuing professional development and provide the leadership and support necessary to attain the institution's educational, research, and service goals.

Survey Team
Standard 4 Element Rating Table

Standard 4	Faculty Preparation, Productivity, Participation, and Policies
Element	
4.1	Sufficiency of Faculty
4.2	Scholarly Productivity
4.3	Faculty Appointment Policies
4.4	Feedback to Faculty
4.5	Faculty Professional Development
4.6	Faculty/Dean Responsibility for Educational Program Policies

Standard 4 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 4 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 4 Faculty Preparation, Productivity, Participation, and Policies

4.1 SUFFICIENCY OF FACULTY

A medical school has in place a sufficient cohort of faculty members with the qualifications and time required to deliver the medical curriculum and to meet the other needs and fulfill the other missions of the medical school.

- 4.1 a The medical school has a sufficient number and types of faculty members to deliver the medical education program at each campus.
- 4.1 b The directors of required learning experiences, hospital site directors, campus site directors (includes longitudinal integrated clerkship site directors) and the chair of the curriculum committee (or equivalent committee) have the appropriate amount of protected time (time with salary support or release from other responsibilities) to fulfill their responsibilities in the medical education program.
- 4.1 c The medical school anticipates faculty retirements and plans recruitment activities to minimize any negative impact on the delivery of the medical education program at each campus.
- 4.1 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has a sufficient number and types of faculty members to deliver the medical education program. There are 525 full-time, 319 part-time and 2323 volunteer faculty; 2826 are clinical faculty (Core Appendix C-18). A number of faculty retirements are expected, however with funding from the provost, Alberta Innovate Health Solutions and the Ministry of Alberta Health, most of these positions will be filled. A significant amount of clinical training is supported by volunteer faculty receiving stipends.
- b. The directors of required learning experiences, hospital site directors, site directors (including longitudinal integrated clerkship site directors) and the chair of the curriculum committee have the appropriate amount of protected time to fulfill their responsibilities in the medical education program (Core Appendix C-19). The associate dean, undergraduate medical education is the chair of the curriculum committee with a 0.6 FTE position that he considers adequate.
- c. The medical school anticipates faculty retirements and plans recruitment activities to minimize any negative impact on the delivery of the medical education program at each campus. The Planning and Priorities Committee reviews all proposed new faculty positions from an education point of view. There are ~20 projected retirements in the coming year. Discussion during the site visit revealed that 25 new FTE associated with the Precision Medicine strategic priority are being hired. The reduction of basic science positions has been mitigated by the new hires.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

4.2 SCHOLARLY PRODUCTIVITY

The medical school's faculty, as a whole, demonstrate a commitment to continuing scholarly productivity that is characteristic of an institution of higher learning.

- 4.2 a The scholarly productivity (articles in peer-reviewed journals, published books/book chapters, co-investigators or PIs on extramural grants, or other peer-reviewed scholarship) of the medical school's faculty, as a whole, over the last three years is consistent with its research/scholarly mission and characteristic of an institution of higher learning.
- 4.2 b The medical school requires some faculty members to engage in scholarly work for promotion, and if applicable tenure.
- 4.2 c The medical school fosters and supports faculty members' development as scholars by appropriate means.
- 4.2 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a.) The scholarly productivity of the medical school's faculty, as a whole, over the last three years is consistent with its research/scholarly mission and the characteristic of an institution of higher learning. Table 4.2-1 (Core Appendix C-20) provides the faculty scholarly activity per department. Research funds are in excess of \$160M/year. The success rate in CIHR operating grants is above the national average.
- b.) The medical school expects all fulltime faculty to engage in scholarly work. Allocation of required time for research is designated for each faculty member. The school's documents outline the expectations for faculty performance, promotion, or tenure for fulltime and clinical faculty.
- c.) Time for research is explicitly allocated with a faculty appointment and all faculty are oriented to scholarly expectations and supports towards achievement. Faculty performance is reviewed every 2 years (tenured) and every year (non-tenured) with feedback and mentorship. A system has been established for peer review of grants before submission which seems to have improved CIHR/Tri-Council success rates. Faculty development programs are available as well as consultation services for grants through the Office of Health & Medical Education Scholarships.
- d.) Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

4.3 FACULTY APPOINTMENT POLICIES

A medical school has clear policies and procedures in place for faculty appointment, renewal of appointment, promotion, granting of tenure, remediation, and dismissal that involve a faculty member, the appropriate department head(s), and the dean, and provides each faculty member with written information about his or her term of appointment, responsibilities, lines of communication, privileges and benefits, performance evaluation and remediation, terms of dismissal, and, if relevant, the policy on practice earnings.

- 4.3 a The medical school's or university's policies and procedures for faculty appointment, renewal of appointment, promotion, granting of tenure, remediation, and dismissal are clear.
- 4.3 b If the medical school has different employment (career) tracks, the description of the requirements for each track is clear. The information about career tracks is communicated to faculty as well as the selection or assignment process, and the requirements for advancement within the career tracks.
- 4.3 c Each faculty member is given written information about his or her term of appointment, responsibilities in teaching, research and where relevant patient care, lines of communication, privileges and benefits, performance evaluation and remediation, terms of dismissal, and if relevant, the policy on practice earnings.
- 4.3 d Each faculty member is notified regularly of the terms and conditions employment including privileges, benefits, compensation including policies on practice earnings, and responsibilities in teaching, research and where relevant patient care.
- 4.3 e Each faculty member is notified in timely way when there are changes made to his or her terms of employment including privileges, benefits, compensation including policies on practice earnings, and responsibilities in teaching, research and where relevant patient care.
- 4.3 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school's policies pertaining to faculty appointment, renewal of appointment, promotion, tenure, remediation and dismissal are outlined in the collective agreement, article 1 Tenure & Promotion and the Cumming School of Medicine's Criteria for Appointment, Promotion, Merit and Tenure of Full-Time Faculty and Criteria for Appointment, Promotion and Assessment of Clinical, Adjunct and Adjunct/Research Faculty policies.
- b. The medical school utilizes a wide variety of faculty appointment options available to the faculty. The information about career tracks is communicated to faculty as well as the selection or assignment process, and the requirements for advancement through offer letters, annual/biannual reviews and the documents listed above.
- c. Faculty members receive written communication about their terms of appointment in their letters of offer and each has an online "activity profile" containing expectations relating to teaching, research,

administration and service.

- d. Terms and conditions of employment are conveyed electronically from the president, provost, The University of Calgary Faculty Association (TUCFA), appear in the faculty activity profile and/or are discussed with the department head. If a faculty member is in the Academic Alternate Relationship Plan (AARP), the Independent Service Agreement contains the terms and conditions.
- e. Each faculty member is notified in a timely way when there are changes made to the terms of employment. These are conveyed by the university, the medical school and/or the Faculty Association.
- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

4.4 FEEDBACK TO FACULTY

A medical school faculty member receives regularly scheduled and timely feedback from departmental and/or other programmatic or institutional leaders on his or her academic performance and progress toward promotion and, when applicable, tenure.

- 4.4 a Faculty members receive regularly scheduled and timely feedback from departmental and/or medical education program or university leaders on his or her academic performance and progress toward promotion and, when applicable, tenure (there is documentation to support this statement) at each campus.
- 4.4 b The provision of regular and timely feedback to faculty members is monitored to ensure it occurs.
- 4.4 c The medical school or the university has policies that require faculty to receive regular formal feedback on their performance and their progress toward promotion and, if relevant, tenure.
- 4.4 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Non-tenured faculty receive an annual review and fulltime tenured faculty receive a review every 2 years. Department heads create assessment reports which are submitted to the dean and reviewed by the appropriate committees. Clinical part-time faculty are reviewed less frequently but at a minimum at the point of renewal. Documents reviewed include the school's Evaluation Framework and the template Department Head's Recommendation and Assessment.
- b. The provision of feedback is part of the assessment process with department heads and is monitored by the dean's office. Merit increment and performance is reviewed by the Faculty Merit Committee.
- c. The university and medical school have policies that require faculty to receive regular formal feedback on their performance and their progress toward promotion (see 4.3a. above; DCI 4.4).
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

4.5 FACULTY PROFESSIONAL DEVELOPMENT

A medical school and/or the university provides opportunities for professional development to each faculty member (e.g., in the areas of teaching and student assessment, curricular design, instructional methods, program evaluation or research) to enhance his or her skills and leadership abilities in these areas.

- 4.5 a There are individuals with the requisite expertise and time who assist faculty in improving their teaching and assessment skills.
- 4.5 b The medical school identifies faculty development needs.
- 4.5 c Faculty at all instructional sites and geographically distributed campuses are informed about and have access to faculty development activities.
- 4.5 d When problems are identified with the teaching or assessment skills of a faculty member, the faculty member is provided with support to remediate the deficiencies.
- 4.5 e There are individuals with the requisite expertise and formal activities at the medical school, departmental or university level to assist faculty in enhancing their skills in curriculum design, instructional methods or program evaluation.
- 4.5 f There are individuals with the requisite expertise and formal activities at the medical school, departmental or university level to assist faculty in enhancing their skills in research methodology, publication development, or grant procurement.
- 4.5 g There are specific programs or activities offered to assist faculty in preparing for promotion.
- 4.5 h During the last academic year, a number of faculty development programs (e.g., workshops, lectures, seminars) were provided with good faculty participation.
- 4.5 i Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The Office for Faculty Development and the Teacher Development Unit assist faculty in improving their teaching and assessment skills. Over 120 fulltime and part time faculty members have been trained through the Teaching Scholars in Medicine Program and share expertise within departments, divisions and courses. The Master Teachers program provides continuity of teachers throughout the preclerkship curriculum, is considered a program strength.
- b. The school identifies faculty development needs through needs assessment surveys every 5 years.
- c. Faculty development activities are advertised through websites, invitations, electronic bulletin boards and general faculty emails.
- d. When problems are identified with the teaching or assessment skills of a faculty member they are addressed initially by the appropriate assistant dean and course/rotation chair with appropriate support

and/or remediation offered. All faculty have access to the Office of Faculty Development programs.

- e. There are individuals with the requisite expertise, in addition to formal activities at the medical school, departmental or university level, to assist faculty in enhancing their skills in curriculum design, instructional methods or program evaluation. The Community Health Sciences department offers a Masters with medical education specialization. The Teaching Scholars in Medicine Program and the Master Teachers are a valuable resource for the school, in addition to the offices listed in 4.5a. above.
- f. There is a comprehensive program of internal peer review for all applications for operating grants, infrastructure grants and salary awards overseen by the associate dean, research. Grants officers assist with the entire grant application process for large team grants. Faculty development offerings include workshops and educational sessions aimed at achieving success in research.
- g. There is a four-week series offered semi-annually for new faculty that is open to full and clinical faculty members. The Taylor Institute and Office of Faculty Development run workshops designed to assist with preparing promotion dossiers. The advisor for Academic Relations will support individual faculty members with one-on-one consultation.
- h. During the last academic year, 130 faculty development programs (e.g., workshops, lectures, seminars) were provided with 1118 participants, including residents and faculty.
- i. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

4.6 FACULTY/DEAN RESPONSIBILITY FOR EDUCATIONAL PROGRAM POLICIES

At a medical school, the dean and a committee of the faculty determine programmatic policies.

- 4.6 a There is an executive committee or other similar medical school leadership group responsible for working with the dean to determine medical school policies.
- 4.6 b This executive committee or other similar medical school leadership group meets often enough to fulfill its responsibilities.
- 4.6 c There is a list of priority areas that the committee addressed during the last academic year.
- 4.6 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm, that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There is an executive committee responsible for working with the dean to determine medical school policies.
- b. The dean's Executive Committee meets weekly, the Planning and Priorities Committee meets every 2 weeks and the Faculty Council meets quarterly. Leadership Forum meets monthly with 2 retreats annually. The Strategic Education Council meets every 2 weeks and the Strategic Research Council meets monthly.
- c. There is a list of priority areas that the committee addressed during the last academic year.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

STANDARD 5
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 5: EDUCATIONAL RESOURCES AND INFRASTRUCTURE

A medical school has sufficient personnel, financial resources, physical facilities, equipment, and clinical, instructional, informational, technological, and other resources readily available and accessible across all locations to meet its needs and to achieve its goals.

Survey Team
Standard 5 Element Rating Table

Standard 5	Educational Resources and Infrastructure
Element	
5.1	Adequacy of Financial Resources
5.2	Dean's Authority/Resources for Curriculum Management
5.3	Pressures for Self-Financing
5.4	Sufficiency of Buildings and Equipment
5.5	Resources for Clinical Instruction
5.6	Clinical Instructional Facilities/Information Resources
5.7	Security, Student Safety and Disaster Preparedness
5.8	Library Resources/Staff
5.9	Information Resources/Staff
5.10	Resources used by Transfer/Visiting Students
5.11	Study/Lounge/Storage Space/Call Rooms
5.12	Required Notification to the CACMS

Standard 5 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 5 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 5 Educational Resources and Infrastructure
--------------------------	---

5.1 ADEQUACY OF FINANCIAL RESOURCES

The present and anticipated financial resources of a medical school are adequate to sustain the medical education program and to accomplish other goals of the medical school.

- 5.1 a The dean has authority for the budget of the medical school and the governance of the medical school supports the effective management of its financial resources.
- 5.1 b The trends in past and present financial resources of the medical school indicate that they are stable and adequate to sustain the medical education program and to accomplish other goals of the medical school.
- 5.1 c The anticipated financial resources of the medical school appear to be adequate to sustain the medical education program and to accomplish other goals of the medical school.
- 5.1 d If there is an anticipated decrease in the financial resources of the medical school, there is a plan to address the shortfall.
- 5.1 e If the financial reserves were used over the past three years to balance the operating budget, the financial reserves were restored in a timely manner.
- 5.1 f The dean engages in effective financial planning that addresses the operating budget, current and projected capital needs and financing deferred maintenance of medical school facilities.
- 5.1 g The key findings resulting from an external financial audit are consistent with the other financial data provided by the medical school and indicate that the medical school has adequate operating funds.
- 5.1 h Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The dean has authority for the budget of the medical school and the governance of the medical school supports the effective management of its financial resources. This element is considered to be a strength by the school. The dean is accountable to the provost for budget and finances and has a decentralized model.
- b. The trends in past and present financial resources of the medical school indicate that they are stable and adequate to sustain the medical education program and to accomplish other goals of the medical school. Medical school operating surpluses and balanced budgets including \$47.5M reserves and a \$200M philanthropic gift will address projected research losses (\$13M) through 2011-2018.
- c. The anticipated financial resources of the medical school appear to be adequate to sustain the medical education program and to accomplish other goals of the medical school (Core Appendices C-21 and C-22). There was a decrease in government funding (\$3.6M) with provincially mandated reductions in enrolment. The operating budget was maintained.
- d. The school has a risk mitigation plan in place to address the shortfall described in 5.1.b above.

- e. Financial reserves were not used over the past three years to balance the operating budget.
- f. The dean engages in effective financial planning that addresses the operating budget, current and projected capital needs and financing deferred maintenance of medical school facilities. He has well developed financial management and budget controls.
- g. The medical school has not been externally audited.
- h. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

5.2 DEAN'S AUTHORITY/RESOURCES FOR CURRICULUM MANAGEMENT

The dean of a medical school has sufficient resources and budgetary authority to fulfill his or her responsibility for the management and evaluation of the medical curriculum.

- 5.2 a The chief academic officer (CAO) (dean or vice/associate dean) has sufficient protected time (salary support or release from other responsibilities) to fulfill his or her responsibilities for the management and evaluation of the medical curriculum.
- 5.2 b The CAO participates in medical school-level planning including planning for geographically distributed campuses to ensure that the resource needs of the medical education program (e.g., funding, faculty, educational space, and other educational infrastructure) are considered.
- 5.2 c There is administrative and academic support for the planning, implementation, evaluation and oversight of the curriculum, and for the development and maintenance of the tools (e.g., curriculum database) to support curriculum monitoring and management. The individuals providing the administrative and academic support are accountable to the CAO.
- 5.2 d The number and types of individuals who provide administrative or academic support for the planning, implementation, and evaluation of the curriculum and for student assessment are sufficient. These individuals have adequate protected time (salary support or release time from other responsibilities) to fulfill their responsibilities related to the curriculum.
- 5.2 e The process used to determine the budget for the medical education program and the mechanisms by which funds are distributed to support teaching are appropriate and effective in facilitating delivery of the curriculum.
- 5.2 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The associate dean has sufficient protected time (0.6 FTE) to fulfill his responsibilities for the management and evaluation of the medical curriculum.
- b. The associate dean participates in medical school-level planning to ensure that the resource needs of the medical education program (e.g., funding, faculty, educational space, and other educational infrastructure) are considered.
- c. There is administrative and academic support for the planning, implementation, evaluation and oversight of the curriculum, and for the development and maintenance of the tools to support curriculum monitoring and management. The individuals providing the administrative and academic support are accountable to the associate dean, undergraduate medical education. (Core Appendices C-11 and C-40; Supplemental Appendix S-2).
- d. The number and types of individuals who provide administrative or academic support for the planning, implementation, and evaluation of the curriculum and for student assessment are sufficient. The 3 assistant deans and 7 directors (DCI Table 5.2d) have adequate protected time (0.2-0.5 FTE) to fulfill their responsibilities related to the curriculum.

- e. The process used to determine the budget for the medical education program and the mechanisms by which funds are distributed to support teaching are appropriate and effective in facilitating delivery of the curriculum.
- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

5.3 PRESSURES FOR SELF-FINANCING

A medical school admits only as many qualified applicants as its total resources can accommodate and does not permit financial or other influences to compromise the school's educational mission.

- 5.3 a In setting the size of the medical school entering class, medical school resources, such as space, faculty numbers, and teaching responsibilities are taken in account such that the quality of educational program is not compromised.
- 5.3 b The pressures to generate revenue from tuition, clinical care, and/or research are managed to ensure the ongoing quality of the medical education program.
- 5.3 c Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. In setting the size of the medical school entering class, medical school resources, such as space, faculty numbers, and teaching responsibilities are taken into account such that the quality of the educational program is not compromised. The class size is set by the provincial government.
- b. The pressures to generate revenue from tuition, clinical care, and/or research are managed to ensure the ongoing quality of the medical education program. The undergraduate medical education budget was not reduced with the provincially mandated reduction in enrolment. The provincial government sets tuition and increases have been low over the last 8 years.
- c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

5.4 SUFFICIENCY OF BUILDINGS AND EQUIPMENT

A medical school has, or is assured the use of, buildings and equipment sufficient to achieve its educational, clinical, and research missions.

Note: If the medical school operates one or more geographically distributed campus, provide the data separately for each campus.

- 5.4 a The AAMC CGQ, AFMC GQ, and the ISA show that a majority of respondents are satisfied/very satisfied with the adequacy of lecture halls, large group classroom facilities, small group teaching spaces, and space used for clinical skills teaching at each campus of the medical school.
- 5.4 b If educational spaces used for required learning experience in years one and two of the curriculum (lecture halls, large and small group rooms, and laboratories) are shared with other schools/programs, there is a mechanism for scheduling these spaces that accommodates the needs of the medical education program such that the delivery of the curriculum is not disrupted.
- 5.4 c If the facilities used for teaching and assessment of students' clinical and procedural skills are shared with other schools/programs, there is a mechanism for scheduling these facilities that accommodates the needs of the medical school so that teaching and assessment are not disrupted.
- 5.4 d If there was an increase in class size since the time of the last full survey, teaching space was adjusted to accommodate the increase in class size.
- 5.4 e If an increase in class size is anticipated over the next three years, there is a plan to adjust teaching space if needed to accommodate this increase.
- 5.4 f The facilities and resources for basic, clinical and evaluative research are appropriate to support the research mission of the medical school.
- 5.4 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The DCI Table 5.41 shows that a majority of respondents are satisfied/very satisfied with the adequacy of lecture halls, large group classroom facilities (87-92%), small group teaching spaces (89-96%), and space used for clinical skills teaching (91-93%). This element is considered to be a strength of the medical school. The ISA ranked the sufficiency of buildings and equipment as a strength.
- b. There is a mechanism for scheduling educational spaces that accommodates the needs of the medical education program such that the delivery of the curriculum is not disrupted. The medical education program has priority for booking teaching space to meet the needs of the students and the delivery of the curriculum.

- c. There is a mechanism for scheduling facilities for clinical and procedural skills teaching that accommodates the needs of the medical education program such that the teaching and assessment are not disrupted.
- d. There has been a provincial government mandated reduction in class size over the past 3 years from a high of 180 to the current enrollment of 155.
- e. There are no concerns with the available teaching space which had been designed to accommodate the previous provincially mandated increase in class size.
- f. The facilities and resources for basic, clinical and evaluative research are appropriate to support the research mission of the medical school.
- g. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

5.5 RESOURCES FOR CLINICAL INSTRUCTION

A medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in ambulatory and inpatient settings and has adequate numbers and types of patients (e.g., acuity, case mix, age, gender).

- 5.5 a Data provided by the AAMC CGQ and the AFMC GQ show that the majority of respondents at each campus agree/strongly agree that they had sufficient access to the variety of patients and procedures required for the encounter log in the seven core required clinical learning experiences listed in the survey.
- 5.5 b When selecting inpatient and ambulatory teaching sites for required clinical learning experiences for both rotation-based and longitudinal integrated clerkships, the medical school makes an initial determination and then monitors to ensure there are adequate numbers and types of patients to support the number of students placed at each site.
- 5.5 c Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Data provided by the AAMC CGQ and the AFMC GQ (DCI Table 5.5-3) show that the majority of respondents agree/strongly agree (76-90% 2013; 82-95% 2014; 79-95% 2015) that they had sufficient access to the variety of patients and procedures required for the encounter log in the core required clinical learning experiences listed in the survey. The pediatric rotation has the lower percent of respondents. The ISA indicated this was satisfactory.
- b. When selecting inpatient and ambulatory teaching sites for required clinical learning experiences for both rotation-based and longitudinal integrated clerkships, the medical school makes an initial determination and then monitors to ensure there are adequate numbers and types of patients to support the number of students placed at each site. The students are required to complete a logbook which is reviewed annually by the assistant dean, clerkship and the Clerkship Committee to identify gaps in types and number of patients seen.
- c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

5.6 CLINICAL INSTRUCTIONAL FACILITIES/INFORMATION RESOURCES

Each hospital or other clinical facility affiliated with a medical school that serves as a major location for required clinical learning experiences has sufficient information resources and instructional facilities for medical student education.

- 5.6 a Data from the ISA show that the majority of respondents are satisfied/very satisfied with the space used for clinical skills teaching and education/teaching space (conferences, rounds, academic half-days) at clinical facilities used for required learning experiences at each campus.
- 5.6 b Data from the ISA show that the majority of respondents are satisfied/very satisfied with access to information resources (computers and internet) at clinical facilities used for required learning experiences at each campus.
- 5.6 c Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Data from the ISA (77-89% year 2; 88-91% year 3; DCI Table 5.6-1) show that the majority of students are satisfied/very satisfied with the space used for clinical skills teaching, and other teaching/education spaces. Simulation and procedural skills training resources are satisfactory.
- b. Data from the ISA (91% year 1; 90% year 2; 92% year 3; DCI Table 5.6-1) demonstrate that the majority of students are satisfied/very satisfied with access to information resources.
- c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

5.7 SECURITY, STUDENT SAFETY, AND DISASTER PREPAREDNESS

A medical school ensures that adequate security systems are in place at all locations and publishes policies and procedures to ensure student safety and to address emergency and disaster preparedness.

- 5.7.a Data from the ISA show that the majority of respondents are satisfied/very satisfied with the adequacy of safety and security at all instructional sites.
- 5.7.b There are security systems in place to ensure student safety in each of the following situations:
 - i. on campus during regular classroom hours
 - ii. on campus outside of regular classroom hours
 - iii. at clinical teaching sites used for required learning experiences
- 5.7 c There are protections available to medical students at instructional sites that may pose special physical dangers (e.g., during interactions with potentially violent patients).
- 5.7 d The medical school's or university's policies and procedures to ensure student safety are communicated to students and faculty.
- 5.7 e The medical school or university has disaster preparedness policies, procedures, and plans that are communicated to students, faculty and staff.
- 5.7 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <ul style="list-style-type: none">a. Data from the ISA (82% year 1; 76% year 2; 85% year 3; DCI Table 5.7-2) show that the majority of students are satisfied/very satisfied with the adequacy of safety and security at instructional sites. The ISA highlighted concerns about student awareness and preparedness for emergency and disaster situations at clinical sites, in particular with hostile patients which the school has addressed (see below).b. There are security systems in place to ensure student safety on campus during regular hours and outside of regular classroom hours. There are also multiple security systems in place at clinical learning sites. Some of these are recent and have been improved in response to student concerns.c. The medical school provides training to address dangerous risks, including dealing with violent patients, needle stick injury, and infection control. In the ISA, students suggest additional training on dealing with hostile/dangerous patients in clinical settings. During the site visit, it was determined that there were clear curricular/teaching elements for addressing this issue. An OSCE station with an aggressive patient has been in place for several years.d. Safety related policies are posted on the medical school's website and these policies are addressed at clerkship orientation. A new disaster response guide will be distributed at future orientations. Multiple online and application-based resources also exist to address student safety. The Medical Student Safety Policy provides clear guidelines that address safety and accident/injury avoidance.e. The medical school and university have the required policies on student safety as well as emergency and disaster preparedness. These include a student guide and an Alberta Health Services quick reference card communicating emergency response codes in clinical settings. |
|---|

- | |
|--|
| f. Review of the documentation related to this element and discussions with faculty and students at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. |
|--|

5.8 LIBRARY RESOURCES / STAFF

A medical school ensures ready access to well-maintained library resources sufficient in breadth of holdings and technology to support its educational and other missions. Library services are supervised by a professional staff that is familiar with regional and national information resources and data systems and is responsive to the needs of the medical students, faculty members, and others associated with the medical school.

- 5.8 a Data from the AAMC CGQ and the AFMC GQ show that the majority of students at each campus are satisfied/very satisfied with the library.
- 5.8 b Data from the ISA shows that the majority of students at each campus are satisfied/very satisfied with ease of access to the library resources and holdings (includes virtual access both on and off campus).
- 5.8 c The library services is overseen by a professional staff that is familiar with regional and national information resources and data systems and is responsive to the needs of medical students, faculty and others associated with the medical school.
- 5.8 d Library staff support the medical education program by being involved in curriculum planning; participation in the curriculum committee or its subcommittees; or in the delivery of any part of the medical education program.
- 5.8 e Medical students and faculty have access to electronic and other library resources across all instructional sites both on and off campus, including geographically distributed campuses.
- 5.8 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <ul style="list-style-type: none">a. Data from the AAMC CGQ and the AFMC GQ (86% 2013; 93% 2014; 93% 2015; DCI Table 5.8-1) show that the majority of students are satisfied/very satisfied with the library.b. Data from the ISA (DCI Table 5.8-2) shows that the majority of students are satisfied/ very satisfied with ease of access to the library resources (88% year 1; 82% year 2; 69% year 3) and holdings (82% year 1; 88% year 2; 72% year 3).c. The library services at the Cummings School of Medicine is overseen by a staff of professional librarians who are appropriately informed and knowledgeable about regional and national resources and data systems. The librarians are appropriately qualified to meet the needs of students, faculty and others.d. The library staff members are involved in supporting the undergraduate medical education with specific attention to evidence-based medicine, and are directly involved in teaching students on the topic of information literacy.e. Medical students and faculty have full access to all library resources both on campus and off campus. A range of technological resources are available to facilitate access to library reference services for off-site personnel. |
|---|

- | |
|--|
| f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. The ISA highlights this as an area of strength for this medical school. |
|--|

5.9 INFORMATION TECHNOLOGY RESOURCES / STAFF

A medical school ensures access to well-maintained information technology resources sufficient in scope to support its educational and other missions. The information technology staff serving a medical education program has sufficient expertise to fulfill its responsibilities and is responsive to the needs of the medical students, faculty members, and others associated with the medical school.

- 5.9 a Data from the AAMC CGQ and the AFMC GQ show that the majority of respondents at each campus are satisfied/very satisfied with access to computers and the internet at the medical school.
- 5.9 b Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with:
- i. ease of access to electronic learning materials;
 - ii. adequacy of wireless network in classrooms;
 - iii. study spaces in the medical school;
 - iv. availability of electrical outlets in teaching and study space at the medical school; and
 - v. adequacy of audio-visual technology used to deliver educational sessions (e.g., lectures, academic half-days).
- 5.9 c If a wireless network is not available in classrooms and study spaces at each campus, there are adequate internet access points in large classrooms, small group classrooms and student study spaces.
- 5.9 d The IT services staff members support the medical education program in at least one of the following ways:
- i. being involved in curriculum planning and delivery;
 - ii. assisting faculty in developing instructional materials;
 - iii. assisting in developing or maintaining the curriculum database or other curriculum management applications; or
 - iv. assisting faculty to learn to use the technology for distance education.
- 5.9 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit, confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <p>a. Data from the 2015 AFMC GQ show that the majority of respondents are satisfied/very satisfied with access to computers (92%; DCI Table 5.9-1) and the internet (75%; DCI Table 5.9-1) at the medical school.</p> <p>b. Data from the ISA (DCI Table 5.9-2) show that the majority of students across all years (68%) were not satisfied with the adequacy of the wireless network. A significant technology upgrade has been completed since the ISA questionnaire was deployed and onsite discussion with students in all 3 years indicated this is no longer a concern.</p> <p>c. Not applicable, as the wireless network access is adequate in classrooms and study spaces.</p> <p>d. The IT services staff members support the medical education program through a number of avenues,</p> |
|---|

including innovating in eLearning delivery, video production for learning materials, curriculum database and curriculum management, and support of distance learning.

- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. The eLearning team was identified as a highly effective resource for the medical education program.

5.10 RESOURCES USED BY TRANSFER / VISITING STUDENTS

The resources used by a medical school to accommodate any visiting and transfer medical students in its medical education program do not significantly diminish the resources available to already enrolled medical students.

- 5.10 a The medical school has a process that ensures its resources are adequate to support students already enrolled in its medical education program and i) transfer students and ii) visiting students that are accepted at each campus.
- 5.10 b Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has a process that ensures its resources are adequate to support students already enrolled in its medical education program. The school has not accepted a transfer student in the past 10 years. Any such transfers would be evaluated and supported on a case-by-case basis. Visiting elective students are accepted and are supported with adequate resources and do not impact on Cumming medical students.
- b. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

5.11 STUDY / LOUNGE / STORAGE SPACE / CALL ROOMS

A medical school ensures that its medical students have, at each campus and affiliated clinical site, adequate study space, lounge areas, personal lockers or other secure storage facilities, and secure call rooms if students are required to participate in late night or overnight clinical learning experiences.

- 5.11 a Data from the AAMC CGQ, the AFMC GQ and ISA show that the majority of respondents at each campus are satisfied/very satisfied with the adequacy of student study space at the medical school.
- 5.11 b Data from the AAMC CGQ, the AFMC GQ and ISA show that the majority of respondents at each campus are satisfied/very satisfied with the adequacy/availability of relaxation space at the medical school.
- 5.11 c If study space is not available in the medical school at a campus, or in an affiliated clinical facility, study space is available to students at another accessible location.
- 5.11 d Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with storage space at the medical school.
- 5.11 e Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with storage space at clinical facilities used for required learning experiences.
- 5.11 f Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with on-call rooms in clinical facilities used for required learning experiences.
- 5.11 g In required clinical learning experiences in which students are required to stay overnight, secure on-call rooms are available for their use at each campus.
- 5.11 h Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with on-call rooms for required clinical learning experience.
- 5.11 i Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Data from the AAMC CGQ, the AFMC GQ (86% 2013; 88% 2014; 85% 2015; DCI Table 5.11-1) and ISA (85% year 1; 81% year 2; 84% year 3; DCI Table 5.11-2) indicate that the majority of respondents are satisfied/very satisfied with study space at the medical school.
- b. Data from the AAMC CGQ, the AFMC GQ (82% 2013; 78% 2014; 91% 2015; DCI Table 5.11-3) and ISA (70% year 1; 66% year 2; 84% year 3; DCI Table 5.11-4) show that the majority of respondents are satisfied/very satisfied with the relaxation space provided at the medical school. This is highlighted as a strength in the ISA.
- c. Adequate student study space is provided for students at the medical school. At affiliated teaching hospitals, space is provided in the hospital libraries for student study.

- d. Data from the ISA (42% year 1; 29% year 2; 49% year 3; DCI Table 5.11-5) does not show that the majority of respondents are satisfied/very satisfied with storage space at the medical school. This was believed to be a consequence of a number of thefts of personal property. The school responded with extra security, and more recent surveys as well as onsite discussion with students indicates satisfaction with current storage provisions.
- e. Data from the ISA (47% year 1; 41% year 2; 53% year 3; DCI Table 5.11-6) does not show that the majority of respondents are satisfied/very satisfied with storage space at clinical facilities. The ISA suggests a lack of awareness of physical resources on the part of students as opposed to an absence of resources. The increased efforts to communicate storage resources to students are positively reviewed in the ISA and there are no current concerns on this issue.
- f. Data from the ISA (59% year 2; 72% year 3; DCI Table 5.11-9) show that the majority of respondents are satisfied/very satisfied with on-call rooms in the clinical facilities.
- g. Secure on call rooms are available at all sites where students are required stay overnight for call. As a matter of policy, students are not required to do overnight call at any site where secure call rooms are not available.
- h. This requirement appears to be a duplicate of f.
- i. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

5.12 REQUIRED NOTIFICATIONS TO THE CACMS

A medical school notifies the CACMS of a substantial change in any of the following:*

- a) plans for an increase in entering medical student enrollment on the main campus and/or in existing geographically distributed campuses above the threshold of 10 percent, or 15 medical students in one year or 20 percent in three years;*
- b) decreases in resources available to the medical school in the areas of faculty, physical facilities, or finances;*
- c) plans for a major reorganization of one or more years of the program, the program as whole, or the introduction of a new educational track;*
- d) loss of a clinical facility that was affiliated with the medical school; and/or the*
- e) plans for creation of a new geographically distributed campus, or expansion of the program at an existing distributed campus.*

- 5.12 a Since the time of the last full survey, the medical school has not increased the number of medical students admitted to the program above a threshold of 10 percent or 15 medical students in one year or 20 percent in three years without notifying the CACMS.
- 5.12 b Since the time of the last full survey, the medical school has notified the CACMS with any required notification a)-e) and has provided in the DCI for this element, the CACMS/LCME transmittal letter(s) in response to notifications made by the medical school.
- 5.12 c Review of the documentation related to this element confirms that the requirements listed above are being met by the medical school at the time of the on-site survey visit.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Since the last full survey, the school increased its enrollment from 150 to 180 students. As required, CACMS was notified of this increase.
- b. CACMS was notified of the increase in enrolment and a limited site visit was conducted in 2009. A copy of the transmittal letter is provided in the DCI.
- c. Review of the documentation related to this element confirms that the requirements listed above are being met by the medical school at the time of the onsite visit. Of note, a provincially mandated reduction of medical student enrollment followed in 2012 with the current enrollment set at 155 students.

STANDARD 6
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 6: COMPETENCIES, CURRICULAR OBJECTIVES, AND CURRICULAR DESIGN

The faculty of a medical school define the competencies to be achieved by its medical students through medical education program objectives and is responsible for the detailed design and implementation of the components of a medical curriculum that enables its medical students to achieve those competencies and objectives. The medical education program objectives are statements of the knowledge, skills, behaviors, and attitudes that medical students are expected to exhibit as evidence of their achievement by completion of the program.

Survey Team
Standard 6 Element Rating Table

Standard 6	Competencies, Curricular Objectives, and Curricular Design
Element	
6.1	Format/Dissemination of Medical Education Program Objectives and Learning Objectives
6.2	Required Clinical Learning Experiences
6.3	Self-Directed and Life-Long Learning
6.4	Inpatient/Outpatient Experiences
6.5	Elective Opportunities
6.6	Service Learning
6.7	Academic Environments
6.8	Education Program Duration

Standard 6 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 6 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 6 Competencies, Curricular Objectives, and Curricular Design
--------------------------	---

6.1 *FORMAT / DISSEMINATION OF MEDICAL EDUCATION PROGRAM OBJECTIVES AND LEARNING OBJECTIVES*

The faculty of a medical school define its medical education program objectives in competency-based terms that reflect and support the continuum of medical education in Canada and allow the assessment of medical students' progress in developing the competencies for entry into residency and expected by the profession and the public of a physician. The medical school makes these medical education program objectives known to all medical students and faculty members with leadership roles in the medical education program, and others with substantial responsibility for medical student education and assessment. In addition, the medical school ensures that the learning objectives for each required learning experience are made known to all medical students and those faculty, residents, and others with teaching and assessment responsibilities in those required experiences.

- 6.1 a The medical education program objectives are framed in competency-based terms that reflect CanMEDs and CanMEDs FM competencies.
- 6.1 b The medical education program objectives were reviewed and revised at least once since the time of the last full survey and approved formally by appropriate key committees of the medical school.
- 6.1 c The medical education program objectives are linked to the relevant specific physician competency.
- 6.1 d The medical school has selected appropriate and sufficiently specific assessment methods/instruments to measure medical students' progress in developing the required competencies throughout the medical education program i.e., meeting the medical education program objectives.
- 6.1 e The medical education program objectives are made know to all medical students and faculty members with leadership roles in the medical education program and others with substantial responsibility for medical student education and assessment.
- 6.1 f The learning objectives of each required learning experience are made known to all medical students and those faculty, residents and others with teaching and assessment responsibilities in those required learning experiences.
- 6.1 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical education program objectives are framed as the “Big 10” which reflect the CanMEDS and CanMEDS FM competency framework (Core Appendix C-23).
- b. The Big 10 medical program educational objectives were initially developed in 1999, and most recently reviewed and approved in 2014 and 2015 respectively. The ISA identifies that the majority of students were not aware initially aware of the existence of the Big 10. However due to efforts of

the school over the past two years they now do. Medical students report that the use of learning objectives for their required learning experiences did influence their learning.

- c. There is linkage of the Big 10 to a physician competency framework that is described in the documents. The ISA highlights that students were unaware of the connection between their learning objectives and the Big 10 competencies at the time of the ISA. Discussions with year 1 and year 2 students at the time of the visit indicates they are now aware of the linkage of the Big 10 program objectives and the relationship to their sessional objectives. Students readily describe the “left feet” (a series of footsteps on the floor of the Health Sciences Centre that document the Big 10).
- d. The medical school has selected a broad range of assessment methods that are used at different stages of the curriculum, including after graduation to measure medical students’ progress in developing the required competencies (Core Appendix C-23).
- e. The medical education program objectives are posted on the website, available as hard copies, appear on rotation assessment forms and annually on a data collection tool used with preceptors, in addition to the “left feet” in c. above.
- f. The learning objectives are distributed and made known to all medical students and those faculty, residents and others involved in teaching and assessment for courses, small group sessions and clerkship rotations.
- g. The documentation and discussion with relevant individuals during the onsite visit confirm that the items within this element are being met. Through a process of enhanced communication by program leadership, the student body is now aware of the Big 10 and the connections between the Big 10 to course and learning objectives.

6.2 REQUIRED CLINICAL LEARNING EXPERIENCES

The faculty of a medical school define the types of patients and clinical conditions that medical students are required to encounter, the skills and procedures to be performed by medical students, the appropriate clinical settings for these experiences, and the expected levels of medical student responsibility.

- 6.2 a The faculty has described each patient type, clinical condition, required procedure and skill, and the clinical setting in which they take place for each required clinical learning experience and for those experiences as a whole, including for longitudinal integrated clerkship if offered.
- 6.2 b For each required patient encounter and procedural skill, the faculty has made explicit the required level(s) of student responsibility in each required clinical learning experience and in those experiences as a whole, including in longitudinal integrated clerkship if offered. In nearly every instance the stipulated level of responsibility is: to assist or perform.
- 6.2 c The list of required patient encounters and procedural skills was reviewed and approved by the 'curriculum committee' or other appropriate oversight committee for relevance and comprehensiveness.
- 6.2 d The faculty expect that students have the majority of required patient encounters with real patients keeping in mind patient safety.
- 6.2 e Alternative experiences (e.g., standardized patients, simulations, virtual patients) have been developed for the required patient encounters that are rare, severe or seasonal.
- 6.2 f Medical students, faculty, and residents are informed of the required patient encounters and procedural skills in each required clinical learning experience in which they participate.
- 6.2 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Core Appendix C-24 details the clinical presentations and procedures that students are expected to have encountered, assisted or performed. This includes students in the longitudinal integrated clerkship stream.
- b. The faculty has explicitly stated the level of responsibility for each student. Most are at the level of assist or perform. Those that are at the level of observe are not procedures that students would be expected to perform on completion of the medical education program.
- c. The list of clinical encounters and procedures has been reviewed and modified by the Clerkship Committee and the Undergraduate Medical Education Committee to ensure relevance and comprehensiveness.
- d. The faculty expects the students to complete the vast majority of the clinical encounters with real patients. A process to track this in real time and adjust the learning experience of an individual

student was initiated for the Class of 2016.

- e. Alternative experiences have been developed in Course 8 (the clerkship academic half day) for all required clinical encounters as well as skills and procedures. Students have the opportunity to practice all of these in an alternative environment prior to seeing a patient.
- f. Medical students, faculty, and residents are informed of the required patient encounters and procedural skills. Medical students are required to complete a logbook and on some clinical rotations encounter cards are also used. Faculty are made aware through the preceptor resources webpage and the clerkship handbook.
- g. Review of the documentation and discussions with relevant individuals during the onsite visit confirm that the required clinical experiences are identified, tracked and assessed. The ISA addressed safety of patient encounters explicitly and no concerns were identified. Detailed onsite review of the use of the log book assured the team that the log book is used by students and faculty and all know the requirements.

6.3 SELF-DIRECTED AND LIFE-LONG LEARNING

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.

- 6.3 a There are learning sessions in required learning experiences in the first two years of the curriculum where in the context of a clinical case, students engage in all of the following components of self-directed learning as a unified sequence:
- i. Identify, analyze, and synthesize information relevant to their learning needs
 - ii. Assess the credibility of information sources
 - iii. Share the information with their peers and tutor/facilitator
 - iv. Apply their knowledge to the resolution of the clinical case
 - v. Receive feedback and are assessed on their skills in self-directed learning
- 6.3 b There is sufficient scheduled time in the first two years of the medical education program for self-directed learning sessions described in 6.3.a., to allow students to develop the skills for self-directed learning.
- 6.3 c Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
☐ Satisfactory with a need for monitoring
☐ Unsatisfactory

Evidence to support the above rating

- a. There are learning sessions that allow for the 5 required elements of self-directed learning. This principally occurs in the Integrative Course and the Applied Evidence Based Medicine course in the first two years but also is evident throughout other components of the curriculum.
- b. There appears to be sufficient scheduled time in the first two years for self-directed learning sessions (Core Appendix C-25). The school has a target of 30% of curricular time being available for self-directed learning. It has been identified that they have not reached the target of 30%. The ISA reports that students are very dissatisfied with the availability of study time but indicate efforts are underway to address the issue.
- c. Review of the documentation and discussion with relevant individuals at the time of the onsite visit confirms that the requirements listed above are being met by the medical school. The Less is More task force has been effective resulting in improved efficiencies through the pre-clinical years and improved availability of independent study time, approaching 30%.

6.4 INPATIENT / OUTPATIENT EXPERIENCES

The faculty of a medical school ensure that the medical curriculum includes clinical experiences in both outpatient and inpatient settings.

- 6.4 a Medical students spend an appropriate percentage of time in a) inpatient and b) ambulatory care settings to meet the learning objectives of each required clinical learning experience.
- 6.4 b Data from the AAMC CGQ and the AFMC GQ show that the majority of respondents agree/strongly agree that, when presented with a variety of patients, they have the knowledge and skills to a) care for patients in a hospital setting and b) care for patients in an ambulatory setting.
- 6.4 c Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There is an appropriate balance of inpatient and outpatient activity reflected in the clinical rotations that students undertake (Core Appendix C-26).
- b. The CGQ and GQ data over the past 3 academic years shows that the majority of respondents agree/strongly agree they have the knowledge and skills appropriate to care for patients in a hospital (93-96%) and an ambulatory (92-97%) setting (Core Appendix C-27).
- c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

6.5 ELECTIVE OPPORTUNITIES

The faculty of a medical school ensure that the medical curriculum includes elective opportunities that supplement required learning experiences and that permit medical students to gain exposure to and deepen their understanding of medical specialties reflecting their career interests and to pursue their individual academic interests.

- 6.5 a There are opportunities for elective experiences in the medical curriculum particularly in the later years of the educational program.
- 6.5 b The medical school has policies or practices that require or encourage medical students to use electives to pursue a broad range of interests in addition to their chosen specialty.
- 6.5 c The medical school has or follows a policy (e.g., the AFMC UGME/PGME Policy on Diversification of Electives) that ensures the diversification of electives. Medical students' elective choices are reviewed and adjustments made to ensure the policy is followed.
- 6.5 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There are 16 weeks available for electives during the 3-year curriculum. This is divided into 4-weeks summer elective between year 1 and year 2 with 12 weeks during clerkship. There is additional time available as self-study time during the Applied Evidence Based Medicine course. The school has added an additional 2 weeks in year 3 for the incoming class bringing the total number of weeks available for electives to 18.
- b. The Diversification of Electives policy states that each student must complete electives in “at least two different CaRMS disciplines”. There is a separate electives core document that provides more guidance to students on making appropriate choices of electives.
- c. The Diversification of Electives Policy stipulates that at least 2 CaRMS disciplines must be done as electives. Medical students' elective choices are reviewed by the chair, electives and adjustments made as required.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site visit confirm that the requirements listed above are being met by the medical school.

6.6 SERVICE-LEARNING

The faculty of a medical school ensure that the medical education program provides sufficient opportunities for, encourages, and supports medical student participation in service-learning and community service activities.

- 6.6 a There are opportunities for medical students to participate in service-learning and community service activities during their tenure as a student.
- 6.6 b Data from the ISA show that the majority of medical respondents are satisfied/very satisfied with their access to opportunities to participate in service learning activities.
- 6.6 c The medical school informs medical students about service learning opportunities and encourages medical students to participate in service learning activities.
- 6.6 d The medical school supports student participation in service learning activities (e.g., coordination of student placements, development of opportunities in conjunction with community partnerships or provision of financial support).
- 6.6 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There are multiple opportunities for students to participate in service-learning and community service activities during their time at medical school. Some are student driven and some driven by faculty.
- b. The majority of students are satisfied with the opportunities for service learning although the margin is small in year 2 at 57.5% and largest in year 3 at 77%. The ISA recommends that the school does more to encourage and support service learning opportunities and that this be integrated into the curriculum.
- c. Students are informed of service learning opportunities starting with orientation in year 1. Specific groups will also try to recruit students at different points during their program (for example, the SHINE executive presents to the entire class). The Family Medicine rotation has a service learning opportunity, which includes a reflective component and is available to all students.
- d. The school supports the students' participation in service learning and community activities. There is coordination of student placements and partnerships that have been developed with several organizations with some financial support provided. There is a recognition award for students who are heavily involved in certain volunteer activities. A new initiative has been launched with the development of an office of Strategic Partnerships and Community Engagement (SPaCE) and the appointment of an associate dean July 2015 to lead this initiative. Discussions at the time of the visit indicated that the SPaCE office has been established, a coordinator has been hired with another support person to be hired. A "storefront" will open in September 2016. The associate dean, SPaCE has initiated community engagement activities including the development of research priorities as identified by community agencies and groups.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements are being met by the medical school.

6.7 ACADEMIC ENVIRONMENTS

The faculty of a medical school ensure that medical students have opportunities to learn in academic environments that permit interaction with students enrolled in other health professions, graduate, and professional degree programs, and opportunities to interact with residents in clinical environments and with physicians in continuing medical education activities.

- 6.7 a There are health professions degree programs taught by the medical school faculty where medical students have the opportunity and are encouraged to interact with these programs' students in academic environments at each campus.
- 6.7 b There are graduate degree programs taught by the medical school faculty where medical students have the opportunity and are encouraged to interact with these programs' students in academic environments at each campus.
- 6.7 c There are professional (other than health profession) degree programs taught by the medical school faculty where medical students have the opportunity and are encouraged to interact with these programs' students in academic environments at each campus.
- 6.7 d Medical students have the opportunity and are encouraged to interact with residents and fellows in CFPC and RCPSC accredited programs in clinical environments at each campus.
- 6.7 e Medical students learn about continuing medical education activities for physicians and have the opportunity to participate in appropriate CME activities.
- 6.7 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <ul style="list-style-type: none">a. Core Appendix C- 28 lists the health professions degree programs in which medical school faculty teach. There are opportunities for students to interact with nursing, respiratory technology, social work and paramedic students. There is a pilot of two new initiatives involving a team home visit to a patient with endocrine disease and a trauma simulation.b. Core Appendix C-29 lists the graduate degree programs taught by medical school faculty. The Leaders in Medicine (LiM) program allows medical students to pursue a combined doctor of medicine and graduate degree; this is considered a program strength. There is an Affiliate designation to LiM that provides the opportunity for interested medical students to participate in learning activities associated with the graduate programs.c. A combined MD/MBA program with the Haskayne School of Business enrolled the first student in 2015.d. All medical students have the opportunity to and do interact with residents and fellows in CFPC and RCPSC accredited programs (Core Appendix C-30).e. Medical students learn about, and have the opportunity to participate in, appropriate CME activities. The most common events are rounds and journal clubs. Students may also receive financial support to attend CME type activities if they have a presentation. |
|---|

- | |
|--|
| f. Review of the documentation and discussion with relevant individuals during the onsite visit confirm that the academic environment meets the requirements for this element. |
|--|

6.8 *EDUCATION PROGRAM DURATION*

A medical education program includes at least 130 weeks of instruction.

- 6.8 a The medical education program includes at least 130 weeks of instruction.
- 6.8 b Review of the documentation related to this element at the time of the on-site visit confirms that the requirement listed above is being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Unsatisfactory

Evidence to support the above rating

- a) The medical education program duration is 131 weeks not including orientation (1 week), holidays (8 weeks), CaRMS break (2 weeks) and the end of clerkship study period/clerkship OSCE (3 weeks).
- b) Review of the documentation related to this element at the time of the onsite visit confirms that the requirement listed above is being met by the medical school. In the 2016-17 academic year the incoming class will begin in July, increasing the program duration to 134 weeks.

STANDARD 7
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 7: CURRICULAR CONTENT

The faculty of a medical school ensure that the medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine.

Survey Team
Standard 7 Element Rating Table

Standard 7	Curricular Content
Element	
7.1	Biomedical, Behavioral, Social Sciences
7.2	Organ Systems/Life Cycle/Primary Care/Prevention/ Wellness/ Symptoms/Differential Diagnosis/Treatment Planning/Social and Psychological Determinants of Health
7.3	Scientific Method/Clinical Translational Research
7.4	Critical Judgment/Problem-Solving Skills
7.5	Societal Problems
7.6	Cultural Competence/Health Care Disparities/Personal Bias
7.7	Medical Ethics
7.8	Communication Skills
7.9	Interprofessional Collaborative Practice Skills

Standard 7 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 7 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 7 Curricular Content
--------------------------	-------------------------------

7.1 BIOMEDICAL, BEHAVIORAL, SOCIAL SCIENCES

The faculty of a medical school ensure that the medical curriculum includes content from the biomedical, behavioral, and socioeconomic sciences to support medical students' mastery of contemporary scientific knowledge and concepts and the methods fundamental to applying them to the health of individuals and populations.

- 7.1 a The topics listed in Table 7.1-1 of the DCI are taught and assessed in the curriculum either as an independent required learning, or integrated in a required learning experience(s).
- 7.1 b Data from the AAMC CGQ and the AFMC GQ in Table 7.1-2 of the DCI show that the majority of respondents agree/strongly agree that educational activities in the MD program helped prepare them better for required clinical learning experiences and electives.
- 7.1 c The topics listed in Table 7.1-3 of the DCI are taught and assessed in the curriculum either as independent required learning experiences or integrated into a required learning experience.
- 7.1 d Data from the AAMC CGQ and the AFMC GQ in Table 7.1-4 of the DCI show that the majority of respondents agree/strongly agree that they have a fundamental understanding of the listed issues in social sciences of medicine.
- 7.1 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|--|
| <ul style="list-style-type: none">a. The topics listed in Table 7.1-1 of the DCI are taught and assessed in the curriculum. There is no specific course for these topics but all are captured in learning events of the integrated curriculum. There are changes being made to the teaching of nutrition in the curriculum.b. Data from the AAMC CGQ and the AFMC GQ Table 7.1-2 (Core Appendix C-31) show that an aggregated majority (61%) of respondents agree that the basic science education prepared them for required clinical learning experiences and electives. In 2015 and consistent with the prior 2-year data, biochemistry (31%), genetics (47%), microanatomy/histology (45%) and nutrition (44%) fall below 50%. The nutrition content has been enhanced with additional instructional modules. Discussions at the time of the visit supports that all domains of basic science education are covered in the curriculum and that students may not perceive adequate coverage with the basic science integrated into the case-based clinical presentation curriculum. There have been planning meetings between the associate dean and the relevant department heads to make content more explicit.c. All topics listed in Table 7.1-3 of the DCI are taught and assessed either as independent required learning experiences or integrated into a required learning experience.d. Data from the AAMC CGQ and the AFMC GQ Table 7.1-4 (Core Appendix C-32) show that the majority of students agree/strongly agree that they have the fundamental understanding of the listed issues. There has been improvement for law in medicine from 42% in 2013 to 58% in 2015.e. Review of the documentation related to this element and discussions with students and faculty at the time of the onsite visit confirm that the requirements listed above are being met by the medical |
|--|

school. Outcome measures including the LMCC results, CaRMS match rates and the program graduate survey provide external validation that training in the basic sciences is appropriate.

7.2 ORGAN SYSTEMS / LIFE CYCLE / PRIMARY CARE / PREVENTION / WELLNESS / SYMPTOMS / SIGNS / DIFFERENTIAL DIAGNOSIS, TREATMENT PLANNING, IMPACT OF BEHAVIORAL / SOCIAL FACTORS

The faculty of a medical school ensure that the medical curriculum includes content and clinical experiences related to each organ system; each phase of the human life cycle; continuity of care; and preventive, acute, chronic, rehabilitative, end-of-life, and primary care in order to prepare students to:

- a) Recognize wellness, determinants of health, and opportunities for health promotion and illness prevention.*
- b) Recognize and interpret symptoms and signs of disease.*
- c) Develop differential diagnoses and treatment plans.*
- d) Recognize the potential health-related impact on patients of behavioral and socioeconomic factors.*
- e) Assist patients in addressing health-related issues involving all organ systems.*

- 7.2 a The topics listed in Table 7.2-1 of the DCI are taught and assessed in the curriculum either as an independent required learning experience, or integrated in a required learning experience(s).
- 7.2 b Data from the AAMC CGQ and the AFMC GQ provided in Table 7.2-2 of the DCI show that the majority of respondents indicate that the topics listed in Table 7.2-2 are adequately addressed in the curriculum.
- 7.2 c AAMC CGQ data and AFMC GQ data presented in Table 7.2-3 of the DCI show that the majority of respondents agree/strongly agree that, when presented with a variety of patients, they have the knowledge and skills to perform the physician tasks listed in Table 7.2-3.
- 7.2 d The following topics are taught and assessed in the curriculum:
 - i. normal human development and the life cycle
 - ii. adolescent medicine
 - iii. geriatrics
 - iv. continuity of care
 - v. end of life care
- 7.2 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The topics listed in Table 7.2-1 of the DCI are taught and assessed in the curriculum either as an independent required learning experience or incorporated into the required learning experiences of the integrated curriculum.
- b. Data from the AAMC CGQ and the AFMC GQ (Table 7.2-2; Core Appendix C-33) show that the majority of respondents agree that the topics listed are adequately addressed. The school has self-identified long-term health care, pain management and infectious disease prevention as areas for further curricular improvement (appropriate instruction 73%; 65%; and 81% respectively in 2015).
- c. AAMC CGQ data and AFMC GQ data (Table 7.2-3; Core Appendix C-34) show that the majority of

respondents (84-99% in 2015) agree/strongly agree that, when presented with a variety of patients, they have the knowledge and skills to perform the physician tasks listed in the table.

- d. The listed topics are taught and assessed in the integrated curriculum.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

7.3 SCIENTIFIC METHOD/CLINICAL/ TRANSLATIONAL RESEARCH

The faculty of a medical school ensure that the medical curriculum includes instruction in the scientific method (including hands-on or simulated exercises in which medical students collect or use data to test and/or verify hypotheses or address questions about biomedical phenomena) and in the basic scientific and ethical principles of clinical and translational research (including the ways in which such research is conducted, evaluated, explained to patients, and applied to patient care).

- 7.3 a The medical curriculum includes either in an independent required learning experience or integrated in a required learning experience(s), instruction in and assessment of content related to the scientific method. These curricular experiences include hands-on or simulated exercises in which medical students collect or use data to test and/or verify hypotheses or to experimentally study biomedical phenomena.
- 7.3 b The medical curriculum includes either in an independent required learning experience or integrated into a required learning experience(s), formal learning objectives that address a) the basic scientific and ethical principles of clinical and translational research and b) how this research is conducted, evaluated, explained to patients and applied to patient care.
- 7.3 c Students' acquisition of knowledge on a) the basic scientific and ethical principles of clinical and translational research, and b) how this research is conducted, evaluated, explained to patients and applied to patient care is assessed.
- 7.3 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical curriculum includes hands on and simulated exercises in the application of the scientific method within the integrated curriculum. The bulk of the learning and assessment occurs in the Applied Evidence Based Medicine course (AEBM).
- b. The integrated medical curriculum includes learning objectives addressing the basic scientific and ethical principles of clinical and translational research and how this research is conducted, evaluated and applied to patient care. This is prominently captured in the AEBM course but also occurs within other aspects of the integrated curriculum.
- c. The MSS (p 108) identified that the program's scientific method curriculum did not systematically cover how research information is explained to patients. Discussion at the time of the visit with the assistant dean, pre-clerkship confirms that this has been addressed and is now explicitly taught and assessed in Integrative Course year 2.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

7.4 CRITICAL JUDGMENT/PROBLEM-SOLVING SKILLS

The faculty of a medical school ensure that the medical curriculum incorporates the fundamental principles of medicine and provides opportunities for medical students to develop clinical decision-making skills (i.e., clinical reasoning and clinical critical thinking) including critical appraisal of new evidence, and application of the best available information to the care of patients. These required learning experiences enhance medical students' skills to solve problems of health and illness.

- 7.4 a Clinical decision-making skills including critical appraisal of new evidence related to the care of patients is appropriately taught and assessed either in a required learning experience or integrated into a required learning experience.
- 7.4 b Application of the best available information to the care of patients is appropriately taught and assessed either as a required learning experience or integrated into a required learning experience.
- 7.4 c Medical problem solving skills are appropriately taught and assessed either as a required learning experience or integrated into a required learning experience.
- 7.4 d AAMC CGQ and AFMC GQ data show that the majority of respondents agree/strongly agree that they have the knowledge and skills to perform the following:
 - i. reason clinically
 - ii. incorporate evidence-informed decision-making into patient care
 - iii. access evidence-informed treatment guidelines
 - iv. use technology to access information at the time of a patient encounter (just in time/point of care) if needed.
- 7.4 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Clinical decision-making skills including critical appraisal of evidence are taught and assessed in several different components of the curriculum. Assessments including MCQ exams, In-Training Evaluation Reports (ITERS) and OSCEs are used throughout the stages of training.
- b. Application of the best available information to patient care is taught and assessed in the Applied Evidence Based Medicine course (AEBM) and integrated into other components of the curriculum. In the clinical learning experiences, this is most explicitly done in the Family Medicine and Obstetrics and Gynecology rotations.
- c. Medical problem solving skills are taught and assessed in all parts of the curriculum (for example, small group learning and clinical correlations in courses 1-7). There is explicit emphasis on medical problem solving skills in the Integrative Course prior to beginning clerkship and throughout the clerkship.
- d. AAMC CGQ and AFMC GQ data (Core Appendix C-35) show that the majority of respondents (89-98% in 2015) agree/strongly agree that they are confident in their skills for clinical reasoning and clinical problem solving. The CGQ/GQ data is supported with program outcome data found in the

DCI 8.4 a.

- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

7.5 SOCIETAL PROBLEMS

The faculty of a medical school ensure that the medical curriculum includes instruction in the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of common societal problems.

- 7.5 a The curriculum includes instruction and has relevant learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of domestic violence/abuse.
- 7.5 b The curriculum includes instruction and has relevant learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting (if relevant), and treatment of the medical consequences of substance abuse.
- 7.5 c The curriculum includes instruction and has relevant learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting (if relevant), and treatment of the medical consequences common societal problems.
- 7.5 d Medical students are assessed on the learning objectives related to the common societal problems included in the curriculum.
- 7.5 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The curriculum includes instruction and assessment of the issues related to domestic violence and abuse (Core Appendix C-36).
- b. The curriculum includes instruction and assessment of the issues related to substance abuse.
- c. The curriculum includes instruction and assessment of the issues related to common societal problems, notably smoking, obesity and disability. A new curricular thread in nutrition is being introduced.
- d. Medical students are assessed on the common societal issues with the weighting towards MCQs and a specific clerkship OSCE station on domestic violence.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

7.6 CULTURAL COMPETENCE / HEALTH CARE DISPARITIES / PERSONAL BIAS

The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding:

- a) The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.*
- b) The basic principles of culturally competent health care.*
- c) The recognition and development of solutions for health care disparities.*
- d) The importance of meeting the health care needs of medically underserved populations.*
- e) The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society.*

- 7.6 a There are learning objectives related to cultural competence in health care in required learning experiences including clinical learning experiences in the curriculum.
- 7.6 b There are explicit learning objectives in required learning experiences including clinical learning experiences related to:
- i. identifying and providing solutions for health disparities
 - ii. identifying demographic influences on health care quality and effectiveness
 - iii. meeting the health care needs of medically underserved populations
- 7.6 c Data from the AAMC Canadian Graduation Questionnaire (CGQ) show that the majority of respondents agree/strongly agree with the statement: “I was appropriately trained to care for individuals from backgrounds different from my own” and with the AFMC Graduation Questionnaire (AFMC GQ) statement: “I was appropriately trained to care for individuals from all backgrounds”.
- 7.6 d The curriculum prepares medical students to be aware of their own gender and cultural biases and those of their peers and teachers.
- 7.6 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There are learning objectives in several courses that span all three years of the curriculum related to cultural competence.
- b. There are explicit learning objectives in required learning experiences including clinical experiences for the identified topics. Objectives related to i) identifying and providing solutions for health disparities are found in the year 2 Global Health Unit of Medical Skills; ii) identifying demographic influences on health care quality and effectiveness are found in the year 1 Population Health course; and iii) meeting the health care needs of medically underserved populations are also found in the Population Health course.
- c. Data from the AAMC CGQ (91% in 2013; 96% in 2014) and the AFMC GQ (86%) show that the

majority of respondents agree/strongly agree with the relevant statement regarding preparation for residency and caring for individuals from different or diverse backgrounds (Core Appendix C-37).

- d. The curriculum prepares students to be aware of their own cultural and gender biases. The school has also taken steps to explicitly look for evidence of bias within lectures and provide feedback to faculty to ensure these can be addressed.
- e. Review of the documentation and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

7.7 MEDICAL ETHICS

The faculty of a medical school ensure that the medical curriculum includes instruction for medical students in medical ethics and human values both prior to and during their participation in patient care activities and requires its medical students to behave ethically in caring for patients and in relating to patients' families and others involved in patient care.

- 7.7 a The medical curriculum includes instruction and assessment of the following topics in an independent required learning experience, and/or integrated into a required learning experience(s):
 - i. biomedical ethics
 - ii. ethical decision-making
 - iii. professionalism
- 7.7 b AAMC CGQ and the AFMC GQ data show that majority of respondents agree/strongly agree that they understand the ethical and professional values expected of the profession as listed in Table 7.7-2 of the DCI.
- 7.7 c The methods used for formative and summative assessment of medical students' ethical behavior in the care of patients are appropriate.
- 7.7 d The medical school uses appropriate methods to remediate medical students' breaches of ethics in patient care.
- 7.7 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical curriculum includes instruction and assessment of biomedical ethics, ethical decision making and professionalism. This can be identified in required learning experiences and integrated learning experiences in all three years of the curriculum.
- b. AAMC CGQ and the AFMC GQ data in Table 7.7-2. (Core Appendix C-38) show that the majority of students agree/strongly agree (89-97% in 2015) that they understand the ethical and professional values expected of the profession.
- c. The formative and summative assessment methods of medical students' ethical behavior in the care of patients are appropriate. A combination of self-reflection, peer assessment and direct observation by faculty is used.
- d. The medical school uses appropriate methods to identify and remediate students' breaches of ethics in patient care.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

7.8 COMMUNICATION SKILLS

The faculty of a medical school ensure that the medical curriculum includes specific instruction in communication skills as they relate to communication with patients and their families, colleagues, and other health professionals.

- 7.8 a There are explicit learning objectives and specific educational activities in required learning experiences, including clinical learning experiences, related to:
- communicating with patients and patient's families
 - communicating with physicians (e.g., as part of the medical team)
 - communicating with non-physician health professionals (e.g., as part of the health care team)
- 7.8 b AAMC CGQ data and AFMC GQ data show that the majority of respondents agree/strongly agree that they have the knowledge and skills related to communication skills listed in Table 7.8-2 of the DCI.
- 7.8 c Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <p>a. There are explicit learning objectives and specific educational activities related to communicating with patients, patient's families, physicians and non-physician health professionals. Communication is taught and assessed in many areas of the curriculum throughout the three years. The Communications curriculum is based on the Calgary-Cambridge guide, developed in part by faculty from the school.</p> <p>b. AAMC CGQ data and AFMC GQ data in Table 7.8-2 show that the vast majority of students (94-99% in 2015) agreed/strongly agreed that they have the knowledge and skills related to perform most of the communication physician tasks (Core Appendix C-39). An acceptable majority of 82% (2015) agreed/strongly agreed with the ability to “discuss the health practices of patients using alternative therapies”.</p> <p>c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. The students report in the ISA and confirm in interviews that the teaching of communication skills in the curriculum is exceptional.</p> |
|---|

7.9 INTERPROFESSIONAL COLLABORATIVE SKILLS

The faculty of a medical school ensure that the core curriculum prepares medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These required curricular experiences include practitioners and/or students from the other health professions.

- 7.9 a There is a linkage between the medical education program objectives and the learning objectives of required learning experiences related to interprofessional collaborative practice skills.
- 7.9 b There are sufficient instances of required learning experiences where medical students are brought together with students or practitioners from other health professions to learn to function collaboratively on health care teams as they provide coordinated services to patients.
- 7.9 c These educational experiences have learning objectives related to the development of interprofessional collaborative practice skills, and medical students' attainment of the learning objectives is assessed.
- 7.9 d The sample forms provided in the DCI for the assessment of medical student's attainment of interprofessional collaborative practice skills are explicit and appropriate.
- 7.9 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There is a linkage between the medical education program objectives and the learning objectives related to interprofessional collaborative practice skills. This is outlined in the goals, objectives and philosophy of the program (Supplemental Appendix S-3).
- b. There are sufficient instances of required learning experiences where medical students learn in conjunction with students from other health professions to function collaboratively on health care teams. This involves students from nursing, respiratory therapy, social work and/or paramedic training. The students report that this has been improving and encourage the school to continue with the strategies to increase interprofessional educational opportunities.
- c. The educational experiences have learning objectives related to the development of collaborative practice skills. The attainment of these skills by medical students is assessed.
- d. The sample forms in the DCI to assess the medical students' attainment of these collaborative practice skills are explicit and appropriate. Forms include those used for interprofessional specific activities (e.g. TraumaSim and KidSim) as well as those for Communication Skills and the Clerkship ITERs.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. The school continues to enhance the development of the collaborative skills for medical students and this will be well supported by the recent appointment of the director of Interprofessional

Education.

STANDARD 8
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 8: CURRICULAR MANAGEMENT, EVALUATION, AND ENHANCEMENT

The faculty of a medical school engage in curricular revision and program evaluation activities to ensure that the medical education program quality is maintained and enhanced and that medical students achieve all medical education program objectives and participate in required clinical experiences and settings.

Survey Team
Standard 8 Element Rating Table

Standard 8	Curricular Management, Evaluation and Enhancement
Element	
8.1	Curricular Management
8.2	Use of Medical Education Program Objectives
8.3	Curricular Design, Review, Revision/Content Monitoring
8.4	Program Evaluation
8.5	Use of Student Evaluation Data in Program Improvement
8.6	Monitoring of Completion of Required Clinical Experiences
8.7	Comparability of Education/Assessment
8.8	Monitoring Time Spent in Educational and Clinical Activities

Standard 8 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 8 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 8 Curricular Management, Evaluation, and Enhancement
--------------------------	---

8.1 CURRICULAR MANAGEMENT

The faculty of a medical school entrust authority and responsibility for the medical education program to a duly constituted faculty body, commonly called a curriculum committee. This committee and its subcommittees or other structures that achieve the same functionality, oversee the curriculum as a whole and have responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum.

- 8.1 a There is a duly constituted faculty body (commonly called the curriculum committee) that has authority and responsibility for the medical education program.
- 8.1 b The membership of the 'curriculum committee' includes faculty, students, educational leaders and administrative staff.
- 8.1 c The 'curriculum committee' and its subcommittees or other structures that achieve the same functionality, oversee the curriculum as a whole and have responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum as articulated in the terms of reference of these committees.
- 8.1 d The committees or groups that implement and deliver the curriculum (e.g., directors of required learning experiences, chairs of committees for years or segments or themes of the curriculum) operate under the authority of the 'curriculum committee' and its subcommittee (i.e., there are reporting lines of these operational committees/groups to the 'curriculum committee').
- 8.1 e The minutes of the 'curriculum committee' provided in the DCI from the last two years show that the 'curriculum committee' has overseen the curriculum as a whole and has demonstrated its responsibility by reviewing and approving any changes to the medical education program objectives and the learning objectives of required learning experiences; changes to the design of the program; ensuring that curriculum content is coordinated and integrated within and across academic years; monitoring the overall quality and effectiveness of all required learning experiences, and the curriculum as a whole; and ensuring that identified deficiencies are addressed (i.e. quality improvement).
- 8.1 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There is a duly constituted faculty body, the Undergraduate Medical Education Committee (UMEC) that has delegated authority and responsibility for the medical education program from the Strategic Education Council. UMEC is chaired by the associate dean, undergraduate medical education.
- b. The membership of the Undergraduate Medical Education Committee includes faculty, department chairs, education leaders, students and administrative staff.

- c. The Undergraduate Medical Education Committee and its subcommittees Pre-clerkship, Clerkship and Student Evaluation Committees, oversee the curriculum as a whole and have responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum as articulated in the terms of reference of these committees (Core Appendix C-40).
- d. Directors of the course and clerkship committees that implement and deliver the curriculum report to the Pre-Clerkship and Clerkship committees respectively. These committees report to the Undergraduate Medical Education Committee and the assistant deans (chairs of Pre-Clerkship and Clerkship) serve on the Undergraduate Medical Education Committee. The leads for segments or themes within the curriculum report to either or both of the Pre-Clerkship and Clerkship Committees and subsequently through to the Undergraduate Medical Education Committee.
- e. Review of Undergraduate Medical Education Committee minutes from the past two academic years and discussion during the onsite visit affirms that UMEC has overseen the curriculum as a whole and has demonstrated its responsibility by: reviewing and approving any changes to the medical education program objectives, the learning objectives of required learning experiences and changes to the design of the program; ensuring that curriculum content is coordinated and integrated within and across academic years; monitoring the overall quality and effectiveness of all required learning experiences and the curriculum as a whole. There is evidence documenting a quality improvement lens with iterative planning in the DCI and MSS ensuring that identified deficiencies are addressed.
- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

8.2 USE OF MEDICAL EDUCATIONAL PROGRAM OBJECTIVES

The faculty of a medical school, through the curriculum committee, ensure that the formally adopted medical education program objectives are used to guide the selection of curriculum content, to review and revise the curriculum, and to establish the basis for evaluating program effectiveness. The learning objectives of each required learning experience are linked to the medical education program objectives.

- 8.2 a The 'curriculum committee' ensures the medical education program objectives are used to select curriculum content and determine its placement in required learning experiences throughout the educational program.
- 8.2 b The 'curriculum committee' ensures that the medical education program objectives are used to evaluate the effectiveness of curriculum.
- 8.2 c Directors of required learning experiences and other educational leaders contribute to the development of the linkage between the learning objectives and the medical education program objectives. The 'curriculum committee' has the overall responsibility to ensure that the medical education program objectives are appropriately linked to the learning objectives of all of the required learning experiences so that the medical education program objectives can be achieved.
- 8.2 d There is appropriate linkage between the medical education program objectives and the learning objectives of required learning experiences.
- 8.2 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The Undergraduate Medical Education Committee ensures the "Big 10" medical education program objectives are used to select curriculum content and determine its placement in required learning experiences throughout the educational program.
- b. The Undergraduate Medical Education Committee ensures that the medical education program objectives are used to evaluate the effectiveness of curriculum.
- c. Directors of required learning experiences and other educational leaders contribute to the development of the linkage between the learning objectives and the medical education program objectives. The Undergraduate Medical Education Committee has the overall responsibility to ensure that the medical education program objectives are appropriately linked to the learning objectives of all of the required learning experiences so that the medical education program objectives can be achieved.
- d. There is appropriate linkage between the program objectives and the objectives of required learning experiences (Core Appendix C-41). The ISA described a lack of linkage, and the variable awareness by the students of the program objectives and the relationship to course objectives is a weakness. This has been addressed by the school over the past two years in a number of ways (see Element Rating 6.1 this report). Discussion with students in years 1 and 2 at the time of the visit indicates this is no

longer a concern.

- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

8.3 CURRICULAR DESIGN, REVIEW, REVISION/CONTENT MONITORING

The faculty of a medical school are responsible for the detailed development, design, and implementation of all components of the medical education program, including the medical education program objectives, the learning objectives for each required learning experience, and instructional and assessment methods appropriate for the achievement of those objectives.

The curriculum committee oversees content and content sequencing, ongoing review and updating of content, and evaluation of required learning experiences, and teacher quality.

The medical education program objectives, learning objectives, content, and instructional and assessment methods are subject to ongoing monitoring, review, and revision by the curriculum committee to ensure that the curriculum functions effectively as a whole such that medical students achieve the medical education program objectives.

- 8.3 a The directors of required learning experiences, teaching faculty and other educational leaders develop and review the objectives for required learning experiences and the ‘curriculum committee’ reviews, revises as needed, and approves the final versions.
- 8.3 b The directors of required learning experiences, teaching faculty and other educational leaders identify the content for required learning experiences and the ‘curriculum committee’ reviews, revises as needed and approves the final versions.
- 8.3 c The directors of required learning experiences, teaching faculty and other educational leaders identify teaching and assessment methods that are appropriate for the learning objectives and the ‘curriculum committee’ reviews, revises as needed and approves the final methods.
- 8.3 d The quality of teaching of individual faculty members is evaluated and the data provided to him or her to improve their teaching. The data are also reviewed by others as needed to ensure assistance is provided for program improvement purposes. The ‘curriculum committee’ ensures the process occurs and reviews aggregated teaching assessment data as part of program evaluation.
- 8.3 e The overall quality and outcomes of required learning experiences are reviewed by the directors of each required learning experience and others with responsibility for the educational program and steps are taken to address areas in need of improvement. The ‘curriculum committee’ reviews the data and ensures program improvement occurs.
- 8.3 f The formal reviews noted in 8.3.a - 8.3.d of all required learning experiences, and the curriculum as a whole, occur on a regular basis.
- 8.3 g The reviews of required learning experiences are thorough and useful in identifying areas of strength and areas in need of improvement
- 8.3 h Curricular content is monitored on a regular basis to identify gaps and unwanted redundancies. The ‘curriculum committee’ ensures that the process occurs and that gaps and unwanted redundancies in content areas are addressed.
- 8.3 i Teaching faculty can directly access information on the content of the curriculum as a whole and for specific required learning experiences, or the information can be provided to them in a timely manner.

- 8.3 j The system used for curricular mapping is effective in identifying where in the curriculum, and to what extent, topics are addressed.
- 8.3 k Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a.-c. The directors for required learning experiences along with teaching faculty and other dedicated educators develop and review learning objectives and identify the content, teaching, and assessment methods that are appropriate for the learning objectives for the required learning experiences. The Undergraduate Medical Education Committee reviews, revises as needed and approves the final versions.
- d. The quality of teaching of individual faculty members is evaluated and the data provided to him or her to improve their teaching. The data are also reviewed by others as needed to ensure assistance is provided for program improvement purposes. The Undergraduate Medical Education Committee ensures the process occurs and reviews aggregated teaching assessment data as part of program evaluation.
- e. The overall quality and outcomes of required learning experiences are reviewed by all of the course/rotation directors, the Student Evaluation Committee and others with responsibility for the educational program and steps are taken to address areas in need of improvement. The Undergraduate Medical Education Committee reviews the data and ensures program improvement occurs with examples provided in the DCI and during discussion at the time of the visit.
- f. The formal reviews noted in 8.3.a - 8.3.d of all required learning experiences occurs on a regular basis and reviewed annually by the Undergraduate Medical Education Committee (Supplemental Appendices S-4 and S-5). The curriculum as a whole is reviewed on a periodic basis with the last full review in 2009. In the interim, task specific reviews of the whole curriculum have been undertaken (DCI 8.3). The next review of the whole curriculum targeting the balance and weighting of pre-clinical and clinical learning is under discussion for late 2016.
- g. The reviews of required learning experiences are thorough and useful in identifying areas of strength and areas in need of improvement.
- h. Curricular content is monitored on a regular basis to identify gaps and unwanted redundancies. The Undergraduate Medical Education Committee ensures that the process occurs and that gaps and unwanted redundancies in content areas are addressed. One illustrative example supporting effective process is the introduction of the Family Medicine Clinical Experience (MDCN 330 for Class of 2013/MDCN 430 for the Class of 2015) increasing the percentage of graduates matched to Family Medicine from ~20% to ~50% for the Class of 2015.
- i. Teaching faculty can directly access information on the content of the curriculum as a whole and for specific required learning experiences, or if needed, the information can be provided to them in a timely manner.
- j. The ISA identified a lack of curriculum mapping and linkage to learning objectives as a program weakness. Based on this student feedback the learning management system (OSLER) curriculum search function has undergone significant improvements. Discussions with faculty and students in years 1 and 2 at the time of the visit indicate this is no longer a concern.
- k. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

8.4 PROGRAM EVALUATION

A medical school collects and uses a variety of outcome data, including national norms of accomplishment, to demonstrate the extent to which medical students are achieving the medical education program objectives and to enhance the quality of the medical education program. These data are collected during program enrollment and after program completion.

- 8.4 a The medical school 'curriculum committee' uses all of the outcome measures listed in Table 8.4-1 to evaluate the extent to which medical students are achieving the medical education program objectives.
- 8.4 b The outcome measures listed in Table 8.4-1 of the DCI are reviewed by the 'curriculum committee' on an annual basis and appropriate steps are taken to improve the quality of the medical education program.
- 8.4 c Medical students' performance on the LMCCQE Part 1 and Part 2 exams at each campus is within the national mean for Canadian first-time test takers for the last three academic years.
- 8.4 d AAMC CGQ and AFMC GQ data provided in the DCI for this element show that the majority of respondents agree/strongly agree that they have developed the clinical skills required to begin a residency program.
- 8.4 e Relevant outcome measures are used by the medical school/'curriculum committee' to evaluate the extent to which the medical education program objectives, in the domains of knowledge, skills and behaviours, are being met.
- 8.4 f Since the time of the last full survey, the medical school 'curriculum committee' has taken appropriate steps to address gaps between desired and actual outcomes when medical students'/graduates' performance is suboptimal in one or more medical education program objectives.
- 8.4 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school uses all but 'practice setting types' of the outcome measures listed in Table 8.4-1 (Core Appendix C-42) and has done so for well over a decade. These outcomes are used to evaluate the extent to which medical students are achieving the medical education program objectives.
- b. The outcome measures listed in Table 8.4-1 (Core Appendix C-42) are reviewed by the Undergraduate Medical Education Committee on an annual basis and appropriate steps are taken to improve the quality of the medical education program.
- c. Medical students' performance on the LMCCQE Part 1 (Core Appendix C-43) and Part 2 (Core Appendix C-44) exams is within the national mean for Canadian first-time test takers for the last three academic years (Core Appendix C-43).
- d. AAMC CGQ and AFMC GQ data provided show that the majority of the respondents (92-93%)

agree/strongly agree that they have developed the clinical skills required to begin a residency program (Core Appendix C-45) and rated the quality of their medical education as good/very good/excellent (Core Appendix C-46).

- e. The Undergraduate Medical Education Committee uses relevant outcome measures to evaluate the extent to which the medical education program objectives, in the domains of knowledge, skills and behaviours, are being met.
- f. Since the the last full survey in 2008, the Undergraduate Medical Education Committee has taken appropriate steps to address gaps between desired and actual outcomes or when program evaluation data of performance is suboptimal in one or more medical education program objectives. Review of submitted policies, minutes, and the ISA support a culture of reflection and renewal.
- g. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

8.5 USE OF STUDENT EVALUATION DATA IN PROGRAM IMPROVEMENT

In evaluating medical education program quality, a medical school has formal processes in place to collect and consider medical student evaluations of their required learning experiences, teachers, and other relevant aspects of the medical education program.

- 8.5 a Medical student evaluation data of all required learning experiences are systematically collected by the medical school.
- 8.5 b The participation rate of medical students in responding to the evaluation form for required learning experiences is sufficient to provide reliable data for program evaluation purposes.
- 8.5 c The ‘curriculum committee’ (or its subcommittee) uses evaluation data to identify problem areas related to required learning experiences or to curriculum structure and/or delivery and takes effective steps to address these identified problems.
- 8.5 d The evaluation summary data for required learning experiences show that the majority of medical students provide feedback and that problems and strengths are identified that can be used for program improvement.
- 8.5 e Medical students’ evaluation data on individual faculty, residents, and others who teach and supervise them in required learning experiences, are collected by the medical school.
- 8.5 f The evaluation data described in 8.5.e. provided by medical students are used to improve the teaching of faculty, residents and others who teach and supervise medical students in required learning experiences.
- 8.5 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Medical student evaluation data of all required learning experiences is systematically collected by the medical school at the end of each course/clerkship rotation and at the end of each academic year.
- b. The participation rate of medical students in responding to the evaluation for required learning experiences is sufficient to provide reliable data for program evaluation purposes. The participation rate for the 2014-15 academic year averaged 71% year 1, 76% year 2 and 51% for the Class of 2015 year 3 students. The AAMC GQ response rate for the Class of 2015 was 80%. The ISA survey was combined with the 2014-15 end-of-academic year surveys for the Classes of 2016 and 2017 (response rates of 91% and 100% respectively).
- c. The Undergraduate Medical Education Committee and the Pre-Clerkship and Clerkship committees uses evaluation data to identify problem areas related to required learning experiences or to curriculum structure and/or delivery and takes effective steps to address these identified problems. This was well documented in the minutes and documents provided.
- d. The evaluation summary data for required learning experiences show that the majority of medical students provide constructive quantitative and qualitative feedback, and that problems and strengths are identified that can be used for program improvement.
- e. Medical students' evaluation data on individual faculty, residents, and others who teach and supervise them in required learning experiences, are collected by the medical school.
- f. The evaluation data described in 8.5.e. provided by medical students are used to improve the teaching of faculty, residents and others who teach and supervise medical students in required learning experiences. Discussion with department heads, faculty and students corroborates that effective processes are in place to address any identified deficiencies in teaching.
- g. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. This was an area of noncompliance at the time of the last full accreditation visit.

8.6 MONITORING OF COMPLETION OF REQUIRED CLINICAL LEARNING EXPERIENCES

A medical school has in place a system with central oversight that monitors, remedies any gaps, and ensures completion of the required patient encounters, clinical conditions, skills and procedures to be performed by all medical students.

- 8.6 a Virtually every student completed (either with real or alternative experiences) all of the required patient encounters and clinical procedures by the time of graduation at each campus over the last three academic years.
- 8.6 b At least 80% of medical students complete the required patient encounters and clinical procedures with real patients at each campus over the last three academic years.
- 8.6 c Standardized patients, simulations, or virtual patients are used to remediate identified gaps in medical students' completion of the required patient encounters and procedures.
- 8.6 d The medical school uses an effective system for students to log their required patient encounters and procedures that can be monitored in real time.
- 8.6 e The completion of the required patient encounters and procedures of each medical student is monitored during all required clinical learning experiences. These data are discussed with the student at the mid-point of a required clinical learning experience by the student's preceptor, director of the required clinical learning experience, site director or designated faculty member. The student's clinical experience is appropriately altered if needed to optimize completion of the required patient encounters and procedures.
- 8.6 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Over the last three academic years every student completed (either with real or alternative experiences) all 78 required "must see" clinical presentations and the ~30 clinical procedures by the time of graduation. All required patient encounters and procedural skills were met by 100% of students (Core Appendix C-47).
- b. At least 80% of medical students completed the required clinical presentations and procedures on real patients over the last three academic years (Core Appendix C-48 and Supplemental Appendix S-6).
- c. All must-see clinical presentations and procedures are also encountered during Course 8 (MDCN520 Comprehensive Clinical Skills Course for Clerkship) as virtual patient cases (~50), standardized patient cases or simulated cases and are used as a means to ensure completion and/or remediation.
- d. The medical school uses an effective system for students to log their required patient encounters and procedures that can be monitored in real time.
- e. The completion of the required patient encounters and procedures of each medical student are monitored during all required clinical learning experiences. The data are discussed with the student at the mid-point of each rotation by the student's preceptor, clerkship director, evaluation coordinator or

designated faculty member. The student's clinical experience is appropriately altered if needed to optimize completion of the required patient encounters and procedures.

- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site visit confirm that the requirements listed above are being met by the medical school. This was an area of compliance with monitoring during follow up of the last full accreditation visit.

8.7 COMPARABILITY OF EDUCATION/ASSESSMENT

A medical school ensures that the medical curriculum includes comparable educational experiences and equivalent methods of assessment across all locations within a given required learning experience to ensure that all medical students achieve the same learning objectives.

- 8.7 a The overview data for Standard 6 Tables 6.0-1 through 6.0-3 and DCI Tables 9.4-2 through 9.4-5 show that medical curriculum includes comparable/similar educational experiences and equivalent/same methods of assessment across all locations within a given required learning experience.
- 8.7 b The faculty at each instructional site at each campus are informed of, and oriented to the learning objectives, required patient encounters and procedural skills (when relevant) and assessment methods for the required learning experience in which they participate.
- 8.7 c Faculty members with responsibility for each required learning experience at each instructional sites communicate with each other regarding planning and implementation of the educational experience, student assessment, and evaluation of the required learning experience to ensure that educational experiences are comparable and methods of assessment are equivalent.
- 8.7 d There are mechanisms for the review and dissemination of student evaluations of their educational experience, data regarding students' completion of required patient encounters and procedural skills (when relevant), and student performance data, and any other information reflecting the comparability of learning experiences across instructional sites.
- 8.7 e The 'curriculum committee' (or its subcommittee) reviews the data described in 8.7.d and takes steps when needed to address lack of comparability in the educational experience identified in the data.
- 8.7 f The strategies used by the medical school to address inconsistencies across instructional sites that were identified in student satisfaction data and/or student performance data are appropriate and likely to address identified problems.
- 8.7 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Tables 6.0-1 through 6.0-3 (DCI Standard 6 overview data) and Tables 9.4-2 through 9.4-5 (Core Appendices C-52 to C-54) show that the medical curriculum includes comparable educational experiences and equivalent methods of assessment across all locations within a given required learning experience.
- b. The faculty at each instructional site are informed of, and oriented to the learning objectives, required patient encounters and procedural skills and assessment methods for the required learning experience in which they participate.
- c. Faculty members with responsibility for each required learning experience at all instructional sites

communicate with each other regarding planning and implementation of the educational experience, student assessment, and evaluation of the required learning experience to ensure that educational experiences are comparable and methods of assessment are equivalent.

- d. There are mechanisms for the review and dissemination of student evaluations of their educational experience, data regarding students' completion of required clinical presentations and procedural skills, and student performance data, and any other information that reflect the comparability of learning experiences across clerkship instructional sites.
- e. The assistant dean Clerkship and the Clerkship Committee review the data described in 8.7d. and take steps when needed to address lack of comparability in the educational experience identified in the data.
- f. The strategies used by the medical school to address inconsistencies across instructional sites identified in student satisfaction data and/or student performance data are appropriate and address identified problems.
- g. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

8.8 MONITORING TIME SPENT IN EDUCATIONAL AND CLINICAL ACTIVITIES

The curriculum committee and the program's administration and leadership implement effective policies and procedures regarding the amount of time medical students spend in required activities, including the total number of hours medical students are required to spend in clinical and educational activities during required clinical learning experiences.

- 8.8 a There is a policy or equivalent document(s) related to the amount of time per week that students spend in required learning activities including required activities assigned to be completed outside of scheduled class time during the first two years of the curriculum.
- 8.8 b This policy was approved by the 'curriculum committee' and is disseminated to students, faculty, residents and others involved in required learning experiences in the first two years of the curriculum.
- 8.8 c The 'curriculum committee' (or its subcommittee) monitors the spent in educational activities of medical students and the time available for study in the first two years of the program on a regular basis.
- 8.8 d There are mechanisms for students to report violations of the policy described in 8.8.a. and steps are taken to rectify identified problems.
- 8.8 e There is a policy or equivalent document related to the time students spend in educational and clinical activities during required clinical learning experiences, including on-call requirements.
- 8.8 f The policy described in 8.8.e. was developed by appropriate faculty members, approved by the 'curriculum committee' and disseminated to students, faculty, residents and others involved in required clinical learning experiences.
- 8.8 g The 'curriculum committee' (or its subcommittee) monitors the effective application of the policies for required clinical learning experiences on a regular basis.
- 8.8 h There are mechanisms for students to report violations of the policy described in 8.8.e., and steps are taken to rectify identified problems.
- 8.8 i Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The Pre-Clerkship - Required Learning Activities policy relates to the amount of time per week that students spend in required learning activities including required activities assigned to be completed outside of scheduled class time during the first two years of the curriculum.
- b. The policy was approved by the Undergraduate Medical Education Committee and is disseminated to students, faculty, residents and others involved in required learning experiences in the first two years of the curriculum.

- c. The assistant dean pre-clerkship and the Pre-clerkship Committee monitors the time spent in educational activities of medical students and the time available for study in the first two years of the program on a regular basis.
- d. There are mechanisms for students to report violations of the policy and steps have been taken to rectify identified problems. The ISA identified independent study time as an area of challenge. In 2015, the Undergraduate Medical Education Committee approved 3 personal flex days per year for each student. The 2014 Less is More Taskforce reviewed the year 1 and 2 curriculum to identify unintentional redundancies. Discussions with the year 1 and 2 students at the time of the visit indicates improvement. Over the last academic year there was 28% of independent study time.
- e. The Clerkship Work Hours policy relates to the time students spend in educational and clinical activities during required clinical learning experiences, including on-call requirements.
- f. The policy described in 8.8.e. was developed by appropriate faculty members, approved by the Undergraduate Medical Education Committee and is disseminated to students, faculty, residents and others involved in required clinical learning experiences.
- g. The assistant dean, clerkship and the Clerkship Committee monitor the application of this policy on a regular basis.
- h. There are mechanisms for students to report violations of clerkship work hours on the anonymous end-of-rotation surveys. The assistant dean, clerkship meets regularly with the clerkship rotation directors. Steps have been taken to address issues identified on the surveys for the Pediatric, Internal Medicine and Surgery rotations in 2014-15. The most recent evaluation data provided by the school for the current academic year and discussion with the clerkship rotation directors and students indicates improvement.
- i. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

STANDARD 9
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 9: TEACHING, SUPERVISION, ASSESSMENT, AND STUDENT AND PATIENT SAFETY

A medical school ensures that its medical education program includes a comprehensive, fair, and uniform system of formative and summative medical student assessment and protects medical students' and patients' safety by ensuring that all persons who teach, supervise, and/or assess medical students are adequately prepared for those responsibilities.

Survey Team
Standard 9 Element Rating Table

Standard 9	Teaching, Supervision, Assessment and Student and Patient Safety
Element	
9.1	Preparation of Resident and non-Faculty Instructors
9.2	Faculty Appointments
9.3	Clinical Supervision of Medical Students
9.4	Assessment System
9.5	Narrative Assessment
9.6	Setting Standards of Achievement
9.7	Timely Formative Assessment and Feedback
9.8	Fair and Timely Summative Assessment
9.9	Single Standard for Promotion/Graduation and Appeal Process

Standard 9 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 9 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 9 Teaching, Supervision, Assessment, and Student and Patient Safety
SM	9.4 Assessment System
	Finding: The 2015 GQ data revealed a small majority of students indicated they were observed performing a history and physical during the Surgery clerkship. There has been improvement on the Class of 2016 mid-year, end-of-rotation evaluations.
SM	9.7 Timely Formative Assessment and Feedback
	Finding: Surveys (GQ, ISA and end-of-rotation) indicate that students were not consistently receiving formal mid-rotation feedback in the Surgery clerkship. Strategies to improve this were implemented in 2015.

9.1 PREPARATION OF RESIDENT AND NON-FACULTY INSTRUCTORS

In a medical school, residents, graduate students, postdoctoral fellows, and other non-faculty instructors who supervise, teach or assess medical students are familiar with the learning objectives of the required learning experience in which they participate and are prepared for their roles in teaching and assessment. The medical school provides resources to enhance and improve residents' teaching and assessment skills, with central monitoring of their participation in those opportunities provided.

- 9.1 a The learning objectives and the methods of assessment of the required learning experience are explained to residents, graduate students, postdoctoral fellows and other non-faculty instructors who supervise, teach or assess medical students before engaging in teaching and assessment activities at all instructional sites.
- 9.1 b Residents at all instructional sites participate in centrally or departmentally delivered faculty development activities to enhance their skills in teaching and assessing medical students.
- 9.1 c The faculty development activities noted in 9.1.b. are mandatory for residents who supervise, teach or assess medical students and attendance is centrally monitored.
- 9.1 d Residents' teaching of medical students is evaluated at all instructional sites by medical students or faculty members, and support is provided to improve residents' teaching when deficiencies are identified.
- 9.1 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The learning objectives and the methods of assessment of the required learning experience are explained to residents, graduate students, postdoctoral fellows and other non-faculty instructors who supervise, teach or assess medical students before engaging in teaching and assessment activities at all instructional sites (Core Appendix C-49). Consultations onsite confirmed that course and rotation directors discuss the learning objectives and methods of assessment for the courses and rotations, which are also readily accessible on the preceptor resources webpage.
- b. Residents at all instructional sites participate in centrally delivered faculty development activities to enhance their skills in teaching and assessing medical students (Core Appendix C-50). The Surgery department's "How to be a good clinical teacher" is mandatory for all PGY1s in a surgical program.
- c. The faculty development activities noted above are mandatory for residents who supervise, teach or assess medical students and attendance is centrally monitored by the PGME office (Core Appendix C-50).
- d. Residents' teaching of medical students is evaluated at all instructional sites by medical students or faculty members, and support is provided to improve residents' teaching when deficiencies are identified.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site visit confirm that the requirements listed above are being met by the medical school.

9.2 FACULTY APPOINTMENTS

A medical school ensures that supervision of medical students is provided throughout required clinical learning experiences by members of the medical school's faculty.

- 9.2 a The medical school has a policy requiring physicians who supervise, teach and assess medical students in required clinical learning experiences to have a faculty appointment in the medical school.
- 9.2 b All physicians who supervise, teach and assess medical students in a required clinical learning experience at all instructional sites have a faculty appointment in the medical school.
- 9.2 c Where direct teaching of students in a required clinical learning experience is carried out by individuals (physicians) who do not hold a faculty appointment, the teaching activities provided by these individuals are overseen by physicians who hold a faculty appointment. The faculty member ensures that the teaching is aligned with the learning objectives, is of good quality, and the learning environment is appropriate.
- 9.2 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has a policy that requires physicians supervising, teaching and assessing medical students in required clinical learning experiences to have a faculty appointment in the medical school.
- b. The DCI showed that all physicians who supervise, teach and assess medical students in clerkship rotations at all instructional sites have a faculty appointment in the medical school; this was confirmed in discussion with the senior leadership.
- c. Where direct teaching of students in a required clinical learning experience is carried out by individuals (physicians) who do not hold a faculty appointment, the teaching activities provided by these individuals are overseen by physicians who hold a faculty appointment. The faculty member ensures that the teaching is aligned with the learning objectives, is of good quality, and the learning environment is appropriate.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. This was an area of noncompliance at the time of the last full accreditation visit.

9.3 CLINICAL SUPERVISION OF MEDICAL STUDENTS

A medical school ensures that medical students in clinical learning situations involving patient care are appropriately supervised at all times in order to ensure patient and student safety, that the level of responsibility delegated to the student is appropriate to his or her level of training, and that the delegated activities supervised by the health professional are within his or her scope of practice.

- 9.3 a The medical school central administration and the departments ensure that medical students in clinical learning situations involving patient care are appropriately supervised at all times to ensure patient and student safety.
- 9.3 b The medical school has policies or guidelines related to medical student supervision during clinical learning experiences involving patient care that ensure student and patient safety.
- 9.3 c There are mechanisms by which medical students can express concern about the adequacy and availability of supervision. The concerns raised by medical students are acted upon.
- 9.3 d The medical school ensures that the level of responsibility delegated to a medical student is appropriate to the student's level of training and experience.
- 9.3 e The activities delegated to a student and supervised by a health professional, who is not a physician, are within the scope of practice of that health care professional.
- 9.3 f AAMC CGQ data show that the majority of respondents at each campus agree/strongly agree that they were appropriately supervised and were given an appropriate level of responsibility.
- 9.3 g AFMC GQ data show that the majority of respondents at each campus agree/strongly agree that 1) the level of supervision a) ensured their safety, and b) ensured the safety of the patients for whom they provided care and 2) that they were given appropriate responsibility for patient care.
- 9.3 h Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school central administration and the departments ensure that medical students in clinical learning situations involving patient care are appropriately supervised at all times to ensure patient and student safety.
- b. The Medical Student Safety policy related to medical student supervision during clinical learning experiences involving patient care explicitly speaks to and ensures student and patient safety.
- c. There are mechanisms by which medical students can express concern about the adequacy and availability of supervision through anonymous end-of-course and end-of-year surveys or through direct reporting to a number of faculty leaders. The rare concerns raised by medical students are acted upon promptly and effectively.
- d. The medical school ensures that the level of responsibility delegated to a medical student is appropriate to the student's level of training and experience.

- e. The activities delegated to a student and supervised by a health professional, for example a nurse practitioner, are within the scope of practice of that health care professional, with ultimate responsibility for supervision remaining with the physician faculty member.
- f. The AAMC CGQ data (DCI Table 9.3-1) show that the majority of respondents agree/strongly agree that they were appropriately supervised (87-99%) and were given an appropriate level of responsibility (79-97%) during the mandatory clinical learning experiences in the last academic year.
- g. The AFMC GQ data (DCI Table 9.3-2) show that the majority of respondents agree/strongly agree that 1) the level of supervision a) ensured their safety (90-97%), and b) ensured the safety of the patients for whom they provided care (88-96%) and 2) that they were given appropriate responsibility for patient care (82-95%).
- h. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

9.4 ASSESSMENT SYSTEM

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.

- 9.4 a The medical school has a centralized system in place that monitors student achievement of the medical education program objectives including core clinical skills throughout the duration of the MD program at all instructional sites.
- 9.4 b Student achievement of the learning objectives of each required learning experience and of the medical education program as a whole is systematically assessed using a variety of measures (including direct observation).
- 9.4 c Appropriate methods specifically designed to assess medical students' acquisition of, knowledge, core clinical skills, behaviours and attitudes, are used in relevant required learning experiences.
- 9.4 d There is comprehensive assessment of students' clinical skills (e.g., OSCE or standardized patient assessment) at appropriate points in the program.
- 9.4 e The 'curriculum committee' (or other relevant governance body) sets the standard of achievement (i.e., establishing the grading policy for all required learning experiences and graduation).
- 9.4 f The assessment system ensures that only competent students advance, and remediation plans are developed and monitored to ensure that identified deficiencies are effectively addressed.
- 9.4 g There is central oversight of the process used to set the exam schedule particularly in the early years of the program.
- 9.4 h AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus agree/strongly agree that they were observed by a faculty member or resident taking a history and received feedback in each required clinical learning experience, OR medical school administrative data show that medical students at each campus were observed taking a history in each required clinical learning experience by a faculty member or resident and received feedback.
- 9.4 i AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus agree/strongly agree that they were observed by a faculty member or resident performing a physical examination and received feedback, OR medical school administrative data show that medical students at each campus were observed performing a physical examination in each required clinical learning experience and received feedback.

- 9.4 j Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☐ Satisfactory
☒ Satisfactory with a need for monitoring
☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <p>a. The medical school has a centralized system in place that monitors student achievement of the medical education program objectives including core clinical skills throughout the duration of the MD program at all instructional sites.</p> <p>b. Student achievement of the learning objectives of each required learning experience and of the medical education program as a whole is systematically assessed using a variety of measures (including direct observation).</p> <p>c. Appropriate methods specifically designed to assess medical students' acquisition of, knowledge, core clinical skills, behaviours and attitudes, are used in relevant required learning experiences (Core Appendix C-51 to C-54).</p> <p>d. There is comprehensive assessment of students' clinical skills (e.g., OSCE in year 1, year 2 and year 3; standardized patient assessments during all encounters for Clinical Skills and the academic half day back in Courses 1-8) (Core Appendix C-52 to C-54).</p> <p>e. The Student Evaluation Committee, overseen by and reporting to the Undergraduate Medical Education Committee, sets the standard of achievement (i.e., establishing the grading policy for all required learning experiences). Progression and graduation of students fall under the purview of the Student Academic Review Committee.</p> <p>f. The assessment system ensures that only competent students advance, and remediation plans are developed and monitored to ensure that identified deficiencies are effectively addressed.</p> <p>g. There is central oversight of the process to set the exam schedule, which is approved by the Undergraduate Medical Education Committee annually.</p> <p>h. AAMC CGQ and AFMC GQ data show that the majority of respondents agree/strongly agree that they were observed by a faculty member or resident taking a history in each required clinical learning experience (59-93% with the 2015 GQ data revealing: Surgery 59%; Emergency Medicine 64% and Internal Medicine 67%; Core Appendix C-51). There has been improvement on the Class of 2016 mid-year, end-of-rotation evaluations October 2015 with the inclusion of the question "staff critiqued your history taking skills": Surgery 84%; Emergency Medicine 100%; and Internal Medicine 82% (DCI Table 9.4-1a).</p> <p>i. AAMC CGQ and AFMC GQ data show that the majority of respondents agree/strongly agree that they were observed by a faculty member or resident performing a physical examination (68-94%) in each required clinical learning experience (Core Appendix C-51). The 2015 GQ data show that 68% students indicated they were observed performing a physical during the Surgery clerkship. The Class of 2016 mid-year, end-of-rotation evaluations in October 2015 show that 68% of students agree/strongly agree that "staff critiqued your physical exam skills" (DCI Table 9.4-1a).</p> <p>j. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school and require monitoring.</p> |
|---|

9.5 NARRATIVE ASSESSMENT

A medical school ensures that a narrative description of a medical student's performance, including his or her non-cognitive achievement, is included as a component of the assessment in each required learning experience in the medical education program whenever teacher-student interaction permits this form of assessment.

- 9.5 a A narrative description of a medical student's performance, including his or her non-cognitive achievement is included as a component of the assessment in all required learning experiences of four weeks duration or greater with small group, or 1:1 learning activities for which there is a summative performance assessment by the tutor/preceptor.
- 9.5 b Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirement listed above is being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <p>a. A narrative description of a medical student's performance, including his or her non-cognitive achievement is included as a component of the assessment in all required learning experiences of four-weeks duration or greater with small group, or 1:1 learning activities for which there is a summative performance assessment by the preceptor. The Student Evaluation: Development and Maintenance policy outlines the expectation for narrative comments by preceptors.</p> <p>b. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirement listed above is being met by the medical school. This was an area of noncompliance at the time of the last full accreditation visit.</p> |
|---|

9.6 SETTING STANDARDS OF ACHIEVEMENT

A medical school ensures that faculty members with appropriate knowledge and expertise set standards of achievement in each required learning experience in the medical education program.

- 9.6 a The medical school ensures that faculty members with appropriate knowledge and expertise set the standards of achievement for required learning experiences and for the curriculum as a whole.
- 9.6 b Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirement listed above is being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school ensures that faculty members with appropriate knowledge and expertise set the standards of achievement for required learning experiences and for the curriculum as a whole.
- b. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirement listed above is being met by the medical school.

9.7 TIMELY FORMATIVE ASSESSMENT AND FEEDBACK

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 typically 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.

- 9.7 a Formative assessment consisting of appropriate measures by which a medical student can measure his or her progress in learning is provided in all required learning experiences.
- 9.7 b Provision of formative assessment in required learning experiences is monitored.
- 9.7 c 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.
 - i. Formal feedback occurs at least at the mid-point of the learning experience or
 - ii. Formal feedback occurs approximately every six weeks for required learning experiences that are semester or year-long (e.g., longitudinal integrated clerkship).
- 9.7 d Provision of formal feedback described in 9.7.c., is monitored to ensure it occurs at all instructional sites.
- 9.7 e Alternate means are provided by which a medical student can measure his or her progress in learning in required learning experiences less than four weeks in length.
- 9.7 f AAMC CGQ data in Table 9.7-2 show that the majority of respondents at each campus agree/strongly agree that they received mid-point feedback on their performance, and AFMC GQ data in Table 9.7-2 show that the majority of respondents at each campus agree/strongly agree that they received feedback early enough in the experience to allow them to improve their performance.
- 9.7 g Evaluation data from required clinical learning experiences for the most recently completed academic year or the ISA show that the majority of respondents at each campus agree/strongly agree that they received mid-point feedback for the required learning experiences in Table 9.7-3.
- 9.7 h Administrative data or evaluation data for the last three academic years show that students in longitudinal integrated clerkships receive formal feedback approximately every six weeks at all instructional sites.
- 9.7 i Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☐ Satisfactory
- ☒ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Formative assessment by which a medical student can measure their progress in learning is provided in all required learning experiences (for example, MCQ and key feature exams, OSCEs, bell ringers in the anatomy lab (also known as peripatetic exams), the logbook and the four associate dean formative MCQs in DCI Table 9.7-1 and Core Appendix C-52 to C-54).
- b. Provision of formative assessment in required learning experiences is monitored by the Student Evaluation Committee and the Pre-clerkship and Clerkship Committees reporting to the Undergraduate Medical Education Committee.
- c. While the clerkship feedback policy explicitly states that feedback is to be provided at the end of 1-2 week experiences, at the mid-point and end of rotation for experiences longer than 2 weeks and every 6 weeks in the longitudinal integrated clerkship stream, evidence from student reports indicates feedback is not consistently provided in the surgery clerkship.
- d. Provision of formal feedback described above is monitored at all instructional sites by the course and rotation directors and the Pre-clerkship and Clerkship committees.
- e. Alternate means are provided by which a medical student can measure his or her progress in learning in required learning experiences less than four weeks in length. Daily preceptor forms are completed for the two-week mandatory clinical learning experiences.
- f. AAMC CGQ data in Table 9.7-2 (Core Appendix C-56) show that the majority of respondents (73-96%) agree/strongly agree that they received mid-point feedback on their performance, and the AFMC GQ data in Table 9.7-2 show that the majority of respondents (75-78%) agree/strongly agree that they received feedback early enough in the experience to allow them to improve their performance.
- g. Evaluation data from the end-of-rotation surveys for required clinical learning experiences for the last three academic years show less than a majority agreeing that mid-rotation feedback was provided in the Surgery clerkship: 52% 2013, 45% 2014 and 47% 2015 (DCI Table 9.7-5). However, the ISA data show that the majority of respondents (68-94%) agree/strongly agree that they received mid-point feedback for the required learning experiences, with Surgery 68% (Core Appendix C-57). The AAMC CGQ and AFMC GQ data for Surgery over the same three years is 73-78% (DCI Table 9.7-2). Strategies to improve mid-rotation feedback in the Surgery rotation were implemented in 2015 with improvement noted. As of December 2015, 70% of surgery clerkship students indicated on their end-of-rotation evaluations that they had received formal mid-rotation feedback and there were no differences across instructional sites (Student end of rotation data as of December 2015: Anesthesia 79%; Emergency Medicine 89% [both of these rotations collect daily feedback forms]; Family Medicine 95%; Internal Medicine 79%; ObGyn 97%; Pediatrics 82%; Psychiatry 94%; Surgery 70%). Discussion during the onsite visit indicates that all students on the surgery rotation now receive collated mid-rotation feedback electronically via email. The surgery clerkship rotation director will meet in person with any student for whom concerns have been raised.
- h. Administrative data for the last three academic years and on site discussion indicate that students in the longitudinal integrated clerkship receive formal feedback approximately every six weeks at all instructional sites (Core Appendix C-58).
- i. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above have recently been met by the medical school and require monitoring.

9.8 FAIR AND TIMELY SUMMATIVE ASSESSMENT

A medical school has in place a system of fair and timely summative assessment of medical student achievement in each required learning experience of the medical education program. Final grades are available within six weeks after the end of a required learning experience.

- 9.8 a All students receive their final grades no more than six weeks after the end of a required learning experience at each campus.
- 9.8 b Provision of final grades is monitored and steps are taken to meet the expected timeline.
- 9.8 c The medical school has a policy or guidelines specifying the timeline for provision of final grades for all required learning experiences.
- 9.8 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. All students receive their final grades no more than six weeks after the end of a required learning experience. The rare exceptions noted in the pre-clinical Family Medicine Clinical Experiences (16 hours in year 1 and 12 hours in year 2 with a family physician preceptor) have been rectified. Students in all year 3 mandatory clinical learning experiences receive their final grades within 4 weeks (Core Appendix C-59).
- b. Provision of final grades is monitored and steps are taken to meet the expected timeline.
- c. The Student Evaluations: Development and Maintenance policy (formerly the Student Evaluation policy) specifies the timeline for provision of final grades for all required learning experiences as less than 6 weeks.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

9.9 SINGLE STANDARD FOR PROMOTION / GRADUATION AND APPEAL PROCESS

A medical school ensures that the medical education program has a single standard for the promotion and graduation of medical students across all locations and a fair and formal process for taking any action that may affect the status of a medical student, including timely notice of the impending action, disclosure of the evidence on which the action would be based, an opportunity for the medical student to respond, and an opportunity to appeal any adverse decision related to promotion, graduation, or dismissal.

- 9.9 a The requirements for promotion (i.e., passing each required learning experience and segment of the curriculum) and graduation (i.e. completing the program as a whole) are the same at all instructional sites.
- 9.9 b A mechanism exists that ensures that the same principles are consistently applied in analyzing student performance data and making pass/fail and advancement decisions at all instructional sites.
- 9.9 c The medical school's requirements for promotion and graduation are made known to students and teaching faculty.
- 9.9 d There is a fair and formal (documented) process for taking any action that may adversely affect the status of a medical student that includes timely notice of impending action, disclosure of the evidence on which the action would be based, an opportunity for the medical student to respond, and an opportunity to appeal any adverse decision related to promotion, graduation, or dismissal in a fair and impartial hearing.
- 9.9 e A description of the process for taking any action that may adversely affect the status of a medical student, and a description of the appeals process are made known to all medical students and teaching faculty.
- 9.9 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The requirements for promotion and graduation are the same at all instructional sites.
- b. A mechanism exists that ensures that the same principles are consistently applied in analyzing student performance data and making pass/fail and advancement decisions.
- c. The medical school's requirements for promotion and graduation are made known to students and teaching faculty in the student handbook, on the policies and guidelines webpage, and as required, in meetings with the course/rotation directors and assistant deans.
- d. There is a fair and formal process outlined in the policies and terms of reference for the Student Evaluation Committee and the Student Academic Review Committee for taking any action that may adversely affect the status of a medical student that includes timely notice of impending action,

disclosure of the evidence on which the action would be based, an opportunity for the medical student to respond, and an opportunity to appeal any adverse decision related to promotion, graduation, or dismissal in a fair and impartial hearing.

- e. The description of the process for taking any action that may adversely affect the status of a medical student, and a description of the appeals process are posted on the website; and are made known to all medical students and teaching faculty in the student handbook and specifically by the course/rotation directors if/when an adverse action (e.g. failure of a course) occurs.
- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

STANDARD 10
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 10: MEDICAL STUDENT SELECTION, ASSIGNMENT, AND PROGRESS

A medical school establishes and publishes admission requirements for potential applicants to the medical education program, and uses effective policies and procedures for medical student selection, enrollment, and assignment.

Survey Team
Standard 10 Element Rating Table

Standard 10	Medical Student Selection, Assignment and Progress
Element	
10.1	Premedical Education/Required Coursework
10.2	Final Authority of Admission Committee
10.3	Policies Regarding Student Selection/Progress and their Dissemination
10.4	Characteristics of Accepted Applicants
10.5	Technical Standards
10.6	Content of Informational Materials
10.7	Transfer Student Qualifications
10.8	Transfer into the Final Year
10.9	Visiting Student Processing
10.10	Visiting Student Qualifications
10.11	Student Assignment

Standard 10 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 10 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 10 Medical Student Selection, Assignment, and Progress
--------------------------	---

10.1 PREMEDICAL EDUCATION/REQUIRED COURSEWORK

Through its requirements for admission, a medical school encourages potential applicants to the medical education program to acquire a broad undergraduate education that includes the study of the humanities, natural sciences, and social sciences, and confines its specific premedical course requirements to those deemed essential preparation for successful completion of its medical curriculum.

- 10.1 a The medical school's course requirements for admission encourage potential applicants to the medical education program to acquire a broad undergraduate education that includes the study of the humanities, natural sciences, and social sciences.
- 10.1 b The courses required for admission to the MD program are restricted to those deemed essential preparation for the successful completion of the medical education program.
- 10.1 c The courses required for admission to the medical education program were reviewed and revised, as needed, since the time of the last full survey.
- 10.1 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school does not currently have pre-requisite course requirements for admission, nor has it in the past. General recommendations are made to potential applicants that encourage a broad undergraduate education.
- b. As there are no pre-requisite course requirements, no determination has been made of courses deemed essential preparation for the successful completion of the medical education program.
- c. The school last reviewed its policy on no required courses in 2014 and analyzed whether students were disadvantaged if they entered the program with little or no traditional pre-medical education. There was no relationship between the number of premedical courses completed and academic performance.
- d. The documentation related to this element and discussions with relevant individuals at the time of the on-site visit confirmed that the requirements listed above are being met by the medical school.

10.2 FINAL AUTHORITY OF ADMISSION COMMITTEE

The final responsibility for accepting students to a medical school rests with a formally constituted admission committee. The authority and composition of the committee and the rules for its operation, including voting privileges and the definition of a quorum, are specified in bylaws or other medical school policies. Faculty members constitute the majority of voting members at all meetings. The selection of individual medical students for admission is not influenced by any political or financial factors.

- 10.2 a The authority and composition of the admissions committee (and its subcommittees if any) and its rules of operation, including voting privileges and definition of a quorum are specified in bylaws or other medical school policies.
- 10.2 b The composition of the admissions committee is appropriate, and the terms of appointment allow sufficient overlap.
- 10.2 c Faculty members constitute a majority of voting members at all meetings.
- 10.2 d Members of the admissions committee and subcommittee members, if applicable, are oriented to the admissions committee's policies and processes, and receive specific training appropriate to their role in the admissions process.
- 10.2 e The admission committee has the final authority for making decisions for entry into the MD program including admission into any combined degree programs. There have been no instances over the past three admission cycles where a decision of the admissions committee regarding the admission of a student into the MD program was challenged, overruled, or rejected.
- 10.2 f There is a policy on conflict of interest relevant to the admissions committee that ensures that conflicts of interests of committee members are identified and dealt with appropriately.
- 10.2 g The criteria used to evaluate applicants, and the process that culminates in the offer of admission, are fair, evidence-based and objective, and not influenced by political or financial factors.
- 10.2 h Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The authority and composition of the admissions committee and its rules of operation, including voting privileges and definition of a quorum are specified in bylaws in the Admissions Committee Terms of Reference.
- b. The composition of the admissions committee is appropriate, and the terms of appointment allow sufficient overlap.
- c. Faculty members constitute a majority of voting members at all meetings.

- d. Members of the admissions committee are oriented annually to the admissions committee's policies and processes, and new members meet individually with the chair and director of admissions to review current issues facing the committee. Members of the File Review Subcommittee and the Multiple Mini Interview assessors also undergo annual training appropriate to their role in the admissions process.
- e. The admission committee has the final authority for making decisions for entry into the MD program including admission into any combined degree programs. There have been no instances over the past three admission cycles where a decision of the admissions committee regarding the admission of a student into the MD program was challenged, overruled, or rejected.
- f. There is a policy on conflict of interest relevant to the admissions committee that ensures that conflicts of interests of committee members are identified and dealt with appropriately. All individuals involved in admissions sign a confidentiality and conflict of interest form annually.
- g. The criteria used to evaluate applicants, and the process that culminates in the offer of admission, are fair, evidence-based and objective, and not influenced by political or financial factors.
- h. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

10.3 POLICIES REGARDING STUDENT SELECTION / PROGRESS AND THEIR DISSEMINATION

The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, policies, and procedures regarding these matters.

- 10.3 a The faculty of the medical school developed and approved the policies, procedures, and criteria for medical student selection.
- 10.3 b The policies, procedures, and criteria for medical student selection are disseminated to potential and actual applicants and their advisors.
- 10.3 c In each of the steps in the admission process to the MD program listed below, standardized procedures are followed, and standardized criteria are used to make the relevant decision by the appropriate individuals or groups (e.g., the admission committee, admission subcommittee or interview committee).
 - i. Preliminary screening for applicants to receive a secondary/supplementary application
 - ii. Selection for the interview
 - iii. The interview
 - iv. The acceptance decision
 - v. The offer of admission
- 10.3 d In each of the steps in the admission process to any joint baccalaureate-MD program or dual degree programs (e.g., MD-PhD) listed below, standardized procedures are followed, and standardized criteria are used to make the relevant decision by the appropriate individuals or groups (e.g., the admission committee, admission subcommittee, or interview committee).
 - i. Preliminary screening for applicants to receive a secondary/supplementary application
 - ii. Selection for the interview
 - iii. The interview
 - iv. The offer of admission
- 10.3 e The authority and composition of the promotion committee (or promotion committees, if there is more than one) and its rules of operation, including voting privileges and definition of a quorum are specified in bylaws or other medical school policies.
- 10.3 f The composition of the medical student promotion committee (or promotion committees if there are more than one) is appropriate to enable the committee to make objective and informed decisions on student promotion.
- 10.3 g There are policies for the assessment, advancement (promotion) and graduation of medical students and the policies for disciplinary action that are available to medical students and teaching faculty.
- 10.3 h Decisions on the advancement of a medical student to the next academic year, phase or segment of the curriculum, and on the graduation of a medical student is made by the committee with the authority to make those decisions.

- 10.3 i Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
☐ Satisfactory with a need for monitoring
☐ Unsatisfactory

Evidence to support the above rating

- a. The faculty of the medical school developed and approved the policies, procedures, and criteria for medical student selection. These were most recently revised in 2011 following a 6-month review, resulting in the current file review scoring system, relative weighting scheme for GPA, MCAT, non-cognitive attributes, and the multiple mini interview. All changes were approved by Executive Faculty Council.
- b. The policies, procedures, and criteria for medical student selection are disseminated to potential and actual applicants and their advisors, via the website <http://www.ucalgary.ca/mdprogram/admissions>.
- c. Standardized procedures and criteria are used to make the relevant decisions by the appropriate individuals or groups concerning preliminary screening of applicants, selection for the MMI interview process, the acceptance decision, and the offer of admission.
- d. The admission process to joint baccalaureate-MD program and dual degree programs (e.g., MD-PhD) follows standardized procedures and criteria. There are no formal baccalaureate-MD programs, but two (one active, and one planned) pipeline scholarship programs include guaranteed admission to the MD program upon satisfactory completion of the undergraduate degree. The selection is based on a process that incorporates elements similar to other applicants with the exception of the MCAT exam scores and the Alternative Admissions Process. There is no separate admissions process for MD-PhD or MD-Masters students. All students interested in the dual degree option must first obtain admission to the MD program, and apply for membership in the Leaders in Medicine program, contingent upon being accepted into the PhD or other advanced degree.
- e. The authority and composition of the Student Academic Review Committee (SARC) and its rules of operation, including voting privileges and definition of a quorum, are specified in the terms of reference for the committee and the Reappraisal and Appeals of Student Evaluation policy.
- f. The composition of the Student Academic Review Committee is appropriate to enable the committee to make objective and informed decisions on student promotion.
- g. There are policies for the assessment, advancement (promotion) and graduation of medical students. The policies for disciplinary action are available to medical students and teaching faculty in the student handbook, on the policies and guidelines webpage and the preceptor resources webpage.
- h. Decisions on the advancement of a medical student to the next academic year and on the graduation of a medical student are made by the Student Academic Review Committee.
- i. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

10.4 CHARACTERISTICS OF ACCEPTED APPLICANTS

A medical school selects applicants for admission who possess the intelligence, integrity, and personal and emotional characteristics necessary for them to become competent physicians.

- 10.4 a The mean overall premedical student performance data for new first year students admitted to the medical school for the last three years provided in Table 10.0-1 of the DCI, indicate that the medical school selects applicants who possess the intelligence necessary for them to become competent physicians.
- 10.4 b The personal and emotional characteristics of applicants considered during the admission process are necessary for them to become competent physicians.
- 10.4 c The personal and emotional characteristics of applicants considered during the admission process were developed, reviewed, and approved by appropriate individuals or groups.
- 10.4 d Members of the admission committee and the individuals who interview applicants (if different than members of the admission committee) are prepared and trained to assess applicants' personal and emotional characteristics.
- 10.4 e There are standard forms used to guide and/or evaluate the results of applicant interview.
- 10.4 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|--|
| <ul style="list-style-type: none">a. The mean overall premedical student performance data for new first year students admitted to the medical school for the last three years indicate that the medical school selects applicants who possess the intelligence necessary for them to become competent physicians (Core Appendix C-60).b. The personal and emotional characteristics of applicants (explicated in the Admissions Manual including communication skills; maturity and insight; commitment to communities and advocacy on the behalf of others; intellectual curiosity, scholarship and research; and organizational, management and leadership skills) considered during the admission process are necessary for them to become competent physicians.c. The personal and emotional characteristics of applicants considered during the admission process were developed, reviewed, and approved by appropriate individuals or groups. At the level of file review, they are drawn from the CanMEDS competencies, and at the level of interviews, from the list of attributes approved by both the Admissions Committee and Faculty Council.d. Members of the Admission committee and the individuals who interview applicants are prepared and trained to assess applicants' personal and emotional characteristics. The required sessions include assessing video examples and a discussion of unconscious bias.e. There is a standard form used to evaluate the results of applicant interview.f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. |
|--|

10.5 TECHNICAL STANDARDS

A medical school develops and publishes technical standards for the admission, retention, and graduation of applicants or medical students with disabilities, in accordance with legal requirements.

- 10.5 a The medical school has technical standards for the admission, retention, and graduation of applicants and students.
- 10.5 b The medical school's technical standards noted in 10.5.a. were developed and approved by the faculty. These technical standards are reviewed and revised when needed on a regular basis.
- 10.5 c The medical school's technical standards noted in 10.5.b. are disseminated to potential and actual applicants, enrolled students and teaching faculty.
- 10.5 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has technical standards for the admission, retention, and graduation of applicants and students.
- b. The medical school's technical standards were developed and approved by the faculty in 2001 and revised in 2010. These technical standards are reviewed regularly by the Undergraduate Medicine Education Committee, most recently in 2013.
- c. The medical school's technical standards are disseminated to potential and actual applicants in the Applicant Manual, and are available to enrolled students and faculty via the medical school's website.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

10.6 CONTENT OF INFORMATIONAL MATERIALS

A medical school's calendar and other informational, advertising, and recruitment materials present a balanced and accurate representation of the mission and objectives of the medical education program, state the academic and other (e.g., immunization) requirements for the degree of Doctor of Medicine and all associated joint degree programs, provide the most recent academic schedule for each curricular option, and describe all required learning experiences in the medical education program.

- 10.6 a The medical school's calendar and other informational, advertising, and recruitment materials
- present a balanced and accurate representation of the mission and objectives of the medical education program
 - state the academic and other (e.g., immunization) requirements for the degree of Doctor of Medicine and all associated joint degree programs,
 - provide the most recent academic schedule for each curricular option, and
 - describe all required learning experiences in the medical education program.
- 10.6 b The materials noted in 10.6.a. are regularly reviewed by leadership in the medical education program to ensure they are accurate and timely.
- 10.6 c Recruitment materials about the medical education program are made available to potential and actual applicants, career advisors, and the public.
- 10.6 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|---|
| <p>a. The medical school's calendar, applicants' manual, and prospective students' website present a balanced and accurate representation of the mission and educational objectives of the medical education program. The academic and other (e.g. immunization) requirements for the Doctor of Medicine degree are stated, and the website links to information about the school's joint degree programs. The most recent academic calendar and required learning experiences are also included.</p> <p>b. The medical school calendar, admissions, and promotional materials are reviewed and revised annually by leadership in the medical education program.</p> <p>c. The Applicant Manual and recruitment materials are available for download on the medical school website. Promotional flyers are also produced and distributed.</p> <p>d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.</p> |
|---|

10.7 TRANSFER STUDENT QUALIFICATIONS

A medical school ensures that any student accepted for transfer or admission with advanced standing demonstrates academic achievements, completion of relevant prior coursework, and other relevant characteristics comparable to those of the medical students in the class that he or she would join.

- 10.7 a The medical school has policies and procedures related to transfer/admission with advanced standing that are made known to potential applicants for transfer and advanced standing and their advisors.
- 10.7 b There are procedures in place for the selection of applicants for transfer or admission with advanced standing whereby the medical school determines the comparability of the applicant's educational program and prior academic achievement to those of medical students in the class they would join.
- 10.7 c In making decisions of accepting transfer students or admitting students with advanced standing, the admission committee or other governance body with the appropriate authority and members of the medical school administrative leadership determine if space and resources are adequate.
- 10.7 d The transfer students and students admitted with advanced standing listed in Table 10.7-1 of the DCI demonstrated academic achievements, completion of relevant prior coursework, and had other characteristics comparable to the medical students in the class that they joined.
- 10.7 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Medical school policies and procedures related to transfer/admission with advanced standing are made known to potential applicants in the online document, Policies and Procedures of Clinical Clerkships. Transfer students are not accepted in the first two years, but may apply for visiting student status for all or part of the third year. Criteria for acceptance include that the student must be in their final clinical year at the school of origin, and will receive the MD degree from that institution.
- b. There are procedures in place for the selection of applicants for transfer whereby the medical school determines the comparability of the applicant's educational program and prior academic achievement to those of medical students in the class they would join.
- c. The associate dean undergraduate medical education and the Student Academic Review Committee make decisions accepting transfer students for the entire clerkship year, including the determination if space and resources are adequate.
- d. No transfer students were admitted during the last three years indicated in the DCI Table 10.7-1. The school does not accept students with advanced standing.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

10.8 TRANSFER INTO THE FINAL YEAR

A medical school accepts a transfer medical student into the final year of a medical education program only in rare and extraordinary personal or educational circumstances.

- 10.8 a Only rare and extraordinary personal or educational circumstances accounted for the decisions to accept any transfer students into the final year of the curriculum during any year since the last full survey visit.
- 10.8 b Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirement listed above is being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Only rare and extraordinary personal or educational circumstances account for decisions to accept any transfer students into the final year of the curriculum, and no students have been accepted during any year since the last full survey visit.
- b. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirement listed above is being met by the medical school.

10.9 VISITING STUDENT PROCESSING

A medical school verifies the credentials of each visiting medical student, maintains a complete roster of visiting medical students, approves each visiting medical student's assignments, provides a performance assessment for each visiting medical student, and establishes health-related protocols for such visiting medical students.

- 10.9 a The medical school verifies the academic credentials and immunization status of each visiting student.
- 10.9 b The medical school approves the assignment of a visiting student after ensuring there are adequate resources (including clinical resources) and appropriate supervision at the site for both the visiting student and any of the medical school's own students.
- 10.9 c The medical school ensures that a performance assessment is provided for each visiting student.
- 10.9 d An accurate and up-to-date roster of visiting medical students is maintained by medical school or university administrative personnel who ensure that the medical school's requirements for visiting medical students are met.
- 10.9 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school verifies the academic credentials and immunization status of each visiting student. Immunization status is confirmed using the Visiting Student Immunization Form.
- b. The medical school approves the assignment of a visiting student after ensuring there are adequate resources (including clinical resources) and appropriate supervision at the site for both the visiting student and any of the medical school's own students.
- c. The medical school ensures that a performance assessment is provided for each visiting student.
- d. An accurate and up-to-date roster of visiting medical students is maintained by medical school administrative personnel who ensure that the medical school's requirements for visiting medical students are met.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

10.10 VISITING STUDENT QUALIFICATIONS

A medical school ensures that any visiting medical student demonstrates qualifications comparable to those of the medical students he or she would join in those educational experiences. This process is overseen and managed within the medical school.

- 10.10 a There are procedures and criteria used by the medical school to determine if the qualifications of potential visiting medical students are comparable to those of the medical students they would join in a clinical experience.
- 10.10 b The process of evaluating whether potential visiting students have comparable qualifications to those of the school's own students is centrally overseen and managed within the medical school.
- 10.10 c Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There are procedures and criteria used by the medical school to determine if the qualifications of potential visiting medical students are comparable to those of the medical students they would join in a clinical experience.
- b. The process of evaluating whether potential visiting students have comparable qualifications to those of the school's own students is centrally overseen and managed within the medical school by the electives program coordinator who completes a standardized checklist and the director, electives (DCI 10.10b).
- c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

10.11 STUDENT ASSIGNMENT

A medical school assumes ultimate responsibility for the selection and assignment of medical students to each location and/or parallel curriculum (i.e., alternative curricular track) and uses a centralized process to fulfill this responsibility. The medical school considers the preferences of students and uses a fair process in determining the initial placement. A process exists whereby a medical student with an appropriate rationale can request an alternative assignment when circumstances allow for it.

- 10.11 a There is a process for medical student assignment in the following circumstances that are relevant to the medical school, wherein students are informed about the assignment process; the student has the ability to select or rank options; and decisions are made using a fair process in determining the initial placement.
 - i. geographically distributed campus
 - ii. parallel curriculum site (e.g., longitudinal integrated clerkship site)
 - iii. required clinical learning experience site (e.g., a hospital)
- 10.11 b There are procedures whereby a student with an appropriate rationale can formally request an alternative assignment which are made known to medical students.
- 10.11 c There are criteria used to evaluate the request for the change taking into consideration the rationale for the request and whether circumstances can allow for the reassignment of the student.
- 10.11 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There is a process for medical student assignment in the University of Calgary Longitudinal Integrated Clerkship (UCLIC) stream and for outreach locations and rotation sites, wherein students are informed about the assignment process; the student has the ability to select or rank options; and decisions are made using a fair process in determining the initial placement.
- b. There are procedures whereby a student with an appropriate rationale can formally request an alternative assignment which are made known to medical students. The Clerkship and Pre-Clerkship Request for Different Assignment policy is available on the webpage, referenced in the student handbook and outlines acceptable and unacceptable criteria. The requests are made to the assistant dean, clerkship, the clerkship coordinator and/or the associate dean undergraduate medical education.
- c. There are criteria used to evaluate the request for the change taking into consideration the rationale for the request and whether circumstances can allow for the reassignment of the student. Acceptable criteria include health related issues and extenuating family circumstances.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

STANDARD 11
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 11: MEDICAL STUDENT ACADEMIC SUPPORT, CAREER ADVISING, AND EDUCATIONAL RECORDS

A medical school provides effective academic support and career advising to all medical students to assist them in achieving their career goals and the school's medical education program objectives. All medical students have the same rights and receive comparable services.

Survey Team
Standard 11 Element Rating Table

Standard 11	Medical Student Academic Support, Career Advising and Educational Records
Element	
11.1	Academic Advising
11.2	Career Advising
11.3	Oversight of Extramural Electives
11.4	Provision of the MSPR
11.5	Confidentiality of Student Educational Records
11.6	Student Access to Educational Records

Standard 11 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 11 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 11 Medical Student Academic Support, Career Advising, and Educational Records
--------------------------	--

11.1 ACADEMIC ADVISING

A medical school has an effective system of academic advising in place for medical students that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff with its counseling and tutorial services and ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or promotion decisions about them.

- 11.1 a The medical school has a system of academic advising in place for medical students (identified as needing assistance based on performance or through self-referral) that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff.
- 11.1 b There are means by which the medical school identifies students experiencing academic difficulty.
- 11.1 c Medical students can self-refer for academic counseling if they perceive the need.
- 11.1 d Medical students at each campus are informed about the availability of academic advising and how they may be identified as needing these services, or how they can access these services if they perceive the need for academic advising.
- 11.1 e Academic advising/counseling is available to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkship).
- 11.1 f The medical school ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or promotion decisions about them.
- 11.1 g The data provided in Table 11.1-4 of the DCI show that only a small percentage of first year medical students and of all medical students at each campus withdrew or were dismissed from the medical school in the last three academic years.
- 11.1 h The data provided in Table 11.1-5 of the DCI show that a small number of medical students at each campus in years 1-4 over the past two academic years:
 - i. withdrew or were dismissed
 - ii. were required to repeat the entire academic year
 - iii. were required to repeat one or more required learning experience
 - iv. moved to a decelerated curriculum
 - v. took a leave of absence as a result of academic problems
- 11.1 i The overall graduation rate and the percentage of medical students that graduated in four years at each campus is very high.
- 11.1 j AAMC CGQ and AFMC GQ data over the last three academic years show that the majority of respondents at each campus were satisfied/very satisfied with academic advising/counseling.

- 11.1 k Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with academic advising/counseling services.
- 11.1 l Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has a system of academic advising in place for medical students (identified as needing assistance based on performance or through self-referral) that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff. All examination results are reviewed by the assistant deans, pre-clerkship and clerkship and any student identified as unsatisfactory (a failing grade) must meet with the relevant assistant dean and referral to student affairs will be recommended as appropriate. Any student with more than one borderline assessment or those that a course or rotation director has concerns about may also be reviewed. Mentorship for students falls under the portfolio of the assistant dean, research and innovation.
- b. The medical school identifies students experiencing academic difficulty through formative exams and other means. Referrals will be made to the director and two associate directors, student affairs as required. Students may also access the student affairs office on their own. The Student Affairs website has links to the Student Survival Guide, the Study Buddy Program and other useful resources. There is an in-house wellness counselor available by appointment.
- c. Medical students can self-refer for academic counseling if they perceive the need.
- d. Medical students are informed about the availability of academic advising on the websites for student affairs and undergraduate medical education and in orientation and other sessions by the assistant deans, undergraduate medical education and the director and associate directors of student affairs. The student handbook outlines that student can seek counseling or advice if they perceive the need. Discussions at the time of the site visit, and explicitly stated in the Student Survival Guide, indicate that the student affairs faculty and staff are well regarded and accessible.
- e. Academic advising/counseling is available to students at the main campus through services available at the medical school as listed above or at the university (for example, the Student Union Wellness Centre). Students in the longitudinal integrated clerkship stream who are away from the medical school campus may access the same services through email, teleconference and/or visits from main campus staff or student travel back to Calgary (Core Appendix C-63).
- f. The director and two associate directors of student affairs have no role in the assessment and promotion of students.
- g. The data provided in Table 11.1-4 of the DCI (Core Appendix C-64) show that no first year medical students withdrew or were dismissed, and less than 0.2% of all medical students at each campus withdrew or were dismissed from the medical school in the last three academic years.
- h. The data provided in Table 11.1-5 of the DCI (Core Appendix C-65) show that a very small number of medical students in years 1-3 over the past two academic years withdrew or were dismissed, were required to repeat one or more required learning experience, were moved to a decelerated curriculum, or took a leave of absence as a result of academic problems. Over the past two academic years, 18 of 985 students (1.8%) were required to repeat the entire academic year.
- i. The overall graduation rate (97.6% averaged over five years), and the percentage of medical students that graduated in three years (91.3% averaged over five years) is very high (Core

Appendix C-66).

- j. AAMC CGQ and AFMC GQ data over the last three academic years (64% 2013; 71% 2014; and 77% 2015) show that the majority of respondents were satisfied/very satisfied with academic advising/counseling (Core Appendix C-61).
- k. Data from the ISA (78% Year 1; 71% Year 2; 85% Year 3) show that the majority of respondents in all years of the program were satisfied/very satisfied with academic advising/counseling services (Core Appendix C-62).
- l. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

11.2 CAREER ADVISING

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

- 11.2 a Faculty members, clerkship directors, and student affairs staff provide career advising to medical students at the main campus and any geographically distributed campuses.
- 11.2 b The career advising system provides appropriate mandatory and optional, and where appropriate confidential career advising activities to students in each year of the program to assist them in evaluating career options, choosing electives and applying to residency programs.
- 11.2 c The medical school provides career advising to students at each campus and to students, who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).
- 11.2 d There are print or online resources available to medical students to support their career investigations.
- 11.2 e There is an individual(s) who is primarily responsible for providing guidance to medical students on their choice of intramural and extramural electives during each year of the curriculum at each campus and to students who are away from the medical school for a six-month or more consecutive period.
- 11.2 f A faculty member is responsible for formally approving medical students' elective choices.
- 11.2 g The percentage of participating medical students who remained unmatched at the end of the second iteration of the Canadian Residency Match Service (CaRMS) match has been low for the last three academic years.
- 11.2 h AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus were satisfied/very satisfied with career planning services and information about specialties.
- 11.2 i Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with career advising.
- 11.2 j AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus were satisfied/very satisfied with guidance when choosing electives.
- 11.2 k Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with guidance when choosing electives.
- 11.2 l Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring

☐ Unsatisfactory

Evidence to support the above rating

- a. Faculty members, clerkship directors, and student affairs staff provide career advising to medical students at the main campus and the longitudinal integrated clerkship sites.
- b. DCI Table 11.2-5 outlines the career advising system that provides mandatory and optional, and where appropriate confidential, career advising activities to students in all three years of the program to assist them in evaluating career options, choosing electives and applying to residency programs. Sample activities include the mandatory meeting with a faculty mentor and a required career in medicine workshop in year 1; mandatory session on pre-clerkship electives and an optional clerkship electives guidance workshop in year 2; a required session on Canadian Residency Match Service (CaRMS) CV and personal letter preparation and an optional CaRMS resident interview session in year 3. The school has recently enhanced this by including a student affairs career advising session prior to the start of medical school.
- c. The medical school provides career advising to students at the main campus and to students who are away from the medical school campus in the longitudinal integrated clerkship stream. Career advising activities for third year students take place when students in the longitudinal integrated clerkship stream are at the main campus.
- d. There are print or online resources available to medical students to support their career investigations.
- e. The director of electives is primarily responsible for providing guidance to medical students on their choice of intramural and extramural electives during each year of the curriculum at the main campus and to students who are away in the longitudinal integrated clerkship.
- f. A faculty member, the director of electives, is responsible for formally approving medical students' elective choices.
- g. The percentage of participating medical students who remained unmatched at the end of the second iteration of the CaRMS match has been below four percent for the last three academic years. These numbers are 1.8% in 2013, 2.3% in 2014, and 3.4% in 2015 (Core Appendix C-71). Within the school's three-year program, students who do not match have the option to extend clerkship education another year. The majority of students (8/9) who have done this from 2011-2014 have successfully matched at the end of four years.
- h. The 2015 AAMC CGQ and AFMC GQ data show that a small majority of respondents were satisfied/very satisfied with career planning services (61%) and information about specialties (68%). Satisfaction concerning information about specialties shows an increasing trend from 60% in 2013 and 62% in 2014 (Core Appendix C-67).
- i. Data from the ISA show that the majority of respondents in all years of the program were satisfied/very satisfied with career advising. While only 59% were satisfied/very satisfied in Year 1, and 52% in Year 2, data for Year 3 shows 73% (Core Appendix C-68).
- j. AAMC CGQ and AFMC GQ data show that the majority of respondents were not satisfied/very satisfied with guidance when choosing electives. Over the past three years, the percent of students who were satisfied/very satisfied were 31% in 2013, 41% in 2014, and 42% in 2015 (Core Appendix C-69).
- k. Data from the ISA show that the majority of respondents in all years of the MD program were not satisfied/very satisfied with guidance when choosing electives. The percent of students who rated guidance when choosing electives as good/very good/excellent were 48% in Year 1, 43% in Year 2, and 61% in Year 3 (Core Appendix C-70). The school addressed these concerns with additional programming. Discussions with faculty and students during the onsite visit confirmed that while many of the issues were related to the compressed three-year curriculum and challenges with the timing of electives that the school was responsive to student concerns. Internal data on satisfaction with recent programming was very high. (MSS 11.2h lists the following internal student feedback data: Roundtable on Preclinical Electives Guidance – 79%,

Careers in Medicine Workshop – 87%, Clerkship Electives Guidance Workshop – 78%, and CaRMS Matching: Myths and Facts - 84%).

1. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. This was an area of non-compliance at the time of the last accreditation. The MSS finding for this element was SM. Although the CQG/GQ data and the ISA data show that students are not satisfied with career guidance and guidance when choosing electives, discussion at the time of the site visit indicates that students are satisfied with the attention to and activities implemented over the past 12 months to address this problem.

11.3 OVERSIGHT OF EXTRAMURAL ELECTIVES

If a medical student at a medical school is permitted to take an elective under the auspices of another medical school, institution, or organization, a centralized system exists in the dean's office at the home school to review the proposed extramural elective prior to approval and to ensure the return of a performance assessment of the student and an evaluation of the elective by the student. Information about such issues as the following are available, as appropriate, to the student and the medical school in order to inform the student's and the school's review of the experience prior to its approval:

- a) Potential risks to the health and safety of patients, students, and the community;*
- b) The availability of emergency care;*
- c) The possibility of natural disasters, political instability, and exposure to disease;*
- d) The need for additional preparation prior to, support during, and follow-up after the elective;*
- e) The level and quality of supervision; and*
- f) Any potential challenges to the code of medical ethics adopted by the home school.*

- 11.3 a There is a centralized system in the dean's office of the home school at each campus to review and approve proposed electives taken by the school's own students under the auspices of another medical school, institution, or organization before the medical student is permitted to begin the elective.
- 11.3 b There is an appropriate mechanism for the review of the following points for extramural electives where there is a potential risk to medical student and patient safety.
 - i. potential risks to the health and safety of patients, students, and the community;
 - ii. the availability of emergency care;
 - iii. the possibility of natural disasters, political instability, and exposure to disease;
 - iv. the need for additional preparation prior to, support during, and follow-up after the elective;
 - v. the level and quality of supervision; and
 - vi. any potential challenges to the code of medical ethics adopted by the home school.
- 11.3 c The medical school effectively prepares and supports medical students before, during, and after electives where there is a risk to student and patient safety.
- 11.3 d The centralized system described in 11.3.a., ensures that a performance assessment of the student and an evaluation of the elective experience by the student are returned to the medical school.
- 11.3 e The evaluation data on extramural electives provided by students to the centralized system in the dean's office of the home medical school at each campus is used to inform, among other things, future decisions regarding approval of other requests for the same elective experience from other medical students.
- 11.3 f Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. There is a centralized system in the dean's office to review and approve proposed electives taken by the school's own students under the auspices of another medical school, institution, or organization before the medical student is permitted to begin the elective. All are approved by the summer elective & clerkship elective coordinators in consultation with the director, electives as needed.
- b. For extramural electives, there is a thorough mechanism for the review of all aspects (i-vi in the element) where there is a potential risk to medical student and patient safety. International electives undergo risk rating and require additional approval from Risk Management and the vice president International.
- c. The medical school effectively prepares and supports medical students before, during, and after electives where there is a risk to student and patient safety. Pre-departure training and post-trip debriefing are conducted by the Global Health office.
- d. The elective coordinators' centralized system described in 11.3.a., ensures that a performance assessment of the student is returned to the school and an evaluation of the elective experience by the student is completed on One45.
- e. There is an electronic flagging system for the One45 evaluation data on extramural electives completed by medical students. These alerts are sent to, and reviewed by, the director, electives and the assistant dean, clerkship and are used to inform future decisions regarding whether or not there will be approval of other requests for the same elective experience from other medical students. The assessment is based on risk, potential harm and the educational value of the elective experience if the deficiencies are reversible.
- f. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

11.4 PROVISION OF THE MEDICAL STUDENT PERFORMANCE RECORD

A medical school provides a Medical Student Performance Record required for the residency application of a medical student only on or after October 1 of the student's final year of the medical education program.

- 11.4 a The medical school provides the Medical Student Performance Record only on or after October 1st of the student's final year of the medical education program.
- 11.4 b Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school provides the Medical Student Performance Record after October 1st of the student's final year of the medical education program. In order to include clerkship performance data that extends into early October, the school typically releases the MSPR in early November prior to the CaRMS deadline (Core Appendix C-72).
- b. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

11.5 CONFIDENTIALITY OF STUDENT EDUCATIONAL RECORDS

At a medical school, student educational records are confidential and available only to those members of the faculty and administration with a need to know, unless released by the student or as otherwise governed by relevant legislation. A medical school follows policy for the collection, storage, disclosure and retrieval of student records that is in compliance with relevant privacy legislation.

- 11.5 a The medical school at each campus has and follows policy(ies) for the collection, storage, disclosure and retrieval of student academic/educational records that is in compliance with relevant privacy legislation.
- 11.5 b A medical student's academic/educational record/file is kept in a separate location from his or her health record/file at each campus.
- 11.5 c There is a policy and procedure that specifies which individuals have the right to review a medical student's academic/educational file. The individual(s) at each campus who is responsible for providing access to a student's academic/educational file ensures that only those authorized individuals are given access.
- 11.5 d Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has and follows a Student File Policy for the collection, storage, disclosure and retrieval of student academic/educational records that is in compliance with relevant privacy legislation.
- b. A medical student's academic file is kept in a separate location from health records or other non-academic information. Students do not receive health care at the main campus. Academic files are not maintained at the longitudinal integrated clerkship locations.
- c. The school's Student File Policy specifies which individuals have the right to review a medical student's academic file. The associate dean and his administrative assistant are responsible for providing access to a student's academic/educational file ensuring that only those authorized individuals are given access.
- d. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

11.6 STUDENT ACCESS TO EDUCATIONAL RECORDS

A medical school has policies and procedures in place that permit a medical student to review and to challenge his or her educational records, including the Medical Student Performance Record, if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.

- 11.6 a The medical school has policies and procedures in place that permit a medical student to review all components of their educational records including the Medical Student Performance Record. Students do not have access to any reference letter used in the admission process when the referee was assured it would not be provided to the student.
- 11.6 b Medical students are given access to review their educational records in a reasonably short period of time after the request has been made at each campus.
- 11.6 c A medical student can challenge the following if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.
 - i. content of the MSPR
 - ii. examination performance, tutor/preceptor assessment in a required learning experience
 - iii. final grade for a required learning experience
- 11.6 d Formal medical school policies and procedures related to medical students' ability to review and challenge their records, including the length of time it takes for students to gain access to their records are made known to students and teaching faculty at each campus.
- 11.6 e The Medical Student Performance Record is completed using objective data by an individual(s) who has had no role in providing personal counseling, or health services including psychiatric/psychological counseling.
- 11.6 f The medical school corrects factual errors, and removes misleading and/or inappropriate information from the educational record of a medical student once the error, misleading and/or inappropriate information has been identified, investigated and confirmed.
- 11.6 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school has policies and procedures in place that permit a medical student to review all components of their educational records including the Medical Student Performance Record. Students do not have access to any reference letter used in the admission process when the referee was assured this would not be provided to the student. The policies are posted online: <http://www.ucalgary.ca/mdprogram/home/ume-policies-guidelines> at a tab entitled "UME student policies and guidelines".
- b. According to the policy, medical students are given access to review their educational records within two business days after the request has been made.

- c. A medical student can challenge MSPR content, examination scores, preceptor assessment, and final grades, if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.
- d. Formal medical school policies and procedures related to medical students' ability to review and challenge their records, including the length of time it takes for students to gain access to their records are made known to and readily accessible to students and teaching faculty through online policies. This information is also available in the student handbook.
- e. The Medical Student Performance Record is pre-populated from the computerized evaluation database, completed by the undergraduate medical education administrative coordinator and then reviewed and signed by the associate dean, undergraduate medical education. Neither of these individuals have a role in providing personal counseling, or health services including psychiatric/psychological counseling.
- f. The Medical Student Performance Record policy outlines the process whereby students may request the undergraduate medical education management team review specific comments and recommend edits that do not materially affect the content of the comment (for example, comments relating to the program and not the student; inappropriate language; indicating a specific choice of discipline; personal health information) (Core Appendix C-72).
- g. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

STANDARD 12
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 12: MEDICAL STUDENT HEALTH SERVICES, PERSONAL COUNSELING, AND FINANCIAL AID SERVICES

A medical school provides effective student services to all medical students to assist them in achieving the program's goals for its students. All medical students have the same rights and receive comparable services.

Survey Team
Standard 12 Element Rating Table

Standard 12	Medical Student Health Services, Personal Counseling and Financial Aid Services
Element	
12.1	Financial Aid/Debt Management Counseling/Student Educational Debt
12.2	Tuition Refund Policy
12.3	Personal Counseling/Well-being Programs
12.4	Student Access to Health Care Services
12.5	Non-involvement of Providers of Student Health Services in Student Assessment
12.6	Student Access to Health and Disability Insurance
12.7	Immunization Guidelines
12.8	Student Exposure Policies and Procedures

Standard 12 Summary of Findings

The following is the Summary of Survey Team Findings for Standard 12 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (US). The findings are listed in order by the number of the element.

Element Rating SM, US	Standard 12 Medical Student Health Services, Personal Counseling and Financial Aid Services
SM	12.1 Financial Aid / Debt Management Counseling / Student Educational Debt
	Finding: The school has an optional financial literacy curriculum delivered over the three years with recent changes in 2015. Similarly, significant changes to the bursary program have been made. The impact of these changes is uncertain.
US	12.5 Non-Involvement of Providers of Student Health Services in Student Assessment / Location of Student Health Records
	Finding: Although the school has a policy to address non-involvement of providers, the policy does not delineate the responsibility of the faculty and the school, but leaves the onus on the student. Discussions with faculty during the site visit indicated a lack of awareness of this policy.

12.1 FINANCIAL AID / DEBT MANAGEMENT COUNSELING/ STUDENT EDUCATIONAL DEBT

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.

- 12.1 a The medical school ensures that required and optional financial aid and debt management counseling/advising activities (including one-on-one sessions) are available to medical students in each year of the curriculum at each campus.
- 12.1 b The medical school ensures that financial aid management services are available to students who are away from the medical school for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).
- 12.1 c The medical school initially determines and subsequently evaluates the adequacy of financial aid staffing.
- 12.1 d The medical school ensures that conflicts of interests for those providing debt management counselling and information on student loans are identified and appropriately managed.
- 12.1 e The medical school has awarded bursaries, grants and scholarships and extended loans to students over the past three academic years.
- 12.1 f Since the time of the last full survey, the medical school or university has engaged in activities to increase the amount and availability of scholarship, bursary, grant and loan support for medical students.
- 12.1 g The medical school and the university have worked to limit tuition increases or limit student debt since the time of the last full survey.
- 12.1 h AAMC CGQ and AFMC GQ data show that the average overall medical education debt of all graduating students over the last three years is comparable to that of other Canadian medical schools.
- 12.1 i Data from the AAMC CGQ and the AFMC GQ and the ISA show that the majority of respondents at each campus are satisfied/very satisfied with financial aid administrative services, and overall educational debt management counselling.
- 12.1 j Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☐ Satisfactory
- ☒ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The medical school introduced a 3-year optional financial aid and debt management counseling/advising activities (including one-on-one sessions) in 2014. After working with MD

- Financial Management™ through 2014 and most of 2015, the financial aid manager introduced a financial literacy curriculum that will be further developed and delivered in-house as of October, 2015 without the involvement of MD Financial Management™ (Supplemental Appendix S-7).
- b. Financial aid management services are made available to students in the longitudinal integrated clerkship stream through visits from central campus personnel, email, teleconference and videoconference. Large group sessions take place when all students are back at the Calgary campus.
 - c. The financial aid office is located at the central university and the adequacy of staffing is determined by the university. The Cumming School of Medicine director of admissions and financial aid and the financial aid manager indicated that they are able to adequately address student financial needs.
 - d. MD Financial Management™ was involved in the delivery of the financial literacy curriculum and individual counseling until recently. The school severed the relationship in the fall of 2015 to minimize external influences. The debt management counseling and information on student loans are now provided by the financial aid manager. Students remain able to invite MD Financial Management™ to deliver presentations but the content has to be approved by the school first.
 - e. The medical school has awarded bursaries, grants and scholarships to students over the past three academic years totaling ~ \$1M/year. As of 2015, the school has designated ~\$150,000 annually to be distributed as “Special Bursaries” for students with significantly greater than average financial need and limited access to other resources. For this academic year, a total of \$135,000 was distributed to 6 students.
 - f. Since the last full accreditation visit in 2008, student financial support provided by the University of Calgary has increased by an average of 2.5% per year. Although representing a relatively small proportion of the total funding provided, the school’s internal scholarship funds have also increased by an average of 10.4% per year. Discussions with the director, admissions and financial aid at the time of the onsite visit indicated that the school’s financial efforts will focus on those students with the greatest financial need and those with the greatest debt.
 - g. Student tuition is provincially regulated. Since the last full accreditation, annual tuition and fees have increased at a rate of 2.2% per year on average. In October 2015, the provincial government announced a further freeze on post-secondary tuition in Alberta.
 - h. AAMC CGQ and AFMC GQ data show that the average overall medical education debt of all graduating students over the last three years is higher than the national average for Canadian medical schools (Core Appendix C-75). The average student indebtedness of Cumming School of Medicine students exceeded the national average by 13.1% (MSS 12.1 h provides % exceeding national average for 2009-2014). The school speculates this may relate to cost of living and the inability to work part time in the compressed 3-year curriculum. (N.B. Tables 12.-7 to 12.1-9 Average Overall Educational Debt and Medical School Indebtedness would correspond to the tables required for Core Appendix C-76 to C-78; these tables were not provided in the DCI and therefore this was not identified until after the site visit at the time the report was being finalized and the relevant Core Appendix items were being inserted).
 - i. Data from the AAMC CGQ and the AFMC GQ (Core Appendix C-73) show an increasing trend with the majority of respondents satisfied/very satisfied with financial aid administrative services over the past two years: 51% in 2013; 63% in 2014 and 75% in 2015. The ISA indicates rates of satisfaction (good/very good/excellent) for Year 1 82%; Year 2 75%; and Year 3 88% (Core Appendix C-74).
 - j. Data from the AAMC CGQ and the AFMC GQ also show an increasing trend (47% in 2013; 61% in 2014 and 71% in 2015) of respondents satisfied/very satisfied with the overall educational debt management counseling (Core Appendix C-73). The ISA indicates that the majority of students (Year 1 79%; Year 2 67%; Year 3 80%) were satisfied/very satisfied with debt management counseling (Core Appendix C-74).
 - k. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. The “Financial Literacy curriculum”, which was recently implemented in October 2015 and is being further developed, requires monitoring.

12.2 TUITION REFUND POLICY

A medical school has clear, reasonable, and fair policies for the refund of a medical student's tuition, fees, and other allowable payments (e.g., payments made for health or disability insurance, parking, housing, and other similar services for which a student may no longer be eligible following withdrawal).

- 12.2 a The medical school has clear, reasonable, and fair policies for the refund of a medical student's tuition, fees and other allowable payments (e.g., payments made for health or disability insurance, parking, housing, and other similar services for which a student may no longer be eligible following withdrawal).
- 12.2 b These policies are disseminated to and are accessible by medical students.
- 12.2 c Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The policy for tuition refund is described in the Cummings School of Medicine Tuition Fee Model. A tuition credit is applied when a student goes on an approved leave of absence (more common) or withdraws from the program. If the student is not returning to school, they may request a refund from the university finance office. The general fees of ~\$600 are not refundable and this applies to all University of Calgary degree programs. Similar non-refund of general fees may be seen at other Canadian universities. Discussions at the time of the site visit indicate there have been no concerns raised.
- b. The university academic calendar includes the tuition refund policy. Discussion with the two associate directors for student affairs and the manager of undergraduate medical education indicate that the policy is outlined in the student handbook. Students taking a leave of absence or withdrawing from the program are informed of the refund policy by student affairs or undergraduate medical education.
- c. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

12.3 PERSONAL COUNSELING / WELL-BEING PROGRAMS

A medical school has in place an effective system of personal counseling for its medical students that includes programs to promote their well-being and to facilitate their adjustment to the physical and emotional demands of medical education.

- 12.3 a The medical school provides personal counseling and well-being programs to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).
- 12.3 b Medical students are informed about the availability of personal counseling and well-being programs provided by the medical school at each campus.
- 12.3 c Data from the AAMC CGQ and the AFMC GQ over the past three academic years show that the majority of respondents at each campus are satisfied/very satisfied with personal counseling provided by the medical school.
- 12.3 d Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with the availability and confidentiality of personal counseling services provided by the medical school.
- 12.3 e Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with well-being programs provided by the medical school.
- 12.3 f Data from the AAMC CGQ and AFMC GQ show that the majority of respondents at each campus are satisfied/very satisfied with programs that promote effective stress management, a lifestyle balance and overall well-being.
- 12.3 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The student affairs office provides personal counseling and well-being programs to students, including those in the longitudinal integrated clerkship. The student affairs personnel enlists the Alberta Medical Association's Physician and Family Support Program and the University of Calgary's Counselling Centre for professional counselling services for medical students as necessary.
- b. Medical students are informed about the availability of personal counseling and well-being programs provided by the medical school. A second associate director of Student Affairs was hired in July 2015 with the specific mandate to enhance the wellness programs. In the 2015-2016 academic year student affairs introduced wellness and personal counseling to the incoming students prior to the start of the school year.
- c. Data from the AAMC CGQ and the AFMC GQ (Core Appendix C-79) over the past three academic years show that increasingly the majority of respondents are satisfied/very satisfied with

- personal counseling provided by the medical school (58% in 2013; 73% in 2014 and 79% in 2015).
- d. Data from the ISA (Core Appendix C-81) show that the majority of respondents rated the accessibility (81% year 1; 77% year 2 and 88% year 3) and confidentiality (92% year 1; 90% year 2 and 91% year 3) of personal counseling services as good/very good/excellent.
 - e. Data from the ISA (Core Appendix C-81) show that the majority of respondents (83% in year 1; 70% in year 2 and 85% in year 3) were satisfied/very satisfied with well-being programs provided by the medical school.
 - f. Data from the AAMC CGQ and AFMC GQ (Core Appendix C-80) show that the majority of respondents (59% in 2013; 68% in 2014 and 68% in 2015) are satisfied/very satisfied with programs that promote effective stress management, a lifestyle balance and overall well-being.
 - g. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. The more recent ISA data show that a very high percentage of students are satisfied with the well-being programs, as well as the accessibility and confidentiality of personal counseling services.

12.4 STUDENT ACCESS TO HEALTH CARE SERVICES

A medical school facilitates medical students' timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required learning experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care.

- 12.4 a The medical school at each campus facilitates medical students' timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of required learning experiences.
- 12.4 b Medical students at all instructional sites and campuses are informed about availability and access to health services.
- 12.4 c The medical school at each campus has policies and procedures in place that permit students to be excused from required learning experiences including required clinical learning experiences to seek needed care.
- 12.4 d The policies and procedures described in 12.4.c. are disseminated to medical students, faculty, and residents.
- 12.4 e The AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with student health services and mental health services.
- 12.4 f Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with student health services and mental health services.
- 12.4 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. Students have access to the Student Health Services Clinic on the main campus, which provides primary and urgent care, and is in reasonable proximity for students in the program. All students are encouraged to obtain a personal family physician. The Alberta Medical Association maintains a list of family physicians who are willing to accept medical students.
- b. Medical students are informed about availability and access to health services at the time of their initial offer of admission to the program.
- c. The medical school Attendance Policy permits students to be excused from required learning experiences including required clinical learning experiences to seek needed care.
- d. The Attendance Policy above is disseminated to medical students (student handbook and course/rotation syllabi) and faculty and residents (preceptor resource webpage; course/rotation syllabi and orientation to clerkship rotations). Student affairs will inform faculty when students are to be excused from formal learning experiences.
- e. The AAMC CGQ and AFMC GQ data (DCI Table 12.4-1) show that increasingly, the majority of respondents are satisfied/very satisfied with student health services (55% 2013; 71% 2014; 81%

2015) and mental health services (51% 2013; 67% 2014; 73% 2015).

- f. Data from the ISA (DCI Table 12.4-2) show that the majority of respondents are satisfied/very satisfied with student health services (79% year 1; 70% year 2; 87% year 3) and mental health services (82% year 1; 81% year 2; 88% year 3).
- g. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

12.5 NON-INVOLVEMENT OF PROVIDERS OF STUDENT HEALTH SERVICES IN STUDENT ASSESSMENT / LOCATION OF STUDENT HEALTH RECORDS

The health professionals who provide health services, including psychiatric/psychological counseling, to a medical student have no involvement in the academic assessment or promotion 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.

- 12.5 a The medical school has and follows a policy that no 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 promotion of that student.
- 12.5 b The medical school informs students, residents and faculty of this policy mentioned in 12.5.a.
- 12.5 c The medical school maintains medical student health records in accordance with legal requirements for security, privacy, confidentiality, and accessibility.
- 12.5 d There is a policy and procedure that specifies which individual's have the right to review a medical student's health record/file. The individual(s) at each campus who is responsible for providing access to a student's health record/file ensures that only those authorized individuals are given access.
- 12.5 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☐ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☒ Unsatisfactory

Evidence to support the above rating

- a. While a school policy exists that providers of health and/or psychiatric/psychological services to a student have no involvement in the student's academic assessment, the policy places the onus for declaring the relationship on the student (Supplemental Appendix S-8). Discussion with the associate and assistant deans, undergraduate medical education and the course/clerkship directors at the time of the visit revealed that the program believes that it must be the student's responsibility to declare any conflict and ask for another supervision because the undergraduate medical education program has no information about students' physical and mental health. There was no evidence provided that the school assured the policy was monitored or followed.
- b. The policy was developed in 2015, approved in February 2016 and is available on the undergraduate medical education policy website. Discussion with teaching faculty at the time of the visit indicates there is a lack of awareness of the policy.
- c. The medical school maintains medical student health records in accordance with legal requirements for security, privacy, confidentiality, and accessibility. No student health records are kept by the undergraduate medical education office. Any health records provided to student affairs are not shared with the undergraduate medical education office.
- d. There is no policy required as no medical care is provided within the medical school. There are no student health records kept within undergraduate medical education with the exception of the occasional doctor's note kept within the student record (no health information but rather this is

provided for a student to be excused from a required learning experience).

- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are not being met by the medical school.

12.6 STUDENT ACCESS TO HEALTH AND DISABILITY INSURANCE

A medical school ensures that health insurance is available to each medical student and his or her dependents and that each medical student has access to disability insurance.

- 12.6 a Health insurance is available to each medical student and his or her dependents at each campus.
- 12.6 b Medical students at each campus are informed of the availability of health insurance on entry into the medical education program.
- 12.6 c AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with the availability of health insurance.
- 12.6 d Disability insurance is available to each medical student at all campuses.
- 12.6 e Medical students are informed about the availability of disability insurance on entry into the medical education program.
- 12.6 f AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with the availability of disability insurance.
- 12.6 g Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- | |
|--|
| <ul style="list-style-type: none">a. Health insurance is available to all students and their dependents through Alberta Health, a publicly funded universal health insurance plan.b. All students, as Canadian citizens or permanent residents, are already enrolled with their provincial health care plan on entry into the medical education program.c. No question was asked on the 2015 AFMC GQ data with respect to the availability of health insurance. The ISA (DCI Table 12.6-1) data show that 69% of students were satisfied/very satisfied with the availability of health insurance.d. Disability insurance is available to all medical students from the Alberta Medical Association and other insurance brokers.e. Medical students are informed about the availability of disability insurance on entry into the medical education program through the student handbook and presentations in the financial literacy curriculum. Students are made aware of the existence of insurance brokers, as well as the plan offered by the Alberta Medical Association. Disability insurance is discussed with students as part of the financial literacy curriculum.f. The AAMC CGQ and AFMC GQ data show that 75% of students are satisfied/very satisfied with the awareness of and access to student disability insurance. The ISA (DCI Table 12.6-1) indicates 84% of respondents were satisfied/very satisfied with disability insurance availability.g. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school. |
|--|

12.7 IMMUNIZATION GUIDELINES

A medical school follows accepted guidelines that determine immunization requirements and ensures compliance of its students with these requirements.

- 12.7 a The immunization requirements for students in the medical education program follow national and provincial recommendations.
- 12.7 b Immunizations are provided at locations close to where students participate in required learning experiences including required clinical learning experiences.
- 12.7 c Immunizations are provided at low or no cost to medical students.
- 12.7 d There is an effective system at each campus to monitor students' immunization status to ensure compliance with immunization requirements prior to involvement in patient care activities.
- 12.7 e Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

- a. The immunization requirements for students in the medical education program follow the provincial recommendations.
- b. The Student Health Clinic on main campus administers vaccinations to medical students to meet the required vaccinations.
- c. As occupational vaccinations are not an insured service through Alberta Health, the clinic charges a nominal fee of \$35 for vaccination. Certain vaccinations are provided free of charge by Public Health, while others, such as Hepatitis B and Varicella, must be paid for by the student.
- d. There is an effective system to monitor students' immunization status to ensure compliance with immunization requirements prior to involvement in patient care activities. An RN has been hired as the vaccination coordinator and provides the same service to the Faculty of Nursing. No students are allowed to participate in patient care activities until their immunization status is up to date.
- e. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

12.8 STUDENT EXPOSURE POLICIES / PROCEDURES

A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards, including:

- a) The education of medical students about methods of prevention.*
- b) The procedures for care and treatment after exposure, including a definition of financial responsibility.*
- c) The effects of infectious and environmental disease or disability on medical student learning activities.*

All registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk.

- 12.8 a The medical school has policies in place that address medical student exposure to infectious and environmental hazards that include:
 - i. education of medical students about methods of prevention.
 - ii. procedures for care and treatment after exposure, including the definition of financial responsibility.
 - iii. effects of infectious and environmental disease or disability on medical student learning activities.
- 12.8 b Medical students and visiting medical students learn how to prevent exposure to infectious diseases, especially from contaminated body fluids at all instructional sites before students are permitted to participate in patient-care activities.
- 12.8 c Medical students and visiting medical students are informed of the medical school's policies and procedures related to exposure to infectious and environmental hazards (contaminated body fluids, infectious disease screening and follow-up, hepatitis B vaccination, and HIV testing) at all instructional sites before students are permitted to participate in patient-care activities.
- 12.8 d Medical students and visiting students at all instructional sites learn about the procedures to be followed in the event of exposure to blood-borne (e.g., needle-stick injury) or air-borne pathogens.
- 12.8 e AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with the education about exposure to and prevention of infectious diseases (e.g., needle-stick).
- 12.8 f AAMC CGQ and AFMC GQ data show that a very high percentage of respondents at each campus indicate that: "I know what to do if I am exposed to an infectious or environmental hazard like a needle stick injury".
- 12.8 g Data from the ISA show that the majority of respondents at each campus are familiar with the protocol following exposure to infectious and environmental hazards.

- 12.8 h Review of the documentation related to this element and discussions with relevant individuals at the time of the on-site survey visit confirm that the requirements listed above are being met by the medical school.

RATING

- ☒ Satisfactory
☐ Satisfactory with a need for monitoring
☐ Unsatisfactory

Evidence to support the above rating

- a. The Medical Student Safety and the Staff and Student – Accident and Incident Reporting policies along with the Protocol for Injuries, Incidents and Exposures address medical student exposure to infectious and environmental hazards that include the education of medical students about methods of prevention and procedures for care and treatment after exposure, including the definition of financial responsibility. Medical students in Alberta have educational licenses through the College of Physicians and Surgeons of Alberta (CPSA). The effects of infectious and environmental disease or disability on medical student learning activities are addressed by the CPSA’s 2003 guideline on Blood Borne Infections in Health Care Workers (Supplemental Appendix S-9). The Alberta Health Services policies address exposures to infectious and environmental hazards.
- b. Medical students and visiting medical students learn how to prevent exposure to infectious diseases, especially from contaminated body fluids at all instructional sites before students are permitted to participate in patient-care activities. Formal education regarding environmental hazards, personal protective equipment and exposure prevention are covered in the first course of the curriculum. Onsite discussion revealed that visiting medical students learn how to prevent exposure to infectious diseases through an online mandatory orientation module through the Alberta Health Services, which is also completed by all Cumming School of Medicine students.
- c. Cumming School of Medicine students are informed of the policy regarding infectious and environmental hazards as part of the curriculum, prior to the commencement of clinical duties. Visiting students are informed of these policies on the visiting students’ page on the program’s website and as part of their Alberta Health Services orientation module.
- d. Medical students and visiting students learn about the Protocol for Injuries, Incidents and Exposures to be followed in the event of exposure to blood-borne or air-borne pathogens. The protocol is available online and on identification badges.
- e. ISA data (Core Appendix C-82) show that a high percentage of respondents (87% year 1; 86% year 2; 87% year 3) were satisfied/very satisfied with the education about exposure to and prevention of infectious diseases (e.g., needle-stick).
- f. AAMC CGQ and AFMC GQ data (Core Appendix C- 83) show that a high percentage of respondents (94% 2013; 94% 2014; 90% 2015) indicated “I know what to do if I am exposed to an infectious or environmental hazard like a needle stick injury”.
- g. Data from the ISA (Core Appendix C-84) show that the majority of respondents (78% year 1; 80% year 2; 83% year 3) report being familiar with the protocol following exposure to infectious and environmental hazards.
- h. Review of the documentation related to this element and discussions with relevant individuals at the time of the onsite visit confirm that the requirements listed above are being met by the medical school.

APPENDIX