Cumming School of Medicine (CSM)

University of Calgary

Medical School Self-Study Report

CACMS visit details:

Virtual review: October 21-23, 2024

In-person: December 2 & 3, 2024

Prepared for:

Committee on Accreditation of Canadian Medical Schools (CACMS)

July 2024

TABLE OF CONTENTS

Section	Pages
INTRODUCTION	
Prior Accreditation History	3-4
Management of Satisfactory with Monitoring or Unsatisfactory Elements	5
Accreditation Process Self-Study Description	6
EVALUATION OF ELEMENTS	
MSS 1	7-14
MSS 2	15-19
MSS 3	20-32
MSS 4	33-38
MSS 5	39-50
MSS 6	51-63
MSS 7	64-75
MSS 8	76-85
MSS 9	86-98
MSS 10	99-111
MSS 11	112-120
MSS 12	121-130
MSS STEERING COMMITTEE SUMMARY STATEMENT	131
APPENDICES	
Appendix A – Self-Study Task Force Committees	131-135
Appendix B – Acronyms & Definitions	136-139

INTRODUCTION – PRIOR ACCREDITATION HISTORY

University of Calgary Cumming School of Medicine				**Last full site visit (2016) Updated: July 22, 2024**			
Standard / Element	**Full Visit June 2016**	Status Report May 2018	Status Report September 2019	Status Report January 2022	Notification - Curricular Change September 2022	Status Report May 2023	Notification – Enrollment Increase and New Campus October 2023
Standard 1	C				--		--
1.4	U	SM	S		--		--
Standard 3	CM	C			--		--
3.2	SM	S			--		--
3.3	U	S			--		--
3.6	SM	S			--		--
Standard 6	C				--		--
6.3	SM	S			--		--
Standard 9	CM	C			--		--
9.4	SM	S			--		--
9.7	SM	SM	SM	U	--	S	--
Standard 11	C				--		--
11.2	SM	S			--		--
Standard 12	CM	C			--		--
12.1	SM	SM	S		--		--
12.5	U	S			--		--
Follow-up 1	Status report on all SM & U	Status Report on 1.4,9.7 & 12.1	Status Report on 9.7	Status Report on 9.7			Site visit team to pay particular attention to the concerns as part of the next full accreditation visit in the AY2024-2025.
Due date	March 2018	August 1, 2019	December 1, 2021	March 15, 2023			
Follow-up 2	--	--	--	--			
Due date	--	--	--	--			

Accreditation status	Cont’ full accred. – 8-yr term	Cont’ full accred. – 8-yr term	Cont’ full accred. – 8-yr term	Cont’ full accred. – 8-yr term	Cont’ full accred. – 8-yr term	Cont’ full accred. – 8-yr term	Cont’ full accred. – 8-yr term
Next full survey	Spring 2023 (AY 2023-2024)	Spring 2023 (AY 2023-2024)	Spring 2023 (AY 2023-2024)	Spring 2023 (AY 2023-2024)	Fall 2024 (AY 2024-2025) (delayed from spring to fall) AY 2024-2025.	Fall 2024 (AY 2024-2025)	Fall 2024 (AY 2024-2025)

INTRODUCTION: Management of Satisfactory with Monitoring and Unsatisfactory Elements

Element	2016 Issue	Resolution	Ongoing Work
1.4	NTHSSA affiliation agreement is unclear regarding the responsibility for treatment/follow-up when a student is exposed to infections, environmental hazard or other occupational injury.	UCalgary legal counsel identified Article 4 as describing the NTHSSA's responsibilities and actions in the event of any accident, incident or unusual occurrence.	UCalgary legal counsel reviews all affiliation agreements on request to ensure ongoing compliance with accreditation standards.
3.2	Repository of research opportunities was created, no data available to demonstrate the impact on student awareness of research opportunities.	Additional data provided demonstrated a steady increase in the number of students choosing to do research projects outside of structured curricular time.	There is a repository of research opportunities/research supervisors maintained by the UME Research Committee. The Professional Role course has protected time for research initiatives.
3.3	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.	New Equity Guidelines for Search & Selection Committees and new recruitment advertising with a commitment to fostering diversity were implemented. As of 2018, 41% of CSM faculty members were women.	The CSM Equity Framework identifies faculty from structurally marginalized groups as the diversity group of focus. The Inclusive Excellence Hiring Initiative / Indigenous Scholars Pathway commit to hire 3 Black & 3 Indigenous scholars in 2023-24. A survey is planned to gauge recruitment success.
3.6	Recommendations of the Student Mistreatment Task Force have been adopted/implementation, however no data on delivery and impact were available.	Information provided regarding mistreatment website usage, number of students accessing the Student Advisors for Mistreatment, and procedure summary for mistreatment reports.	A CSM Safe Mistreatment Reporting process is in development and will be administered by CSM Human Resources as a neutral body to prevent conflicts of interest and concerns of retaliation.
6.3	Students expressed a high level of dissatisfaction with the amount of time for self-directed learning.	Details provided regarding independent study times in each curricular year.	The RIME curriculum has at least 14 hours/week of protected time for self-directed and life-long learning.
9.4	Direct observation of surgical clerkship students taking a history and performing a physical examination was previously identified as deficient, the noted improvement required monitoring for sustainability.	Graduate Questionnaire (GQ) and school-reported data were provided as evidence of the improvement sustainability.	History & physical exam skill observation is mandatory in all clerkships with completion of 10 successful EPAs required. GQ 2023 data demonstrated that all mandatory clerkships had observed history of > 93% except surgery (83%) and observed physical exam in > 95% except surgery (85%).
9.7	AFMC GQ (76%) and End of Rotation Survey (63-66%) data show that the provision of timely formative feedback in Surgery is unsatisfactory. Data demonstrating the sustained achievement of timely formative feedback throughout an entire 12-month period are required.	2023 details provided regarding GQ data, policies and formative exams.	EPAs are mandatory in clerkship, internal data show that 727 EPAs were completed by unique 138 students for the class of 2022 surgical rotations. Surgery clerkship students complete a mid-point formative MCQ prior to the end of the 2nd week of the 4-week block and if unsatisfactory must meet with their preceptor to discuss strategies and resources to promote success.
11.2	Activities addressing student satisfaction with electives guidance have been implemented, but data on their effectiveness are needed.	GQ data and details provided on recent events related to choosing electives.	The Student Advocacy and Wellness (SAW) Hub has increased capacity in many areas of support. GQ 2023 data show 79% of the class of 2023 were satisfied / very satisfied with the guidance provided when choosing electives, compared to 65.1% (2021) and 42% (2015).
12.1	Debt continues to be higher than the national average. A Financial Literacy curriculum was implemented in 2015 but needs to be monitored for effectiveness.	Details provided regarding the Financial Literacy curriculum and other initiatives to reduce debt.	The purposeful recruitment of students from pipeline application pathways and inability to work due to the year-round curriculum contribute to high debt. Students are currently directed to the UCalgary main campus for financial aid/debt management assistance in addition to a recently hired (2024) financial literacy consultant.
12.5	Policy to address the non-involvement of providers of Student Health Services in student assessment does not delineate the CSM's responsibility and leaves the onus on the student.	Policy was resolved to delineate faculty responsibility, and is communicated via the ITER, website and clerkship leaders.	This process began in 2016 and in the first year there were 2157 ITER "boxes" checked, with a total of 6 indicating a conflict, all of which were deemed minor and did not result in removing the faculty from involvement.

INTRODUCTION - ACCREDITATION PROCESS SELF-STUDY DESCRIPTION

The Accreditation Steering Committee (ASC) began the Medical School Self-Study (MSS) process in June 2023 following the completion of the majority of DCI Elements by the sub-committees and the availability of the raw Independent Student Analysis (ISA) data. It was decided that the ASC would function as the *committee of the whole** to fulfill the responsibilities of the MSS Steering Committee, with individual faculty members and medical students recruited to complete the MSS for each Element based on their review of the related DCI and ISA data.

A total of 35 faculty members and 8 students were involved in this process, with the medical students working collaboratively with the faculty members to write the MSS. The faculty members and students were provided with instructions on how to complete the MSS during an information session facilitated by the Faculty Undergraduate Accreditation Lead (FUAL).

The first drafts of the MSS Elements were received between August-November 2023 and reviewed by the FUAL and/or Accreditation Administrator for relevance, completeness and accuracy. Ratings other than "Satisfactory" were flagged for review by the ASC. The ASC reviewed these throughout Fall 2023, recommended a different rating if required, and referred the Elements back to the relevant sub-committee for revisions to the DCI when necessary. The sub-committees then revised the DCI and MSS according to the feedback or explained why revisions were not made, and/or why they supported the initial rating and/or content.

A first draft of the DCI and MSS was completed in December 2023 and was sent to the pre-accreditation review team consisting of two members of senior UME leadership at CACMS-accredited schools. An in-person pre-accreditation review was conducted on January 24 and 25, 2024. Verbal (January 25) and written (February 5) recommendations from the team were reviewed by the ASC, and revisions to the DCI and MSS were recommended to the sub-committees as necessary. The DCI and MSS were continuously updated through June 2024 as new information became available, including new Graduate Questionnaire (GQ) data and the Class of 2026 pre-accreditation survey data (*Supplemental Appendix 8.5-1 B*).

Final revisions were completed in June 2024, with final accreditation documents forwarded to CACMS in July 2024.

*Committee of the Whole: According to Roberts Rules of Order, Newly Revised, (11th edition), "An assembly can also designate all of its members present to act as a committee, which is called a committee of the whole and is distinguished from an ordinary committee".

EVALUATION OF ELEMENTS

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 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.

1.1 STRATEGIC PLANNING AND CONTINUOUS QUALITY IMPROVEMENT

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

Requirement 1.1-1

The medical school engages in ongoing strategic planning that establishes its short and long-term programmatic goals.

Analysis of evidence for requirement 1.1-1

The new Dean began his term in July 2022 and strategic engagement for the new plan started at the same time. A deep engagement process was undertaken with the entire CSM community until late spring 2023 and the strategic plan was completed in the Fall of 2023. It was published on-line in November 2023 after final input from the leadership team. The present plan is called Reimagining Health for All: Ahead of Tomorrow. It builds on the academic strength of previous plans as the CSM is a research-intensive faculty in a research- intensive university. The academic mission is built on the strength of multiple educational units and seven world class research institutes. The focus on precision medicine continues to be embedded within the plan.

The six priorities move the school to expand its social accountability mission to have impact for the people of Calgary and communities (first priority pillar). The other five pillars include education, discovery science, a commitment to Indigenous health, striving for social justice through health equity and transforming health through a learning health system. The plan is accompanied by an implementation and metrics strategy with a budget plan to enable these objectives.

The plan will be a living document on the website and will change through yearly continuous quality improvement cycles and regular reporting (dashboards) of the key performance indicators (KPIs). The CSM has not regularly reported on the KPIs in a public fashion and is committed to improving this aspect of the planning process.

Requirement 1.1-2

The medical school engages in ongoing continuous quality improvement processes that result in the achievement of measurable outcomes that are used to improve educational program quality.

Analysis of evidence for requirement 1.1-2

The medical school engages in ongoing continuous quality improvement (CQI) processes that result in the achievement of measurable outcomes that are used to improve educational program quality. CQI is central to all of the educational programs as well as the medical school. The CSM has recently completed successful accreditation of: a) PGME programs (2022), b) CME and Professional Development (2018), c) simulation facility (March 2023). An internal University of Calgary unit review was completed for the CSM in spring 2023 with recommendations made in nine areas that align with the new strategic plan. In addition, the Provost's office coordinates internal educational unit reviews and recently these have included: a) Bachelor of Health Sciences – 2019, b) Bachelor of Community Rehabilitation (2023) and c) UME (2016).

These reviews led to the decision to redesign the UME curriculum. This process was initiated in 2018 and has culminated in an entirely new UME pre-clerkship curriculum (launched July 2023). Re-Imagining Medical Education (RIME) is a shift to a generalist, spiral and patient centric approach. There is an increased focus on generalism, delivery

of clinical content in a "spiral" model (i.e. reinforces previous learning and encouraging increases in content complexity as learner competency grows), and greater inclusion and integration of structural competencies and Indigenous health in all courses.

Two examples illustrated ongoing CQI initiatives that resulted in measurable outcomes to the quality of the educational experience. One example involved an identified need for closed-caption and transcription extraction options on podcasts early during Block 1 of the RIME curriculum, and the second example involved student-driven learning on a family medicine clerkship. Both initiatives resulted in positive outcomes.

Requirement 1.1-3

The medical school engages in ongoing continuous quality improvement processes that ensure effective monitoring of the medical education program's compliance with accreditation standards.

Analysis of evidence for requirement 1.1-3

The CSM engaged in continuous quality improvement processes through a series of committees and processes. A full curriculum review occurred in 2018 and ongoing compliance with accreditation standards is monitored by the Undergraduate Medical Education Committee (UMEC), with regular reports received from its sub-committees: Pre-Clerkship Committee (PCC), Clerkship Committee (CC), Curriculum Innovation and Oversight Committee (CIOC), Research Committee and Student Evaluation Committee (SEC-UME). Those committees are charged with monitoring of (and when necessary, making modifications) the UME program components that are relevant to accreditation standards. This process is defined in the sub-committees' terms of reference.

Details were provided regarding several internal and external outcomes measures that are used to guide the monitoring of accreditation standards and subsequent curricular changes. Such initiatives included several (14) student evaluation strategies, eight unique program evaluation strategies as well as disseminated results to UME leadership for regular review. Overall, feedback is obtained in multiple ways from both students and faculty for incorporation into the programming and curriculum. UMEC tracks specific KPIs that are shared with course leads on a regular basis.

Two examples were provided regarding effective monitoring of the education program's compliance with accreditation standards. These included the release of information in a timely manner (DCI 9.8) as well as exposure to inpatient and outpatient experiences throughout their training (DCI 6.4).

1.1.1 SOCIAL ACCOUNTABILITY

A medical school is committed to addressing the priority health concerns of the populations it has a responsibility to serve. The medical school's social accountability is:

- ***a) articulated in its mission statement;***
- ***b) fulfilled in its educational program through admissions, curricular content, and types and locations of educational experiences;***
- ***c) evidenced by specific outcome measures.***

Requirement 1.1.1-1

The medical school is committed to addressing the priority health concerns of the populations it has a responsibility to serve.

Analysis of evidence for requirement 1.1.1-1

The CSM strategic plan clearly articulates its commitment to social accountability, and several priority populations have been identified. These include rural Albertans, the Indigenous communities and equity deserving groups facing health inequities. Several offices and initiatives have been established to address the priority health concerns of the populations that CSM serves. These include the 2023 CSM Strategic Planning advisory groups.

Other groups involved in addressing priority health concerns include the Indigenous Health Program of the Indigenous, Local & Global Health (ILGH) Office, (overseen by an Advisory Committee), the Distributed Learning Rural Initiatives (DLRI) Office, Global Health Partners, O'Brien Institute for Public Health, The Patient and Community Engagement Research (PaCER), The Patient and Community Engagement Research (PaCER), The Libin Cardiovascular Institute and the Alberta Children's Hospital Research Institute (ACHRI).

Requirement 1.1.1-2

The medical school's social accountability is:

- *a) articulated in its mission statement*
- *b) fulfilled in its educational program through admissions, curricular content, and types and locations of educational experiences*
- *c) evidenced by specific outcome measures*

Analysis of evidence for requirement 1.1.1-2

There are several statements in the mission statement that pertain to a clearly articulated focus on social accountability.

The UME admissions process contributes to the social accountability mandate through several means. There is significant support for Indigenous applicants, and the Pathways to Medicine program includes a focus on lower socio-economic status applicants and those from Indigenous or rural backgrounds. There is also a Black Applicants Admissions Process (BAAP) and an Alternate Admission Process that provide an opportunity to admit applicants who demonstrate an exceptional ability to assist the CSM in meeting its social accountability mission.

Both the old (Legacy) as well as the new (RIME) curriculum highlight social accountability through several key curricular initiatives. The RIME curriculum was designed with social accountability as a key focus. The types and locations of educational experiences in the pre-clerkship highlight a focus on social accountability with mandatory experiences in primary care, as well as mandatory experiences in Indigenous communities. Students are also given opportunities to practice across the city in community-embedded clerkship experiences, including the inner-city Sheldon M. Chumir Health Centre, providing care to patients from immigrant populations, marginalized communities, those with addiction use disorder, etc.

The outcome measures noted include measurable outcomes related to specific identified goals. These goals include the following: the admissions goal, which is to increase the diversity of the students; the curricular content goal, which is to educate and empower students to meet community needs; the goal of increasing the number of team-based, interprofessional, community-engaged, self-driven and problem-based learning approaches to support student-centered learning and the development of critical thinking, reflective practice, problem solving and lifelong learning skills; and the locations of educational experiences goal which is to educate students in under-resourced / marginalized / vulnerable and diverse community settings.

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.

Requirement 1.2-1
The medical school has in place and follows effective conflict of interest policies and procedures applicable to:

- *i) board members*
- *ii) faculty members*
- *iii) any individuals with responsibility for the medical education program*

Analysis of evidence for requirement 1.2-1

There is evidence of comprehensive policies and procedures relating to conflict of interest applicable to board members, faculty members, and to any individuals with responsibility for the medical education program. Policies for both the Cumming School of Medicine and Alberta Health Services are provided as appendices. The policies clearly define conflict of interest in easy-to-understand language and are applicable to all of the specified groups: i) board members, ii) faculty members, iii) any individuals with responsibility for the medical education program. Procedures relating to reporting of conflict of interest are clearly laid out within the document.

The conflict-of-interest policies of Alberta Health Services, applicable to students and faculty members working in AHS facilities, are also clearly noted and are synergistic with CSM policies.

Communication of the conflict-of-interest policies is included in faculty and staff onboarding, and well as email reminders and information accessible across multiple areas of the CSM website.

Requirement 1.2-2
The medical school has in place and follows effective policies and procedures to avoid the impact of conflicts of interest in the operation of:

- *i. the medical education program*
- *ii. its associated clinical facilities*
- *iii. any related enterprises*

Analysis of evidence for requirement 1.2-2

The evidence and examples provided demonstrate a commitment to identifying possible COI and avoidance of such situations in a timely manner. The mechanism for management of conflicts of interest appears to be robust involving the Dean and an arm's length committee. A mitigation strategy describing levels of risk is provided.

1.3 MECHANISMS FOR FACULTY MEMBER PARTICIPATION

A medical school ensures that there are effective mechanisms (including committee structures) in place for any faculty member to directly participate in decision-making related to the medical education program, including opportunities for discussion about, and the establishment of, policies and procedures for the program, as appropriate.

Requirement 1.3-1
The medical school ensures that there are effective mechanisms in place for direct faculty member participation in decision-making related to the medical education program.

Analysis of evidence for requirement 1.3-1

All UME committees have faculty as voting members. Of the 10 major standing committees of the medical school (Table 1.3-1A) 80% have > 50% of the total number of voting members being faculty members. Committee terms of reference ensure wide representation from across the CSM.

In 2020 the CSM launched a committee structure working group and the role of this committee is to make recommendations about how to break down barriers and create processes for equity, diversity and inclusion on committees. General guidelines were provided and CSM committees will be scrutinized regarding inclusiveness. This newly formed committee contained broad representation from across the faculty.

Requirement 1.3-2
The medical school ensures that there are opportunities for faculty member participation in discussions about, and the establishment of, policies and procedures for the program, as appropriate.

Analysis of evidence for requirement 1.3-2

All CSM faculty members are members of Faculty Council. These meetings occur regularly and include presentation and discussion of policy-relevant material. All decanal level positions report in person to Faculty Council on their portfolios and bring policy change requests to this forum.

At the UME level, faculty teaching in the program complete end of course surveys that request input on the organization and content of the course. The survey results are reviewed by UME leadership, the course chair and course committee, and changes to the course or related faculty development occur as necessary.

The 2018 UME Curriculum Review Taskforce was comprised of faculty members, and requested input from faculty, students and alumni across the CSM. UMEC implemented several of the recommendations, and the Re-Imagining Medical Education (RIME) curriculum resulted from this review. The RIME initiative also solicited extensive feedback from across the CSM, including faculty involved in teaching and the clinical realm. There was broad representation from departments in the curriculum development.

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

Requirement 1.4-1

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

Analysis of evidence for requirement 1.4-1

The DCI provides evidence that the Student Placement Agreements (SPAs) for the three health institutions (Alberta Health Services, NTHSSA, and Covenant) cover the requirements related to access to resources, primacy of the program, faculty appointments, environmental hazards, and learning environment. The documents contain the appropriate signatures.

The terms of these agreements are indefinite, however, the DCI states that the AHS/UCalgary agreement is currently under review by AHS and UCalgary legal departments with the intent to define an end date.

1.5 RESPONSIBILITIES AND PRIVILEGES OF THE DEAN

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

Requirement 1.5-1
The medical school has policy documents that describe the responsibilities and privileges of its dean and those to whom the dean delegates authority (e.g., vice, associate, assistant deans), department heads, senior administrative staff, faculty members, and committees.

Analysis of evidence for requirement 1.5-1

Two foci are presented in the pertinent documents for this Element.

1. Committee structures that govern CSM. Faculty Council operates under the Post Secondary Learning Act with delegated responsibilities through General Faculties Council (University) to CSM's Faculty Council. Faculty Council is responsible for setting policy related to programs of study, admission/withdrawal, granting degrees and other activities. In the event that Faculty Council does not achieve a quorum, Faculty Council Committee can act. There are a number of subcommittees (e.g., Strategic Education Council, Strategic Research Council) that report to Faculty Council. They are responsible for specific aspects of the CSM (e.g., education, research) and to manage the powers, responsibilities and functions delegated by Faculty Council.
2. Roles of the Dean and the Senior Leadership Team reporting to the Dean. The Dean's job description outlines the expertise required as well as accountabilities to leadership in strategic directions, education, research and innovation, outreach and engagement, and administration. The Dean chairs Faculty Council/Faculty Council Committee. The Dean's direct reports include:
    a. Vice-Dean whose direct reports include the Department Heads
    b. Senior Associate Dean – Education whose direct reports include the Associate Deans responsible for educational programs
    c. Senior Associate Dean – Research whose responsibilities are to foster and develop research within CSM, oversight for the seven research institutes, and related matters pertaining to research within CSM, the University and externally
    d. Senior Associate Dean – Health Research whose responsibilities include all health research all clinical trials, as well as innovation and commercialization
    e. Senior Associate Dean – Faculty Affairs whose responsibilities include the Academic Medicine and Health Services Program, University of Calgary Medical Groups, Faculty Affairs programs and related operations (e.g., communications, marketing, fund development, external relationships)
    f. Senior Associate Dean – Health Equity and Systems Transformation whose responsibilities are to develop policies and actions that support equity culture and increased diversity of the CSM, including development of a social accountability plan with the Indigenous, Local and Global Health Office leadership team.
    g. Senior Director whose responsibilities include the coordination of administrative, operational and financial affairs.

    Each of the members of the Leadership team chair committees reporting to Faculty Council/Faculty Council Committee.

Collectively, the committee and job descriptions detail roles and responsibilities within CSM.

Requirement 1.5-2
These policy documents are publicized.

Analysis of evidence for requirement 1.5-2

The documents are available on websites or by requesting them directly from the Dean's Office.

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.

**** Details are found in the CACMS Rules of Procedure.***

Requirement 1.6-1

The medical school ensures that its medical education program meets all eligibility requirements of the CACMS for initial and continuing accreditation.*

Analysis of evidence for requirement 1.6-1

Dr. Todd Anderson, the dean of the medical school, has provided a letter attesting that the Cumming School of Medicine meets the eligibility requirements specified in the CACMS Rules and Procedures.

Requirement 1.6-2

The medical school ensures that its medical education program is either part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine.

Analysis of evidence for requirement 1.6-2

A screen shot of the relevant portion for the University of Calgary calendar (2023-23) was provided in Appendix 1.6-2A indicating that the medical education program is a part of the University of Calgary. As such, the program is a part of a university that has legal authority to grant the degree of Doctor of Medicine.

STANDARD 2: LEADERSHIP AND ADMINISTRATION

A medical school has a sufficient number of faculty members 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.

==

2.1 SENIOR LEADERSHIP, SENIOR ADMINISTRATIVE STAFF AND FACULTY APPOINTMENTS

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

Requirement 2.1-1
The dean and those to whom the dean delegates authority (e.g., vice, associate, assistant deans), department heads, and senior administrative staff and faculty members of the medical school are appointed by, or on the authority of, the governing board of the university or by other individuals who have been given the authority to make these appointments.

Analysis of evidence for requirement 2.1-1

Deans are appointed by the President of the University under the delegated authority of the Board, consistent with the Board's ability to delegate under the Post Secondary Learning Act and the Delegation of Authority Policy, as evidenced in Appendices 2.1-1 A1 and A2. The Vice-Dean and Senior Associate Deans are appointed by the Provost on the recommendation of the Dean. Associate and Assistant Deans and Department Heads are selected by search committees, with final approval by the Dean and Provost.

Appendix 2.1-1 A3 indicates that the President, on the advice of the Dean, appoints a Department Head. The Dean seeks advice from CSM members, and in the case of Clinical Departments from Alberta Health Services – Calgary Zone.

It is indicated that senior administrative staff is recruited by senior leadership in the faculty with approval by the Dean.

Appendix 2.1-1 B indicates that faculty members are appointed by or on the authority of the Board of Governors of the University of Calgary.

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.

Requirement 2.2-1

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.

Analysis of evidence for requirement 2.2-1

Dr. Todd Anderson is an accomplished physician, leader, teacher, and scientist, and has held several leadership roles in the Faculty since 1994, including Vice-Dean, Department Head and Institute Director positions. His extensive experience and multiple leadership roles have prepared him to lead the Cumming School of Medicine to ensure that its clinical, educational, research and social accountability missions are achieved.

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 the dean's responsibilities. The dean's authority and responsibility for the medical education program are defined in clear terms.

Requirement 2.3-1
The dean of the 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 the dean's responsibilities.

Analysis of evidence for requirement 2.3-1

The leadership structure for the University of Calgary ensures that the dean has sufficient access to the Provost and to other key senior leaders, as evidenced by Appendix 2.3-1 A. The dean has frequent meetings with the Provost and VP Academic, the President and Vice-President Research, and other university leaders who carry the final responsibility for the medical education program. The dean also meets with senior leadership in Alberta Health Services on a regular basis.

Requirement 2.3-2
The dean's authority and responsibility for the medical education program are defined in clear terms.

Analysis of evidence for requirement 2.3-2

The dean's authority and responsibility for the medical education program are clearly defined in Appendices 2.3-2 A1 & A2.

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.

Requirement 2.4-1
The 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.

Analysis of evidence for requirement 2.4-1

An organizational structure has been established that strives to support the medical school and the educational, research, and social accountability missions. The CSM has one Vice Dean, five Senior Associate Dean positions, 15 Associate Dean positions and 13 Assistant Dean positions and well as eight Directors, all with dedicated time for their specific roles (*Appendix 2.4-1 A*).

2.5 RESPONSIBILITY OF AND TO THE DEAN

The dean of a medical school with more than one campus is administratively responsible for the conduct and quality of the medical education program and for ensuring sufficient numbers of faculty members at each campus. The principal academic officer at each campus (e.g., regional/vice/associate/assistant dean or site director) is administratively responsible to the dean.

NOTE: Only schools operating more than one campus should respond to element 2.5.

Requirement 2.5-1

The dean of a medical school with more than one campus is administratively responsible for:

i. the conduct and quality of the medical education program at each campus
ii. ensuring sufficient numbers of faculty members at each campus

Analysis of evidence for requirement 2.5-1

N/A

Requirement 2.5-2

The principal academic officer at each campus (e.g., regional/vice/associate/assistant dean or site director) is administratively responsible to the dean.

Analysis of evidence for requirement 2.5-2

N/A

2.6 FUNCTIONAL INTEGRATION OF FACULTY MEMBERS

At a medical school with more than one campus, the faculty members at the departmental and medical school levels at each campus are functionally integrated by appropriate administrative mechanisms (e.g., participation in shared governance; regular meetings with minutes and/or communication; periodic visits; review of student clinical learning experiences, performance, and evaluation data; and review of faculty member performance data related to their academic responsibilities).

NOTE: Only schools operating more than one campus should respond to element 2.6

Requirement 2.6-1

At a medical school with more than one campus, the faculty members at the departmental and medical school levels at each campus are functionally integrated by appropriate administrative mechanisms.

Analysis of evidence for requirement 2.6-1

N/A

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.

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3.1 RESIDENT PARTICIPATION IN MEDICAL STUDENT EDUCATION

Each medical student in a medical education program participates in at least one required or elective clinical learning experience conducted in a health care setting in which the medical student works with a resident currently enroled in an accredited program of graduate medical education.

Requirement 3.1-1
Each medical student in the medical education program participates in at least one required or elective clinical learning experience conducted in a health care setting in which the medical student works with a resident currently enroled in an accredited program of graduate medical education.

Analysis of evidence for requirement 3.1-1

It is noted that during the required clinical learning experiences there are multiple rotations in which students are working with residents who are enrolled in accredited residency programs. Of note, all residency programs in Calgary are presently accredited, with the most recent PGME accreditation survey completed in 2022.

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.

Requirement 3.2-1
The medical education program is conducted in an environment that fosters the intellectual challenge and spirit of inquiry appropriate to a community of scholars.

Analysis of evidence for requirement 3.2-1

The investments in (and success of) CSM scholarship, the extensive range of research platforms, the strong network of research institutes, and the breadth of opportunities available to learners all suggest that the environment is strongly conducive to the intellectual challenge and spirit of inquiry.

Requirement 3.2-2
The medical education program provides sufficient opportunities, encouragement, and support for medical student participation in research and other scholarly activities

Analysis of evidence for requirement 3.2-2

The DCI documents the wide range of research opportunities available for medical students (e.g. LIM, AEBM, critical appraisal projects, research electives), the structural elements of the undergraduate curriculum that foster an interest in scholarly inquiry (e.g. Big 10 graduation objectives), and the dedicated resources that have been made available to encourage participation in scholarly activity (e.g. UME research committee and associated elements; travel grants of $1000 available to all students).

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 demonstrate progress towards mission-appropriate diversity outcomes among its medical students, faculty members, senior academic and educational leaders, 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.

Requirement 3.3-1

The medical school in accordance with its social accountability mission has effective policies and practices in place to demonstrate progress towards mission-appropriate diversity outcomes among its:

- *i. medical students*
- *ii. faculty members*
- *iii. senior academic and educational leaders*
- *iv. other relevant members of its academic community*

Analysis of evidence for requirement 3.3-1

The Cumming School of Medicine (CSM) has defined its commitment to social accountability as obliging CSM to direct education, research, service activities and resources towards the priority health and equity concerns of the diverse communities it serves. The Social Accountability Task Force Report and Recommendations (Appendix 3.3-1 A7) were formally adopted by the CSM in the fall of 2022, reaffirming the CSM commitment to social accountability and diversity outcomes. The school's common purpose and values are reflected in its commitment to multiple local, national and international mission appropriate strategies as well as the creation, support and sustainability of several local offices. Specifically, institutional practices are reinforced by the CSM and university formal commitments to the ii'taa'poh'to'p Strategy (U of Calgary Indigenous strategy), Scarborough charter, Dimensions program, Canada Research Chairs Program Action Plan, Declaration on Research Assessment, Okanagan Charter and Campus Mental Health Strategy. School practices are also guided by formal commitments to Indigenous Health Dialogue, Association of Faculties of Medicine (AFMC) Joint commitment to action, Black Medical Students Association Calgary Calls to Action and Black Medical Students of Canada list of recommendations to Canadian Faculties of Medicine. The CSM diversity mandate is supported by CSM offices including the Offices of Health Equity and Systems Transformation, Indigenous, Local and Global Health, Precision Equity and Social Justice, Faculty Development and Performance and Office of People, Culture, and Health Promotion. These policies and practices are applicable to the medical student, faculty, senior academic, education leaders and larger academic communities. There are multiple policies and practices in place to demonstrate progress towards mission-appropriate diversity outcomes.

Requirement 3.3-2

The medical school engages in ongoing, systematic, and focused recruitment and retention activities to demonstrate progress towards mission-appropriate diversity outcomes among its:

- *i. medical students*
- *ii. faculty members*
- *iii. senior academic and educational leaders*
- *iv. other relevant members of its academic community*

Analysis of evidence for requirement 3.3-2

"The Cumming School of Medicine is dedicated to creating a community that is representative of all Albertans and their experiences. We are committed to processes that advance equity and inclusion for all applicants and encourage applicants to celebrate what makes them unique and individual. The enrollment of a diverse group of medical students improves not only health care delivery in the province of Alberta but also the educational experience of all MD students at the University of Calgary" Section 6, MD Admissions Framework and Process.

i. Medical Students

The school has several processes for mission-appropriate diversity recruitment strategies for medical students. This includes pathways and processes to support students from lower socio-economic, Indigenous, racialized and rural backgrounds. This includes a Support To Entry Program (STEP) for equity deserving groups, Black applicants'

admission process, alternate admissions process and several outreach activities by the medical school and members of the school community. Selection criteria are made transparent and annually published so that applicants from equity deserving groups can be empowered to make fully informed decisions about where and how to spend their financial and time resources. At the admissions level there is representational diversity amongst file reviewers and interviewers, implicit bias training for all involved in admissions processes and all successful applicants must provide proof of completion of Coursera's Indigenous Canada Admissions Criteria course. There is a mentorship program for prospective interested students and a financial assistance program to help qualifying students prepare and register for the MCAT exam.

The school has created multiple clubs and inviting spaces to cultivate a sense of place and community for its students. This includes groups related to financial assistance, Indigenous health, Black students, students for gender and sexual diversity, disability inclusion, Asian and Muslim students, amongst others. This includes spaces that are multi-faith, inclusive washrooms and changerooms, cultivating inclusion signage and the Indigenous hub, to mention a few. Champions of EDIA activities are recognized through awards, preferentially given to students from equity deserving groups. The RIME curriculum has a specific mandate to be socially accountable and aims to train physicians who are change agents to collectively improve health and well-being in the communities they serve. Emerging themes of health equity, structural competency, wellness, and professional identity are embedded throughout the curriculum. The medical school clearly engages in ongoing, systematic, and focused recruitment and retention activities to demonstrate progress towards mission-appropriate diversity outcomes at the medical student level.

ii/iii/iv. Faculty Members/Senior Academic and Educational Leaders/Other relevant members of academic community
The CSM Equity framework is the guiding document for revisions to the CSM criteria for appointment, renewal, transfer, promotion and merit assessment for academic staff. This framework attempts to address the implicit bias and systemic discrimination that has been cited in an abundance of research in academic health sciences that negatively impacts members of marginalized groups through their career trajectory. Mission appropriate diversity recruitment and retention strategies for faculty members include the use of inclusive language and imagery, inclusive hiring pathways for Black and Indigenous scholars, the setting of faculty standards to ensure an anti-racist and anti-oppression lens is applied to all CSM committees and inclusive hiring and selection training to be completed by faculty members. There are recruitment onboarding mentorship opportunities through research communities, alumni association and the Black Physicians of Alberta Association. Retention activities include Office of Faculty Development and Performance offerings related to reconciliation, social justice, career and teacher development to support faculty, as well as awards and recognition for work that promotes, supports and elevates EDIA activities.

Requirement 3.3-3
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.

Analysis of evidence for requirement 3.3-3

There are several programs in place aimed at achieving diversity among qualified applicants for medical school admission as mentioned above in 3.3-2. This includes the Pathways to Medicine scholarship program, Support to Entry Program (STEP), Indigenous Health Program and the Black Applicant Admissions Process. Evaluation of these programs and policies is still in its early stages.

The MD Admissions Office collects voluntary demographic data on applicants and matriculants to measure progress of diversity focused policies and practices. The results from this data and the impact of these practices and policies are still in their early stages and more time and data are needed to ensure progress is being made.

A few evaluation metrics that are reported are the Black Medical Students Association of Canada (BMSAC) 2021 and 2023 report card surveying of how Canadian medical schools rank based on the BMASC's Calls to Action on cultivating inclusive environments for Black learners in undergraduate medical education (Supplemental Appendix 3.3-3 A3). In a grading system based on the OMSAS Undergraduate Grade Conversion Table, the CSM achieved in the A+ to B- range across categories, representing good progress and commitment to the Calls to Action. Moving forward, there are plans to measure progress through repeated measures of a voluntary self-identification demographic census throughout CSM. This will allow for measurements of success to ongoing medical school policies and activities in increasing diversity of students, faculty, and leadership.

Although there is little evaluation data to show that mission appropriate diversity outcomes are being achieved there are clear plans in place for evaluation of these programs in the near future.

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, national origin, race, sex, diverse sexual orientation, gender identity, and gender expression. 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 reported incidents with a view to preventing their repetition.

Requirement 3.4-1
The medical school and its clinical affiliates do not discriminate on any grounds as specified by law including, but not limited to, age, creed, national origin, race, sex, diverse sexual orientation, gender identity, and gender expression.

Analysis of evidence for requirement 3.4-1

The CSM Code of Conduct stipulates that the University endeavors to create and maintain a positive and productive learning, working, and living environment where there is respect for the dignity of all and fair treatment of individuals. To support this, there are multiple policies, processes, and standards in place at the medical school, university, and clinical affiliates levels (Alberta Health Services) that address discrimination, harassment, and misconduct. Details of these policies, processes and standards are listed in several associated appendices.

At the CSM, reporting of complaints related to discrimination is handled by the Precision Equity and Social Justice Office (PESJO). From 2021 to June 2023 there were 43 reports received and handled by the PESJO office.

The Faculty Advocates Against Mistreatment (FAAM) also received and responded to reports of discrimination by medical students. This program was retired in January 2024 but had received and responded to 3 reports during its existence.

The Student Advocacy and Wellness Hub (SAWH) is another place where students can voice discrimination complaints. SAWH intake advisors then support and direct students to the next appropriate office or course of action depending on each specific situation, student need and student preference. There is no formal process to report this data.

Requirement 3.4-2
The medical school and its clinical affiliates foster an environment in which all individuals are treated with respect.

Analysis of evidence for requirement 3.4-2

The medical school and its clinical affiliates foster an environment of respect through mechanisms that include both policies and programs. This includes the University's Code of Conduct, Harassment and Accommodations policies. These policies are faculty and student facing and accessible through university and PESJO office websites. The Code of Conduct is widely distributed to faculty and is currently being updated with input and perspectives from equity deserving groups. The UME provides an orientation for its students and all faculty can participate in several workshop offerings through the OEDI to convey and enhance respect in the workplace. The University of Calgary, CSM and AHS have all issued statements against discrimination. Both the University of Calgary and AHS have been recognized as top-diversity employers which reflects their commitment and excellence in fostering environments where all individuals are treated with respect.

More recently, with the appointment of a new Associate Dean UME in January 2024, channels for enhanced and ongoing direct communication between UME students and UME leadership have been established. This includes ongoing meetings with students and student leadership and increased representation of students and the student voice on committees and decision-making bodies. Data from the ISA show that 81-95% of students agree that the medical school fosters an environment in which people are treated with respect and 90-97% of students agree that the hospitals where they were assigned fostered environments where they were treated with respect. These results are very promising.

Requirement 3.4-3
The medical school and its clinical affiliates take steps to prevent discrimination.

Analysis of evidence for requirement 3.4-3

The new CSM Strategic Plan emphasizes EDI and reconciliation throughout. This serves as the foundation upon which policy, education, and training to prevent discrimination exists. Policies include The Equitable Search & Selection Operating Standard, Inclusive Language Operating Standard and Criteria for Merit, Tenure and Promotion. As mentioned earlier, all successful applicants to the MD program must complete an Indigenous Awareness course. All faculty who are part of search and selection must complete implicit bias training, and joining a committee requires members to answer some questions related to EDI and Reconciliation. The CSM has recently begun an EDI and Indigenous Awareness campaign to further education and awareness on these topics. The OFDP and PESJO offices offer several workshops on topics related to social justice and reconciliation to build faculty skills and knowledge in preventing and addressing discrimination. As a clinical affiliate, Alberta Health Services (AHS) anti-racism advisory committee has provided several recommendations to address individual and systemic racism which are now being implemented. There are clearly several policies and programs at the medical school, university, and clinical affiliates levels designed to prevent discrimination.

Requirement 3.4-4
The medical school and its clinical affiliates provide a safe mechanism for reporting incidents of known or apparent anti-discrimination breaches.

Analysis of evidence for requirement 3.4-4

There are several mechanisms for safe reporting of incidents of known or apparent anti-discrimination breaches for the CSM. Appendix 3.4-1 A12 UME Student Mistreatment clearly outlines the four ways students can report mistreatment: Anonymously through course surveys, directly to UME non-anonymously, report to Faculty Advisors Against Mistreatment and via main campus channels. The current faculty process sits mainly with the Office of Precision Equity and Social Justice (PESJO). Any individual can report breaches to the CSM discrimination policy to the Associate Dean PESJO through email or an online submission form which allows for anonymity. When concerns are received, the Associate Dean initiates appropriate action, balancing the safety of the individual with the need for follow up action items. These processes are currently being revised to address concerns around navigability, fear of reprisal and communication/clarity around the timeline and process. This revised process will be administered through the *CSM Informal Resolution Guidelines* by CSM Human Resources, personnel external to the CSM clinical and academic faculty to prevent possible conflicts of interest and concerns around retaliation. This process will serve as an alternate for those CSM members who are experiencing mistreatment but don't want to access formal channels. This process will include navigation of resources, different reporting options and a committee of those with lived experience and expertise to advise and guide. As part of this process, CSM Human Resources will provide data stewardship related to the process. Other mechanisms for reporting include:

- University of Calgary's Protected Disclosure and Research Integrity Office (PDRI) to make formal reports of breach of university policy, including acts of discrimination.
- External provider Confidence Line to anonymously report a wrongdoing.

Medical students, in addition, have several other methods for reporting available. These include:
1) Using the UME 'A Safe Space' website to confidentially report a concern to the Associate Dean
2) Through program surveys and evaluation forms
3) Directly to the Associate or Assistant Deans of UME
4) The University of Calgary's Student Conduct Office for student non-academic misconduct including breaches of the University's *Harassment Policy*

If contact information is provided, the Faculty Advisors Against Mistreatment, Associate Dean or Assistant Dean discuss concerns with the individual, clarify the issues and explain the investigation process and help the individual decide on next course of action.

All residency programs have an ombudsperson and in August 2023 a new leadership position, Associate Dean of People, Culture and Health Promotion was created with a mandate to create psychologically safe learning and working environments for all faculty and learners.

Clinical affiliate, AHS's Policy on Respectful Workplaces and the Prevention of Harassment and Violence has four related documents that outline processes around breach of the policy. The AHS CMO Diversity and Wellness, provides guidance and advice for concerns including discrimination. New AHS bylaws are being developed that will describe fair and timely processes for addressing issues as they arise at a local level. "Hotspot reporting", in which learners report mistreatment linked to a specific location, is currently in development (Supplemental Appendix 3.4-4 A1 Hotspot).

Overall, there are safe reporting mechanisms for anti-discrimination breaches at the UME, faculty, academic staff and clinical affiliate levels. Based on prior feedback, some are being revised to improve navigability and confidentiality. What is not clear from the DCI is how these processes and polices are shared or made known to students and faculty. It is also not clear how anonymous reports are managed and if they are managed in the same way as identified reports. While multiple reporting mechanisms may be helpful to different groups, multiple reporting mechanisms can also cause confusion and redundancy if reporters are not sure which one to use or go to first. The work towards a centralized CSM mistreatment reporting process should help to address this issue.

The ISA for this topic shows that discrimination is experienced by 3-8% of medical students but only ~25-30% of those discriminated against felt that the medical school and/or hospitals provided safe mechanisms for reporting. There is work to be done in this area and CSM has started this process. This will require further review in coming years to see the results.

Requirement 3.4-5
The medical school and its clinical affiliates provide fair and timely investigation of allegations of discrimination.

Analysis of evidence for requirement 3.4-5

There are several mechanisms in place for the medical school and its affiliates to provide fair and timely investigation of allegations of discrimination. This includes mechanisms at the University, Medical School and AHS levels as listed above in 3.4-3 and 3.4-4. These processes are confidential, can be anonymous and every effort is made to balance the importance of direct information provided by the reporter (when engaged directly) with protecting the individual's privacy and safety. Reporters are usually offered several mechanisms of support and actions are only taken with the reporters' permission and efforts made to tailor action to specific incident and the reporter's needs. The investigation of complaints is fair in that it is guided by policy and procedure and there is due process to determine options for next steps and more formal disciplinary action. There are processes in place to protect privacy of allegations including both written reports and conversations. Some of the processes and procedures are explicit in terms of timelines (i.e. 15 working days for the Code of Conduct Protected Disclosure and 48 hours for any reports to the Associate Dean PESJO office) while others do not specify specific timelines.

Requirement 3.4-6
The medical school and its clinical affiliates provide prompt resolution of reported incidents of discrimination with a view to preventing their repetition.

Analysis of evidence for requirement 3.4-6

The medical school and its clinical affiliates provide a prompt response to any reported incidents of discrimination as outlined above in 3.4-5. Once any report of concern is received, the investigation process is initiated quickly as outlined above. Thereafter, the time taken to achieve resolution varies and depends on each individual circumstance. An approach that balances thorough investigation and prompt resolution is the aim but depending on the circumstance this can vary from weeks to months. There are no specific data to track time to resolution of complaints available.

3.5 LEARNING ENVIRONMENT

A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviours in its medical students, faculty members, and staff at all locations

The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment to:

a) identify positive and negative influences on the maintenance of professional standards
b) implement appropriate strategies to enhance positive and mitigate negative influences
c) identify and promptly respond to reports of violations of professional standards.

Requirement 3.5-1

The medical school ensures that the learning environment of its medical education program at all locations is conducive to the ongoing development of explicit and appropriate professional behaviours in its:

i. medical students
ii. faculty members
iii. staff

Analysis of evidence for requirement 3.5-1

There are several mechanisms in place to ensure that the learning environment of CSM medical education programs at all locations is conducive to the development of explicit and appropriate professional behaviors. This objective is achieved through both collected feedback and ongoing education and faculty development. Student evaluation of the learning environment occurs at multiple time points using multiple approaches. This helps to identify gaps in professional behaviors and triggers processes to support recognition and remediation of identified negative behaviors as soon as possible. Feedback from students is collected in the following ways: daily on-line evaluation of learning sessions, end of course evaluations, preceptor evaluations, elective evaluation forms, end of year survey (across all three years) and an end of training survey. Student feedback is reviewed at the Pre-Clerkship and Clerkship committees, by course, unit and block leads and by the UME office, with oversight by the Associate and Assistant Deans. There is student representation in all major administrative committees, regular "brown bag" lunch meetings between students and the UME leadership team and the specific professionalism and physician health unit course where discussions around professional development and appropriate behaviors takes place.

At the faculty level, feedback about the learning environment is collected and shared back to vice-chairs of education and educational leads within individual departments. Feedback is also sought from faculty at the end of each pre-clerkship course. There are multiple faculty development opportunities offered through the CSM Office of Faculty Development and Performance, including leadership education, workshops on social justice and reconciliation, and career and teaching development. There are also faculty development offerings through the Taylor Institute for Teaching and Learning and Alberta Health Services. Details of these are listed in the DCI. The majority of these offerings are also available for CSM non-faculty staff.

Moving forwards, despite these robust offerings and mechanisms in place, CSM has identified some areas to improve its learning environment and has prioritized the school to actively address the following: Challenge existing frameworks and definitions of "professionalism" and "professional behaviors" to include perspectives of equity deserving groups who have historically not been included in these conversations, transitioning to the RIME curriculum in which key concepts of professional identity development as well as social justice are repeatedly layered into the curriculum as opposed to being stand-alone units, adoption of the Okanagan Charter and the creation of a new Associate Dean of People, Culture and Health Promotion, emphasizing a culture of safety and belonging through a communications campaign and increasing representational diversity as well as supports and mentorship for equity deserving groups across CSM leadership.

Requirement 3.5-2

The medical school and its clinical affiliates share the responsibility in the periodic evaluation of the learning environment in order to:

a) identify positive and negative influences on the maintenance of professional standards
b) implement appropriate strategies to enhance positive and mitigate negative influences
c) identify and promptly respond to reports of violations of professional standards

Analysis of evidence for requirement 3.5-2

Direct feedback from medical students about preceptors, end of course surveys, clerkship surveys and comments about their educational environment are collected and reviewed. Leadership representatives at the medical school regularly meet with its clinical affiliates at various levels to fulfill their shared responsibility for the periodic evaluation of the learning environment and review of this feedback. There are several UME committees (Pre-Clerkship, Clerkship, UMEC and UME management) that have diverse and cross-cutting representation from marginalized groups and students. Outside of the UME, the Strategic Education Council, Department Heads Committee, the former Office of Professional Development, Equity and Diversity (OPED) Subcommittee and Advisory Group, CSM EDIA leads council and then Student Evaluation Committee all meet regularly. The learning environment is discussed as part of these groups' meetings. There is representation from both clinical and academic staff in these groups. The cross-cutting nature of membership and influence in various clinical and academic spheres helps to facilitate ongoing and periodic review of the learning environment. These various committees and groups allow for identifying positive and negative influences on the learning environment and maintaining professional standards.

Positive elements are further identified and amplified through direct medical student feedback on preceptors, recognition of teachers at the annual UME faculty appreciation night, and various educational and EDI awards from both main campus and CSM. The UME Associate Dean sends out yearly recognition letters to all preceptors that summarize the teaching they did for the year and their ratings from students. The faculty performance review tool (distributed directly to Department Heads) provides a summary of relevant information regarding all department members' UME contributions and helps to identify individuals who consistently show excellence in teaching and professional standards.

Negative influences are identified and mitigated through the UME Management Committee (leadership and senior staff) which meets weekly and has a protocol in place to address concerns about preceptors and the learning environment. The CSM Associate Dean PESJO and the University Protected Discloser Advisor (PDA) are invited to these meetings when professionalism concerns are specifically reviewed. When needed, this committee also consults with the College of Physicians and Surgeons of Alberta. Any reporting of unprofessional behaviors can also occur directly through PESJO or through the Student Advocacy and Wellness hub which will then liaise with the UME Management Committee. Hotspot reporting, in which learners report mistreatment linked to a specific location, is innovative and currently in development. Full details on these processes are available in Supplemental Appendix 3.4-1 A1.

The same processes that identify positive and negative influences on the learning environment are also used to identify violations of professional standards. All initial reports to the Associate Dean PESJO (when reply information is provided) are responded to within 2 business days whenever possible with an invitation to speak with the reporter to gather more details. Formal responses to professional standard violations that transgress University of Calgary Harassment policy is responded to by the Student Conduct Office and the Protected Disclosure and Research Integrity Office. The timeline for this is not specifically provided.

Two examples of how negative elements have been mitigated in the past are provided. This includes advocating for and creating a CSM and AHS Sexual Violence educator role to address concerns around sexual and gender-based professional standard violation that were brought forward in the past. Secondly, in 2019, the UME Management Committee and the Assistant Dean, Pre-Clerkship identified issues around discrimination and harassment of learners wearing religious attire in Calgary operating rooms. Follow up from this led to the new provincial AHS policy around Surgical Attire and a series of educational sessions for surgical teams across Calgary. This work is ongoing.

3.6 STUDENT MISTREATMENT

The medical school has policies that define mistreatment, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing mistreatment and retaliation. Mechanisms for reporting mistreatment are understood by medical students and visiting medical students and ensure that any mistreatment can be registered and responded to.

Requirement 3.6-1
The medical school has written policies that define mistreatment.

Analysis of evidence for requirement 3.6-1

There are several written policies that define mistreatment and processes around mistreatment at the medical school and university levels. These include mistreatment definition, harassment policy, sexual and gender-based violence policy and process map, workplace violence policy, code of conduct, student non-academic misconduct policy and procedure, student at risk policy and procedure for protected disclosure policy. Appendix 3.6-1 A1, the Current Mistreatment definition does an excellent job of defining mistreatment and providing several examples and vignettes that outline mistreatment behaviors for students who still may not be clear on what constitutes mistreatment. These case examples are clear and poignant and provide concrete examples to support students who may be faced with uncertainty. Work is currently underway to develop safe mistreatment reporting operating guidelines, with broad consultations across CSM and the University with the goal of incorporating best practices and recommendations of multiple learners and stakeholders.

There are formal and mandatory processes in place for medical students, visiting medical students, residents and new faculty to make them aware of the mistreatment and associated policies and reporting procedures. Administrative staff at the PGME level have been provided with opportunities for learning about avoiding mistreatment. UME staff have not been provided with opportunities for learning about avoiding mistreatment, and this has been identified as an important gap. The entire CSM community has access to several relevant OFDP sessions (i.e. responding to disclosures, moving from bystander to upstander, etc.), the CSM Dean sends out periodic electronic communication throughout CSM and several UME, PGME, PESJO and PDRI websites have available access to policies and procedures related to mistreatment definitions, expectations and reporting.

Requirement 3.6-2
The medical school has effective mechanisms in place for a prompt response to any complaints.

Analysis of evidence for requirement 3.6-2

The formal and informal mechanisms in place for a prompt response to any complaints of mistreatment include the University of Calgary Protected Disclosure and Research Integrity Process, the Workplace Investigation process and the Student Non-academic Misconduct Reporting Process. There are mechanisms in place through feedback at the UME level, the former Faculty Advisors Against Mistreatment (FAAM), PESJO office (reports responded to within 2 days or receival) and Protected Disclosure Office to support students in reporting mistreatment. The Faculty Report Card, which provides collated and anonymized details about incidents and how they were dealt with for specific scenarios is available for students through the UME password protected online curriculum management system. This allows students to see the outcome of their disclosures with enough detail to identify the incident but not enough detail that discloses the identity of the individual teacher or student. Time to resolve complaints is not available and is likely variable depending on the complaint. There is not a formal mechanism in place to assess the effectiveness of these measures, however, overall frequency of reporting of mistreatment has not decreased over time. It is postulated that with increased awareness of polices and processes students are more likely to report what has previously been vastly underreported.

There definitely seems to be a history of challenges around mistreatment reporting and follow up of incidents. In preparation for the 2016 Accreditation review, an ad hoc Mistreatment Task Force was created and several recommendations put forward from this group (Supplemental Appendix 3.6-2 A1). Follow-up reviews from this initiative showed increased awareness and reporting of incidents of mistreatment. However, there have been ongoing concerns and students have felt that the processes developed are not addressing root issues around mistreatment. Therefore, in 2022, through CSM student and faculty driven advocacy efforts, external and internal reviews and reports alongside a robust environmental scan, several initiatives were undertaken to reassess mistreatment at both institutional and faculty levels. There is ongoing work in this area under review by the legal team before it can be introduced and

implemented. The CSM Informal Resolution Guidelines have been created which will be administered by CSM Human Resources, and include personnel external to CSM clinical and academic faculty. Quality improvement measures that will consider ongoing effectiveness of this work include ongoing feedback from students and other stakeholders, developing a registry that collects and tracks information on concern types, processes and responses, and a corresponding plan for evaluation of data.

Requirement 3.6-3
The medical school supports educational activities aimed at preventing mistreatment and retaliation.

Analysis of evidence for requirement 3.6-3

A Student mistreatment presentation series was offered from 2016-2019. This presentation introduced the topic of student mistreatment followed by two videos with guided discussion. This was presented at several departmental sessions, conferences and student information sessions. A research project related to mistreatment was also completed and presented at CCME in 2019. There are no specific educational activities aimed at preventing retaliation. There is an online workshop “Responding to disclosures” which may indirectly address retaliation but is not a specific objective of this workshop.

Requirement 3.6-4
Mechanisms for reporting mistreatment are understood by medical students.

Analysis of evidence for requirement 3.6-4

Data from the ISA shows that there is an increase in understanding around mistreatment reporting mechanisms from Year 1 to Year 4 (61% to 80%) with peak understanding Year 3 (94%). To address the lower rates of understanding in Year 1, students are given a presentation on mistreatment during the orientation period.

Requirement 3.6-5
Mechanisms for reporting mistreatment are understood by visiting medical students.

Analysis of evidence for requirement 3.6-5

This requirement was not something that had been previously required as part of CSM accreditation and thus data has not been previously collected. As a result, there is no data on visiting medical students understanding of mistreatment reporting mechanisms. A new exit survey for visiting elective students is being developed to collect this relevant data moving forwards.

Requirement 3.6-6
Mechanisms for reporting mistreatment ensure that any mistreatment can be registered and responded to.

Analysis of evidence for requirement 3.6-6

The mechanisms by which the medical school ensures a prompt response are listed in detail in 3.6-2 above. The PESJO office (formerly OPED) undertakes record keeping of concerns brought forward that includes dates of receipt, date of initial reply and subsequent meetings and other follow up around desired resolution of the reporter, the respondent and role and the actions taken by the Associate Dean PESJO to reach desired resolution and outcome. These records are de-identified and general aggregate data shared and provided to CSM leadership and PDRI annually. The UME faculty report card, details outlined earlier, also captures details of mistreatment and how it has been responded to. The UME Dean also collects aggregated data internally that captures reports of mistreatment received and the nature of the complaints. At an institutional level, PDRI office retains internal records with aggregate data that is then reported up to UCalgary Legal and the Board of Directors.

The Student Advocacy and Wellness Hub (SAWH) and PGME Office of Residents Affairs and Physician Wellness have standardized intake forms that may include information related to mistreatment, but these are not formally reported beyond these individual offices. The development of the new CSM Informal Resolution Guidelines (noted above) will standardize templates around data collection in mistreatment reporting including concern intake, assessment and classification, response and resolution, follow up of reporter and respondent experiences and then allow for aggregation of data to be shared and reported back to various units as appropriate. There are several supports, services and offices in place to support students who report mistreatment including the Indigenous Health Program, SAWH, Directors of

Resident Support (PGME), Residency Program Ombudsperson, Office of Resident Affairs and Physician Wellness as well as main campus supports. Despite this, as reported in the ISA, only 45-53% of students feel that they can report mistreatment without fear of retaliation.

STANDARD 4: FACULTY MEMBER 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.

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4.1 SUFFICIENCY OF FACULTY MEMBERS

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

Requirement 4.1-1
The medical school has in place a cohort of faculty members with the qualifications and time required to deliver the medical curriculum.

Analysis of evidence for requirement 4.1-1

The CSM has a Planning and Priorities Committee that regularly recruits new faculty. Recruitment priorities are guided by the CSM Strategic Plan and CSM's strategic focus on Precision Medicine and Precision Public Health. The recruitment process involves a review of a potential recruit's CV, cover letter and reference letters by the Department Head's Committee. Protected time for teaching is established annually for GFT and AMHSP faculty members. Non-AMHSP faculty receive payments for teaching.

The medical school was successful in recruiting the many Directors, pre-clerkship educators, and tutorial group facilitators required to launch the RIME curriculum.

Requirement 4.1-2
The medical school has in place a cohort of faculty members with the qualifications and time required to fulfill the other missions of the medical school.

Analysis of evidence for requirement 4.1-2

The CSM Planning and Priorities Committee regularly recruits new faculty. Recruitment priorities are guided by the CSM Strategic Plan and CSM's strategic focus on Precision Medicine and Precision Public Health. The recruitment process involves a review of a potential recruit's CV, cover letter and reference letters by the Department Head's Committee. Protected time for administration, research, and clinical activities is established annually for GFT and AMHSP faculty members.

CSM has identified the importance of expanding faculty with Black and Indigenous lived experience. The Government of Alberta has indicated their strategy to increase medical school enrollment with a renewed focus on family medicine, generalism, and rural medicine, and funding for this has been allocated.

4.2 SCHOLARLY PRODUCTIVITY

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

Requirement 4.2-1
The medical school's faculty members, as a whole, demonstrate a commitment to continuing scholarly productivity that is characteristic of an institution of higher learning.

Analysis of evidence for requirement 4.2-1

The DCI describes the comprehensive CSM criteria for evaluating research excellence, its nationally recognized leadership in revising such criteria to align with the Declaration on Research Assessment (DORA) principles, and the strong and sustained improvements in research funding and recognition within and outside the University of Calgary. These all indicate very strong scholarly productivity, underpinned by institutional commitment to supporting and recognizing such productivity.

4.3 FACULTY MEMBER APPOINTMENTS

A medical school has clear policies and procedures in place for faculty member appointments, 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 the faculty member's 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.

Requirement 4.3-1
The medical school has clear policies and procedures in place that involve the faculty member, the appropriate department head(s) and the dean when dealing with a faculty member's:

- *i. appointment*
- *ii. renewal of appointment*
- *iii. promotion*
- *iv. granting of tenure*
- *v. remediation*
- *vi. dismissal*

Analysis of evidence for requirement 4.3-1

The General Faculty Council (GFC) Academic Staff Criteria and Processes Handbook (2021), CSM Faculty Guidelines 2023 and The University of Calgary Faculty Association (TUCFA) agreement contain information on items i-vi. There is a specific note that remediation is addressed on a case-by-case basis with Department Heads or UME leadership (if the concern is related to education).

Requirement 4.3-2
The medical school provides each faculty member with written information about the faculty member's:

- *i. term of appointment*
- *ii. responsibilities*
- *iii. lines of communication*
- *iv. privileges and benefits*
- *v. performance evaluation and remediation*
- *vi. terms of dismissal*
- *vii. the policy on practice earnings (if relevant)*

Analysis of evidence for requirement 4.3-2

There are specific Letters of Offer for different faculty types, all of which refer to specific documents which include information on items i-vi.

4.4 FEEDBACK TO FACULTY MEMBERS

A medical school faculty member, consistent with the terms of the faculty member's appointment, receives regular and timely feedback from departmental and/or other educational program or university leaders on academic performance, and, when applicable, progress toward promotion or tenure.

Requirement 4.4-1

A medical school faculty member, consistent with the terms of the faculty member's appointment, receives regular and timely feedback from departmental and/or other educational program or university leaders on academic performance, and, when applicable, progress toward promotion or tenure.

Analysis of evidence for requirement 4.4-1

There is a robust and continuous process for feedback to faculty members. Feedback is provided every two years via performance review with the Department Heads (and other relevant leadership). This process is supported by an academic reporting model within the Cumming School of Medicine. Feedback on UME activities are provided directly to the faculty member via the annual Faculty Performance Report (FPR), which outlines teaching activities, feedback scores, committee contributions and other facets of performance in this arena. These Faculty Performance Reports are also copied to the Department Heads for use in the performance review process.

All full-time faculty were recently reviewed as part of the progression through the ranks process, including considerations for merit awards related to contributions through the pandemic and outstanding achievement awards.

The processes in place ensure the regular and timely feedback is provided to faculty members to assess performance and guide progression.

4.5 FACULTY PROFESSIONAL DEVELOPMENT

A medical school and/or the university provides opportunities for professional development in those areas needed to fulfill faculty members' obligations to the medical education program and to enhance faculty member's skills and leadership abilities.

Requirement 4.5-1
A medical school and/or the university provides opportunities for professional development in those areas needed to fulfill faculty members' obligations to the medical education program and to enhance faculty member's skills and leadership abilities.

Analysis of evidence for requirement 4.5-1

The CSM provides a wide range of professional development opportunities to faculty members through the Office of Professional Development & Performance (OFDP), the Office of Continuing Medical Education & Professional Development (CME & PD), and the Indigenous, Local & Global Health Office (ILGHO). Additional opportunities are available through faculty members' individual Departments as well as the UCalgary Taylor Institute for Teaching & Learning. Appendix 4.5-1 C demonstrates the variety of sessions offered and attendance at the OFDP sessions.

4.6 GOVERNANCE AND POLICY-MAKING PROCEDURES

The dean or a dean's delegate and a committee, the majority of which are faculty members at a medical school, determine the governance and policy-making procedures of the medical education program.

Requirement 4.6-1
The dean or a dean's delegate and a committee, the majority of which are faculty members at a medical school, determine the governance and policy-making procedures of the medical education program.

Analysis of evidence for requirement 4.6-1

CSM Faculty Council is a CSM-wide committee, chaired by the Dean, whose membership includes all full-time CSM academic staff. The Council serves as the senior academic governing body on the academic affairs of the Faculty and is responsible to the University's General Faculties Council (GFC). This body is responsible for determining programs of study, determining admission requirements to CSM education programs, authorizing the granting of degrees, and other activities that may be delegated or assigned by GFC or brought to it by the Chair.

The Strategic Education Council (SEC) has delegated authority from the CSM Faculty Council for overall governance of educational programming at CSM. SEC is the body within CSM that authorizes the granting of degrees in the UME program and the approval of UME course changes. The SEC meets monthly, and the majority of members are faculty within CSM. There is also the Undergraduate Medical Education Committee (UMEC) that reports to SEC and, through it, to Faculty Council. The UMEC is the central/direct governance and policy-making body for the undergraduate medical program, and it meets at least quarterly.

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.

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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.

Requirement 5.1-1
The present and anticipated financial resources of the medical school are adequate to sustain the medical education program and to accomplish other goals of the medical school.

Analysis of evidence for requirement 5.1-1

Overall funding governance:
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. The Dean engages in effective financial planning during regular meetings with the Senior Director, Vice Dean and Senior Associate Dean, Faculty Affairs, as well as at regular meetings of the Dean's Executive to address issues relating to the operating budget, current and projected capital needs. This ensures that the Dean has a comprehensive understanding of the Faculty's finances and overall effective financial management and budget controls. The Dean is accountable to the Provost for budget and finances, and a regular financial overview is provided at Department Head and Faculty Council meetings. Core infrastructure/base building maintenance is the responsibility of the University. Upgrades and renovations are paid for by the Faculty, and largely funded by philanthropy funds, supplemented by Faculty operating funds, research funding and funding from the Provost. The medical school's financial records have not been externally audited on its own, however the records are audited with the overall finances of the university.

Present financial resources:
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 (Table DCI 5.1-1 A and and the AFMC financial statement in Supplemental Appendix 5.1-1 B1*)*. Current projected operational deficits due to provincial budget cuts and funding freezes are being offset via planned retirements, faculty and staff attrition, utilization of IRNA (Internally Restricted Net Assets) accounts, and vertical cuts to non-core programs (CME, etc.). The school has a risk mitigation plan in place to address current and projected short-term operational deficits.

Anticipated financial resources:
Successive years of cuts to provincial funding to the University of Calgary has resulted in annual budget deficits to the Cumming School of Medicine, although efforts have been made to protect funding to the UME program. A considerable amount of faculty funding has historically been provided through Alberta Health Services. However, this source of funding is also under budget pressures. To limit cuts within the CSM, a reserve fund has been utilized over the past 5 years, with the largest drawdown in 2022-23.

There is robust evidence of budget planning, central oversight, and coordination of budget planning among educational units. Mention is made of a plan to examine additional cost-savings measures, the trajectory of cuts and spend-down of reserve funds points to considerable uncertainty as to the ongoing adequacy of financial resources.

5.2 DEAN'S AUTHORITY/RESOURCES

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

Requirement 5.2-1
The dean of a medical school has sufficient resources and budgetary authority to fulfill the dean's responsibility for the management and evaluation of the medical curriculum.

Analysis of evidence for requirement 5.2-1

The Dean is responsible for the overall CSM faculty budget. This includes working closely with the CSM Senior Director to identify and address budget challenges. Depending on the nature of the budget challenges, the Dean may also strategically elevate issues through appropriate channels. These channels can include discussions with the UCalgary Executive Leadership Team (ELT) such as the Provost, President, Vice Presidents etc., the Alberta Health Services leadership team including the CEO and Zone Medical Director, and Government of Alberta ministers of health or Advanced Education. Such channels provide the opportunity for the Dean to advocate for funding of new initiatives and address budget challenges appropriately beyond the existing budget allocated to the Faculty.

The Associate Dean-UME and the Senior Manager-UME prepare and submit an annual budget to the CSM Senior Director and Senior Associate Dean Education for review. The operating budget for the UME program provides for curriculum delivery including preceptor payments, as well as the operations of the UME office. The budget is based on projected class size, which is determined by the provincial government (Alberta Ministry of Advanced Education), with funding provided accordingly. If there are initiatives that arise outside of the annual budgeting cycle or if budget challenges arise, they are raised to the Dean for further discussion.

The Associate Dean-UME has budgetary authority for the management and evaluation of the medical curriculum and meets regularly (monthly) with the CSM Senior Director and the Senior Associate Dean Education regarding financial resources and issues impacting the program. Program evaluation data are also used to inform resource allocation.

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.

Requirement 5.3-1
The medical school admits only as many qualified applicants as its total resources can accommodate.

Analysis of evidence for requirement 5.3-1

The evidence provided shows that the incoming class size is set between the medical school and provincial government in a way that ensures the provision of adequate resources for class size. The evidence shows that there are adequate resources in Calgary to meet the needs of a growing class and that key areas and resources have been expanded with this growth in mind.

Required Appendices 5.12-1 A3 and A4 detail the planned expansion to a regional medical campus in Lethbridge, in partnership with the University of Lethbridge. This collaborative expansion is in the early phase and current efforts focus on the development of the resources and infrastructure required for the expansion. At present there are no students at the regional medical campus, but the development timeline is ambitious and this Element should be monitored as the regional medical campus is developed and as initial students are enrolled to ensure that adequate infrastructure and resources have been developed.

Requirement 5.3-2
The medical school does not permit financial or other influences to compromise the school's educational mission.

Analysis of evidence for requirement 5.3-2

Evidence is provided that tuition levels are externally set and do not influence the educational program.

5.4 SUFFICIENCY OF FACILITIES AND EQUIPMENT

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

Requirement 5.4-1
The medical school has, or is assured the use of, facilities and equipment sufficient to achieve its educational mission.

Analysis of evidence for requirement 5.4-1

Current facilities and equipment available are more than required for the current enrollments and are highly rated by learners. Expansion of facilities and equipment have been approved to accommodate program expansion and will remain above required needs throughout the period of expansion. Specifically, enrollment expansion and approved increased student enrollment are matched over the next 3 year period ending 2026.

Requirement 5.4-2
The medical school has, or is assured the use of, facilities and equipment sufficient to achieve its clinical mission.

Analysis of evidence for requirement 5.4-2

The Advanced Technical Skills Simulation Lab (ATSSL) is an accredited simulation center used by the CSM and affiliated organizations including Alberta Health Services and Mount Royal University, Southern Alberta Institute of Technology and many CME/CPD events. The ATSSL is supported by the CSM with 9 full time staff and 25 part time staff. The CSM recently received a $3 million grant to renovate the lab over the upcoming year to accommodate the Master of Physician Assistant Studies program.

Requirement 5.4-3
The medical school has, or is assured the use of, facilities and equipment sufficient to achieve its research mission.

Analysis of evidence for requirement 5.4-3

The core research facilities are supported by an annual operating budget and capital equipment support to maintain equipment and purchase new equipment needs. There are a variety of research centers and technical service facilities used by researchers at the CSM. There are multiple sources of funding including CSM budget, user fees, and federal and philanthropic support. Recently the Biosafety Level 3 facility was refurbished and recertified to support COVID 19 research.

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).

Requirement 5.5-1
The medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in:

i. ambulatory settings
ii. inpatient settings

Analysis of evidence for requirement 5.5-1

UME learners at CSM have access to a wide variety of real and simulated clinical environments throughout their training.

In pre-clerkship (both Legacy and RIME curricula), students have clinical training in the Medical Skills Centre, a teaching centre designed to mimic an outpatient clinic. Students complete their initial clinical skills training in this location, with physician preceptors, using Standardized Patients (a cadre of actors who have been trained both in the skill of playing the role of patients, but also as educators, primed to give feedback directly to the learners).

Students then learn more specific aspects of clinical skills through the pre-clerkship, working with physician preceptors and real patients in both the Medical Skills Centre, but also in inpatient and outpatient environments within the health care system. Students work with physicians in clinical core sessions, Family Medicine Clinical Experiences and Career Development weeks during the pre-clerkship. In each of these sessions, students work in inpatient or outpatient environments (or both) based upon the work schedules of the physicians with whom they are training.

Each clerkship is overseen by a group of physicians from the clinical area of the relevant department or division. The clerkship schedules are developed with a mixture of inpatient and outpatient experiences and case mix that mimics the work of a physician practicing in this discipline. Through their clinical encounters, students will see patients of varying age, gender, case mix and acuity – as would be experienced by a practitioner in the clinical area.

While there is no 'gold standard' for what mix of inpatient and outpatient work is 'best', a simulation of the actual working environment appears to be appropriate. This is supported by student feedback from the ISA, GQ, and post-clerkship school-derived data.

Requirement 5.5-2
The medical school has, or is assured the use of, adequate numbers and types of patients (e.g., acuity, case mix, age, gender).

Analysis of evidence for requirement 5.5-2

As described above (requirement 5.5-2) there is no 'gold standard' for the most appropriate number or type of patients for students to see in a clinical environment. At this time, students complete their clinical experiences in busy clinical environments. The program is careful to ensure that appropriate numbers of students are present in clinical environments at any one time, so that the individual experience of each student is not diluted. Student data from the ISA, GQ, and post clerkship school derived data demonstrate that the vast majority of students feel that their access to patients is sufficient for clinical learning.

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.

Requirement 5.6-1
Each hospital or other clinical facility affiliated with the medical school that serves as a major location for required clinical learning experiences has sufficient information resources for medical student education.

Analysis of evidence for requirement 5.6-1

The DCI supports sufficient information resources. ISA data indicated over 95% of 3rd year students agreed with the statement "I consider that information resources available to me (other than computer/Internet access) are sufficient for my learning needs while I am at hospitals/clinical facilities used for required clinical learning experiences."

Requirement 5.6-2
Each hospital or other clinical facility affiliated with the medical school that serves as a major location for required clinical learning experiences has sufficient instructional facilities for medical student education.

Analysis of evidence for requirement 5.6-2

The ISA and DCI support adequate instructional facilities. On the ISA survey 93% of students in clinical rotation agreed with the statement: "I consider that the instructional facilities are sufficient for my learning needs while I am at hospitals/clinical facilities used for required clinical learning experiences."

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.

Requirement 5.7-1
The medical school ensures that adequate security systems are in place at all locations.

Analysis of evidence for requirement 5.7-1

Security coverage at the Foothills campus is provided by Campus Security 24/7 in parallel with Work Alone and SafeWalk programs to support individual student needs. The student areas of the educational complex have University card access after-hours, and CCTV surveillance is used to monitor areas throughout the campus and adjacent medical facilities. Student badges are required to pass controlled access doors into student only areas. The ISA data show high ratings regarding safety and security. The only exception was a rating by 3rd year students of 88% for their understanding/perception of security at clinical teaching sites. This may reflect lack of orientation to the safety and security measures at hospital sites given that there are extensive measures to ensure public and staff safety at all Alberta Health Services sites, or may be a reflection of learning sites where there may be less obvious or developed supports (e.g. community clinical offices).

Requirement 5.7-2
The medical school publishes policies and procedures to ensure student safety.

Analysis of evidence for requirement 5.7-2

Multiple policies, procedures and guides support student safety and are communicated through student orientation from the CSM and AHS.

Requirement 5.7-3
The medical school publishes policies and procedures to address emergency and disaster preparedness.

Analysis of evidence for requirement 5.7-3

The CSM and AHS have active and regularly updated emergency and disaster preparedness policies and procedures in place. AHS performs regular mock disaster events to maintain awareness and understanding of those procedures for all medical facilities within AHS**.** The CSM performs annual evacuation drills to practice for emergency/disaster scenarios. All these policies and procedures are communicated through the CSM and AHS orientations, received before the first year and the beginning of clerkship, respectively.

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 education program.

Requirement 5.8-1
The medical school ensures ready access to well-maintained library resources sufficient in breadth of holdings and technology to support its educational and other missions.

Analysis of evidence for requirement 5.8-1

The evidence presented describes a robust library with access to extensive resources and with collaborative relationships with other medical school libraries. The ISA data provides additional support that the library is an excellent and effective resource.

Although the library is mainly moving towards digital resources, the ISA indicates that the space provided by the library remains key and should be reserved for the intended purpose of quiet studying and scholarship. The ISA does indicate that students have difficulty accessing comparable space when on clinical rotations away from the Foothills Campus.

Requirement 5.8-2
Library services are supervised by a professional staff that is familiar with regional and national information resources and data systems.

Analysis of evidence for requirement 5.8-2

The evidence provided supports the adherence to this requirement and that the library staff is qualified to support the needs of faculty and students.

Requirement 5.8-3
Library professional staff is/are responsive to the needs of the:

- *i. medical students*
- *ii. faculty members*
- *iii. others associated with the medical education program*

Analysis of evidence for requirement 5.8-3

The evidence provided demonstrates that the library staff are responsive and involved with students, faculty, clinical faculty and others, supporting inquiries, library technology, scholarship and research.

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 education program.

Requirement 5.9-1
The medical school ensures access to well-maintained information technology resources sufficient in scope to support its educational and other missions.

Analysis of evidence for requirement 5.9-1

The UME program has demonstrated access to well-maintained information technology resources sufficient in scope to support its educational and other missions.

Embedded IT resources are effective in supporting the program's success, with a focus on local initiatives/infrastructure and support. There is also main UCIT campus support to ensure that there are campus-wide initiatives that are supported.

The MD program has many online learning resources, support, and initiatives that have proven to be very well-received based on the overwhelming positive student feedback over multiple years.

Requirement 5.9-2
The information technology staff serving a medical education program has sufficient expertise to fulfill its responsibilities.

Analysis of evidence for requirement 5.9-2

The UME Academic Technologies (AT) team has demonstrated nationally recognized expertise to support the program. The UME program's IT framework of governance, support, continuous development, integration and ongoing application monitoring is instrumental to program and student support.

Requirement 5.9-3
The information technology staff serving a medical education program is responsive to the needs of the:

- *i. medical students*
- *ii. faculty members*
- *iii. others associated with the medical education program*

Analysis of evidence for requirement 5.9-3

The UME program's AT team has demonstrated they are responsive to the needs of medical students, faculty members and others associated with the medical program through the many supports they have provided/created.

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 enroled medical students.

Requirement 5.10-1

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

Analysis of evidence for requirement 5.10-1

There were no visiting elective students from March 2020-July 2023 due to restrictions related to the COVID 19 pandemic; this was done in coordination with other CACMS accredited schools. Table 5.10-1 B notes only one transfer student in the past three years.

There is a clear description of the process regarding the potential impact of visiting and transfer students on already enrolled medical students. Visiting students are permitted on rotations where their presence does not compromise the educational experience of those enrolled at the CSM. Transfer students are rare and only accepted into Year 3 after an assessment of capacity to accept.

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.

Requirement 5.11-1
The medical school ensures that its medical students have, at each campus and affiliated clinical site, adequate study space.

Analysis of evidence for requirement 5.11-1

The medical school has several areas for students to study in including the library, several classrooms that could be booked, the Indigenous hub, the atriums, as well as the two student lounges. Three of the five hospitals in Calgary have a library that students have access to 24 hours a day and could study there if desired.

Requirement 5.11-2
The medical school ensures that its medical students have, at each campus and affiliated clinical site, adequate lounge areas.

Analysis of evidence for requirement 5.11-2

The medical school, located in the Health Sciences Centre, has significant lounge space with both the Feasby lounge as well as the newly opened Interprofessional Learner Lounge. Medical students also have access to resident and physician lounges at each of the five hospitals.

Significant concern was raised in the ISA regarding the Interprofessional Learner Lounge (IPLL) regarding both the delay in opening as well as the degree of inclusiveness permitted when the lounge was indeed opened. The delay in opening was attributed to the COVID-19 pandemic, where there were manpower as well as raw material concerns. Final inspections were also a barrier which delayed the opening by several months. The noted delays, as well as the goal for an inclusive environment, has been addressed in the DCI. Students voiced concerns in the ISA regarding the desire to have an exclusive medical student only lounge. The DCI noted that this second lounge was meant to serve the entire student body, and be inclusive and welcoming to all CSM students. As specified in the Okanogan charter, as well as the CSM Strategic Plan, the objectives of inclusiveness, openness, and a welcoming environment to all students, regardless of their area of study, was the goal when deciding to open the InterProfessional Learner Lounge to all learners.

Requirement 5.11-3
The medical school ensures that its medical students have, at each campus and affiliated clinical site, adequate personal lockers or other secure storage facilities.

Analysis of evidence for requirement 5.11-3

Personal lockers were noted to be available to all students with specific locations identified in the DCI. The ISA indicates that students may not have been aware of the location of the lockers and initiatives are in place to increase awareness.

Requirement 5.11-4
The medical school ensures that its medical students have, at each campus and affiliated clinical site, adequate and secure call rooms if students are required to participate in late-night or overnight clinical learning experiences.

Analysis of evidence for requirement 5.11-4

It is specified in the DCI that if a call room is not available for a clinical clerk, they must be permitted to leave work no later than 11:00 PM.

5.12 REQUIRED NOTIFICATIONS TO THE CACMS

A medical school is required to notify* the CACMS in any of the following circumstances:

- ***a) changes in enrollment, student distribution and/or the resources to support the educational program;***
- ***b) creation of a new or expansion of a campus;***
- ***c) changes in curriculum;***
- ***d) changes in program delivery at an existing campus;***
- ***e) changes in governance or ownership.***

****Details regarding the notification are found in the CACMS Rules of Procedure.***

Requirement 5.12-1

The medical school is required to notify the CACMS in any of the following circumstances:*

- *a) changes in enrollment, student distribution and/or the resources to support the educational program*
- *b) creation of a new or expansion of a campus*
- *c) changes in curriculum*
- *d) changes in program delivery at an existing campus*
- *e) changes in governance or ownership*

Analysis of evidence for requirement 5.12-1

The medical school is fully compliant with this notification requirement. Since the 2016 accreditation the medical school has notified CACMS regarding several changes, as noted below.

a. Changes in enrollment, student distribution and/or the resources to support the educational program -submitted June 15, 2023 and CACMS response Oct 13, 2023 (Appendices 5.12-1 A3 and 5.12-1 A4)
b. Creation of a new or expansion of a campus - submitted June 15, 2023 and CACMS response Oct 13, 2023 (Appendices 5.12-1 A3 and 5.12-1 A4)
c. Changes in curriculum submitted June 27, 2022 and CACMS response Sept 26, 2022 (Appendices 5.12-1 A1 and 5.12-1 A2)

STANDARD 6: COMPETENCIES, CURRICULAR OBJECTIVES, AND CURRICULAR DESIGN

The faculty of a medical school defines 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, behaviours, and attitudes that medical students are expected to exhibit as evidence of their achievement by completion of the program.

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6.1 PROGRAM AND LEARNING OBJECTIVES

The faculty of a medical school defines 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 those 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 members, residents, and others with teaching and assessment responsibilities in those required experiences.

Requirement 6.1-1
The faculty of a medical school define its medical education program objectives in competency-based terms.

Analysis of evidence for requirement 6.1-1

The CSM medical education program objectives, also known as the Big 10 graduation objectives, are provided in Appendix 6.1-1 A, and these are currently under review. A final version is in development, with comprehensive stakeholder involvement. CanMEDS role-based competencies have been mapped to each of the 10 Program objectives. These competencies are linked to both student assessment strategies and program evaluation strategies.

Requirement 6.1-2
The medical education program objectives reflect and support the continuum of medical education in Canada.

Analysis of evidence for requirement 6.1-2

The graduation objectives, embedded CanMEDS competencies, and programmatic assessment elements are designed to prepare learners to enter residency. The medical education program imparts lifelong learning skills and exposes learners to the CanMEDS roles and workplace-based assessment. The goal of this exposure is to further facilitate their transition into competency-based residency education.

Requirement 6.1-3
The medical education program objectives 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.

Analysis of evidence for requirement 6.1-3

The graduation objectives, embedded CanMEDS competencies, and programmatic assessment elements are designed to track learner progress and prepare learners to enter residency with a focus on what is required to serve the public as a physician.

Requirement 6.1-4
The medical school makes these medical education program objectives known to all medical students and those faculty members with leadership roles in the medical education program and others with substantial responsibility for medical student education and assessment.

Analysis of evidence for requirement 6.1-4

The objectives are readily available to students, leaders and faculty. Student orientation sessions, inclusion on leadership agendas and requirements for faculty to acknowledge awareness of the objectives on all electronic evaluations ensure that all students, leaders and faculty are regularly reminded both of the content and how to easily access the objectives throughout each academic year. Evidence of student awareness of objectives is strong. The ISA data revealed that 95% or more of the students in each year reported that they were aware of the medical education program objectives.

Requirement 6.1-5

The medical school ensures that the learning objectives for each required learning experience are made known to all medical students and those faculty members, residents, and others with teaching and assessment responsibilities in those required experiences.

Analysis of evidence for requirement 6.1-5

The pre-clerkship objectives are readily available to students and preceptors via OSLER and FreshSheet (the on-line curriculum repository). The learning objectives are provided to instructors when they are preparing to teach pre-clerkship learning experiences allowing them to easily review the objectives in a timely manner.

The clerkship objectives are readily available via an open access website. A variety of additional methods are in place to communicate the learning objectives to those with teaching responsibilities. These include email reminders, student held reminder cards, posted printed materials, resident workshops, departmental/sectional websites or communication platforms, newsletters, leadership meetings, and links embedded within assessment forms. Greater than 93% of the students in each year reported that they were aware of the learning objectives for each required learning experience.

6.2 REQUIRED PATIENT ENCOUNTERS AND PROCEDURES

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.

Requirement 6.2-1

The faculty of a medical school defines the:

- *i. types of patients and clinical conditions that medical students are required to encounter*
- *ii. skills and procedures to be performed by medical students*
- *iii. the appropriate clinical settings for these experiences*
- *iv. the expected levels of medical student responsibility*

Analysis of evidence for requirement 6.2-1

Types of patients and clinical conditions (aligned with the MCC clinical presentations) are outlined clearly according to clinical setting and level of responsibility in Table 6.2-1 A. Table 6.2-1 B provides evidence of the clinical setting and level of responsibility for each skill and procedure.

Of note, these tables include pre-clerkship elements in the Legacy curriculum. In the RIME curriculum, the clinical presentations set the foundation for the curriculum map and are detailed in Supplemental Appendix 6.2-1 C.

6.3 SELF-DIRECTED AND LIFE-LONG LEARNING

The faculty of a medical school ensures that the medical curriculum includes self-directed learning experiences and unscheduled time 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; appraisal of the credibility of information sources; and feedback on these skills.

Requirement 6.3-1
The faculty of the medical school ensures that the medical curriculum includes self-directed learning experiences 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; appraisal of the credibility of information sources; and feedback on these skills.

Analysis of evidence for requirement 6.3-1

Legacy Pre-Clerkship Curriculum - the undergraduate program ensured multiple opportunities for self-directed learning experiences as described in the material related to CARDS, Integrative I and II, Intro to Clinical Practice I and II and Applied Evidence Based Medicine (AEBM). In particular, the AEBM course allowed students to undertake independent studies and pursue either a research topic of their choice or shadow a preceptor in any given discipline to build a foundation of EBM for the final project. Collectively CARDS and the various courses enabled students to self-assess their knowledge and skills, identify learning needs, analyze and synthesize relevant information, appraise the quality of resources and receive feedback on these activities.

The courses were designed to help students identify information sources, critique the information sources, prepare and present critically appraised topics following analysis and synthesis, work through reflective assignments in Ethics, Global Health and Course 5, appraise information sources, and get feedback within small group settings and assignments from preceptors.

CARDS is a cornerstone of the undergraduate curriculum for all students (including those currently engaged in the RIME curriculum and those at more advanced levels including the clerkship). CARDS provides clinical cases about symptoms, diseases, investigations, and management. Unlike cases that are presented face-to-face or on paper, CARDS can generate an infinite number of clinical scenarios quickly. CARDS permits students to identify gaps in their knowledge, analyze relevant information and receive immediate feedback. As this innovation is web-based and available at all times, students can quickly select cases to verify their approach to clinical problems as well as areas where they believe they have concerns.

The RIME Curriculum is designed for integration and spirality such that students listen to podcasts, access relevant resources, and identify areas they need to further address by coming together with peers and preceptors. Participation in CARDS provides immediate feedback on performance and areas that need addressing. The Professional Role course has been designed to allow students to explore career and scholarship interests.

Several of the clerkships have built in opportunities for self-directed learning (e.g., anesthesia, obstetrics and gynecology, family medicine, internal medicine, and psychiatry). Materials provided through the clerkship program and within specific clerkship rotations provide students with resources (e.g., reading and guidelines) to improve their learning and understanding of concepts. Learners also have the ability to self-assess with feedback provided when they access the clerkship-level CARDS created to be at a more challenging level. The clerkship-level CARDS decks provide clerks with the ability to test their knowledge with questions related to complex clerkship concepts and have the benefit of detailed explanations that have been built into the program.

UCLIC (University of Calgary Longitudinal Integrated Clerkship) has been designed so students have academic sessions where they present family medicine topics and get feedback. They also have independent study time. The Community Engagement Project enables the students to identify and build a relationship with a community agency, develop a project to meet a community gap, implement and report on the project.

Requirement 6.3-2
The faculty of the medical school ensures that the medical curriculum includes unscheduled time to allow medical students to develop the skills of lifelong learning.

Analysis of evidence for requirement 6.3-2

There is unscheduled time for students to develop skills of lifelong learning along the 3-year curriculum. During the Legacy curriculum, students had three half days per week of scheduled independent study time. The RIME curriculum provides 14 hours per week of independent study time.

The clerkship curriculum, whether the students are in the traditional curriculum or UCLIC, provides independent study time in a variety of ways across the different rotations. In some cases, it is at specific times in the rotation to undertake learning that will be required for the rotation (e.g., pelvic exam in obstetrics and gynecology or preparation of a patient centered care project in family medicine).

6.4 OUTPATIENT / INPATIENT EXPERIENCES

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

Requirement 6.4-1
The faculty of the medical school ensures that the medical curriculum includes clinical experiences in outpatient settings.

Analysis of evidence for requirement 6.4-1

Students have outpatient clinical experiences throughout medical school. In the Legacy curriculum, the Clinical Correlations course allowed students to join a preceptor for several hours of clinical exposure over the pre-clerkship months, to expose them to a mix of outpatient and inpatient medicine. Clinical Correlations ran throughout Courses I-VII. Secondly, the Family Medicine Clinical Experience was a longitudinal course that paired students with two different family medicine preceptors, predominantly in the outpatient setting, for seven half-days. Thirdly, the Career Development program allowed students to have three weeks of clinical exposure (mix of inpatient and outpatient depending on the specialty selected) in three different areas of medicine of the student's choice. The fourth opportunity was the Applied Evidence Based Medicine (AEBM) course, which included the choice of either a research elective or a 30-hour clinical elective in their second year. In the AEBM course the student joined a preceptor in an outpatient, inpatient or a mix of both over their weeks together. Students also have/had the opportunity to shadow preceptors throughout their pre-clerkship years.

Finally, service learning, which is referred to in curriculum as "Community Engaged Learning", was a course incorporated into Year 1 and 3, allowing students to work closely with community partners.

Despite the pre-clerkship early exposure to outpatient clinical learning UCalgary, the ISA data recommend stronger leverage of outpatient clinical partners to enhance physical exam skills training (e.g., through simulations and enhanced correlations) as well as stronger integration of evidence-based medicine skills throughout pre-clerkship. Though the ISA reflects moderate endorsement of encouragement (79-88%) and opportunity (75-89%) to participate in service learning, increasing student's exposure to community work and strengthening such partnerships between the medical school and the local community would all strongly align with the desired mission of socially accountable training.

All clinical opportunities listed, except the Clinical Correlations course, are included in the RIME curriculum. The rhythm of the RIME curriculum allows for greater weekday flexibility to schedule outpatient clinical shadowing experiences. Preliminary data indicated that that, of the 43 students who responded to the optional pre-accreditation survey in May 2024, 100% noted that they had clinical experiences in outpatient/ambulatory setting. In terms of service learning, 91% of those responding to the survey noted encouragement to participate in service learning and 95% had participated in service learning by the 10th month of their first academic year.

In clerkship, students complete mandatory rotations in multiple specialties, many of which include outpatient clinical experiences.

In the 2023 Graduate Questionnaire, 97.8% of graduating medical students indicated they felt comfortable caring for both hospitalized and ambulatory patients. The ISA found that 94.6%, 96.6% and 100% of students have had clinical experiences in outpatient medicine in the first, second and third years of training respectively.

Requirement 6.4-2
The faculty of the medical school ensures that the medical curriculum includes clinical experiences in inpatient settings.

Analysis of evidence for requirement 6.4-2

Students have multiple inpatient medicine experiences. In the Legacy curriculum, Clinical Correlations often took place in the inpatient setting. The 30-hour AEBM clinical component could be done in either an outpatient or inpatient setting, or a combination of both. Most students chose a clinical experience rather than a research elective for the AEBM course. The Family Medicine Clinical Experience was predominantly outpatient; however, students had the option to work with a family physician who provided inpatient hospitalist care.

In the RIME curriculum, opportunities for clinical experiences in inpatient settings continue to be available through Career Development Weeks and shadowing. Of the 43 first year students who responded to the May 2024 pre-accreditation survey, 84% noted having clinical experiences in the inpatient setting.

All rotations during clerkship include exposure to the inpatient setting, except family medicine which may be solely outpatient.

The ISA identified that 98.6%, 97.4% and 100% of students in years one, two and three respectively report they have had clinical experiences within the inpatient setting.

6.4.1 CONTEXT OF CLINICAL LEARNING EXPERIENCES

Each medical student has broad exposure to, and experience in, generalist care including comprehensive family medicine. Clinical learning experiences for medical students occur in more than one setting ranging from small rural or underserved communities to tertiary care health centres.

Requirement 6.4.1-1
Each medical student has broad exposure to, and experience in, generalist care including comprehensive family medicine.

Analysis of evidence for requirement 6.4.1-1

Pre-Clerkship
In the Legacy curriculum, a significant amount of the didactic and small group teaching students received during the first two years was provided by family physicians.

The RIME curriculum was specifically designed to teach students through a generalist lens, giving them an introduction to generalism from the first day of orientation. Ongoing emphasis on generalist teachers continues, with a curricular shift and emphasis in the teacher expectations. This occurs throughout the curriculum with the *patient of the week*, which allows students to apply their learning to common generalist clinical presentations. In addition, the Family Medicine Clinical Experience continues to run longitudinally throughout both years, and gives students exposure to two different family physician preceptors, for three to four half-days each year, to provide a broad representation of generalist practice and comprehensive family medicine. Of the 43 first year students who responded to the May 2024 pre-accreditation survey, 93% noted broad exposure to generalist care. Exposure to a rural or underserved community is expanded in the RIME curriculum, and students will complete 13 sessions with the community organization in addition to a project on caring for underserved communities.

Clerkship
The largest block during clerkship is family medicine, which is a mandatory rotation lasting 8 weeks. Students also complete a four-week block of general internal medicine (on the medical teaching unit), three weeks of general pediatrics (on the pediatric clinical teaching unit) and two weeks of emergency medicine.

Clerkship opportunities for those who entered the RIME curriculum will be similar to the Legacy curriculum, with UCLIC options as well as rural and tertiary care opportunities.

In the ISA, 100% of third-year students reported having experience in generalist care and 99% of students reported experience in comprehensive family medicine.

Requirement 6.4.1-2
Clinical learning experiences for medical students occur in more than one setting ranging from small rural or underserved communities to tertiary care health centres.

Analysis of evidence for requirement 6.4.1-2

Pre-Clerkship
Some of the clinical experiences during the first two years of the Legacy curriculum, including the Family Medicine Clinical Experience, AEBM clinical experience, and Career Exploration, included weeks in rural medicine depending on the specialty and preceptor chosen.

Clerkship
Most clinical rotations during clerkship are completed in secondary or tertiary health centres. There is also the option to enter the University of Calgary Longitudinal Integrated Clerkship (UCLIC) program, where they spend over 30 weeks of their time in clerkship working in small, rural communities. UCLIC students also complete four-week blocks in internal medicine, surgery and pediatrics at tertiary care centres, allowing students broad exposure to both rural and urban medicine.

Students who are not in UCLIC complete four weeks of urban and four weeks of rural family medicine during their clerkship. Some students in psychiatry and pediatrics also complete rotations in rural communities. A small number of students (up to ten) may also do a four-week international clerkship elective in an underserved developing country.

For those in the Legacy curriculum, the Community Engaged Learning week, which occurred early in clerkship, exposed students to important concepts with respect to caring for vulnerable or underserved populations. Students were paired with a community partner organization to spend three days working in underserved communities within and surrounding the city.

The ISA identified that 96% of students in their third year of medical school had clinical experiences that took place in more than one setting.

6.5 ELECTIVE OPPORTUNITIES

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

Requirement 6.5-1

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

Analysis of evidence for requirement 6.5-1

In the Legacy curriculum, students had three weeks in the Career Exploration program, where they spent a week in three clinical areas of choice (each week was required to be in a different CaRMS entry discipline). Also, during the Applied Evidence Based Medicine (AEBM) course, students were given the opportunity to spend 30 hours of clinical time in an area of interest. The Career Exploration weeks continue in the RIME curriculum.

During clerkship, students have 14 weeks of electives. These electives can be completed locally, across the country at other medical schools, and even globally. There are plentiful elective opportunities spanning all CaRMS entry disciplines, and a wide variety of clinical experiences.

Students complete selectives (clinical rotations under the umbrella of the clerkship that are outside of the core inpatient ward service) in the Internal Medicine, Surgery, and Pediatric rotations. In Surgery and Pediatrics students have two weeks of selective time and in Internal Medicine, students have four weeks of selective opportunities. Students rank their preferences for the particular selective(s) that they wish to complete in each of these areas and, when possible, these requests are honoured.

The ISA data show that by Year 3, 97% of students had the opportunity to supplement required learning experiences with electives, and 92% had the opportunity to pursue their individual academic interests in their electives.

6.6 SERVICE-LEARNING

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

Definition taken from CACMS lexicon

- *Service-learning: A structured learning experience that combines community service with preparation and reflection.*
- *Faculty of a medical school: The complement of appointed individuals (as constituted by the university) working collectively or through a duly constituted group or structure with the authority to speak on behalf of the collective body of faculty members.*

Requirement 6.6-1

The faculty of the medical school ensures that the medical education program:

i. provides sufficient opportunities for medical student participation in a service-learning activity.
ii. encourages medical student participation in a service-learning activity.
iii. supports medical student participation in a service-learning activity.

Analysis of evidence for requirement 6.6-1

The Community Engaged Learning Program in the Legacy curriculum was mandatory for all first-year students, and provided them with content relevant to serving vulnerable populations in the form of small group sessions, lectures, mandatory readings/videos. After reviewing the important concepts, students joined a community partner for two half-days of community service. Content was then reviewed in a final small group session, and students completed a mandatory self-reflection paper. In their third year (clerkship), students also participate in a one-week Community Engaged Learning experience which includes podcasts, an in-person workshop on equity, three days of community service with a community partner, and a final Bystander Intervention Training session. Students then complete a final self-reflection piece.

The RIME curriculum has a similar program within the *Professional Role* course, which allows for longitudinal community engaged learning. Ten large-group sessions are held by community partners to deliver key content, and students then spend 13 half-days with a community partner, spread over the 12 months of pre-clerkship curriculum. A mandatory service-learning project is completed in cooperation with the community partner and presented at a symposium. Students then complete a self-reflection exercise.

The Student Run Clinic operates at the Mustard Seed, which is a non-profit organization that cares for individuals experiencing homelessness and poverty, is another opportunity for students to provide community service. The clinic runs weekly and is supervised by a faculty member.

The ISA found that 88.5% of students in their third year had an opportunity to participate in service learning and 85% reported they were encouraged to participate in a service-learning activity.

Forty-three students from the Class of 2026 responded to a May 2024 pre-accreditation survey and 93% indicated that they were encouraged to participate in a service-learning activity and 93% also indicated that they had an opportunity to participate in a service-learning activity.

6.7 Currently, there is no element 6.7

6.8 EDUCATION PROGRAM DURATION

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

Requirement 6.8-1
The medical education program includes at least 130 weeks of instruction.

Analysis of evidence for requirement 6.8-1

The total number of instructional weeks during the 3-year curriculum meets the minimum of 130. The noted number of instructional weeks is 132.

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.

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7.1 BIOMEDICAL, BEHAVIORAL, SOCIAL SCIENCES

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

Requirement 7.1-1
The faculty of the medical school ensure that the medical curriculum includes content from the biomedical, behavioral, and social sciences to support medical students' mastery of contemporary medical science knowledge and concepts and the methods fundamental to applying them to the health of individuals and populations.

Analysis of evidence for requirement 7.1-1

In the pre-clerkship, students are exposed to content from the biomedical, behavioral, and social sciences using a constructivist approach to support mastery. In the Legacy curriculum, this was accomplished through integration of content from the fundamental sciences organized by body systems, supplemented by longitudinal courses to expand on particular topics. These were regularly reviewed and updated by course leaders and faculty to ensure that they were up to date with ongoing developments relevant to clinical practice. A regular program of assessment was in place to determine mastery of knowledge, including assessment of the students' application of knowledge to individuals through patient interactions and simulated clinical cases, and to populations in the dedicated Population Health course.

In the RIME curriculum, the biomedical, behavioral, and social sciences are presented in an integrated fashion organized by MCC objective, with topics revisited longitudinally through the spiral curriculum. While much of the initial exposure to content is asynchronous, students can apply concepts through tutorial and large group sessions and assess their knowledge in all areas through regular online interactive testing. While the curriculum is newly developed and thus currently up to date, it is governed by a curriculum committee (Curriculum Innovation and Oversight Committee-CIOC) to assess the need for changes on an ongoing basis.

The clerkship is organized into key clinical presentations and procedures, which are regularly reviewed and updated to ensure currency. Students are assessed regularly in the program to ensure that they are achieving mastery of all relevant biomedical, social, and behavioral components of clinical medicine, including their application to clinical practice.

7.2 CURRICULUM ACROSS THE LIFE CYCLE

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, and end-of-life care.

Requirement 7.2-1

The faculty of a medical school ensure that the medical curriculum includes content related to:

- *i. each organ system*
- *ii. each phase of the human life cycle*
- *iii. continuity of care*
- *iv. preventive, acute, chronic, rehabilitative, and end-of-life care*

Analysis of evidence for requirement 7.2-1

i. Each organ system

The Legacy curriculum was systems-based and covered each organ system in the courses. The mandatory electives covered the range of the organ systems to ensure adequate exposure. The RIME curriculum (July 2023 onward) is based on all the established MCC objectives and therefore covers all the organ systems in the body. The pre-clerkship is complemented by the established mandatory clerkship rotations.

ii. Each phase of the human life cycle

The Legacy curriculum covered each phase of the life cycle within the organ system courses. In particular, there was a pediatrics course and a geriatrics component in the Legacy curriculum. In the RIME curriculum, the life cycle is integrated into the cases presented to the students and purposefully covers every stage of the life cycle.

iii. Continuity of care

Continuity of care was taught in the Legacy curriculum with emphasis in Course 8 (the integrative course) and through a special presentation "Falling through the cracks". Additionally, there was a family medicine clinical experience which emphasized continuity of care. In the RIME curriculum, this is implicitly integrated into the curriculum, and cases have been built to show continuity of care throughout a patient's life span.

iv. Preventative, acute, chronic, rehabilitative and end-of-life care

These elements were presented throughout the Legacy curriculum. The medical school reviewed the curriculum in 2018 and found that preventative care and end-of-life care were covered well. Acute care and chronic care were covered in the systems courses. In the RIME curriculum, these elements have been specifically integrated into the curriculum to ensure that they are covered throughout the pre-clerkship.

Requirement 7.2-2

The faculty of a medical school ensure that the medical curriculum includes clinical experiences related to:

- *i. each organ system*
- *ii. each phase of the human life cycle*
- *iii. continuity of care*
- *iv. preventive, acute, chronic, rehabilitative, and end-of-life care*

Analysis of evidence for requirement 7.2-2

i. Each organ system

The Legacy curriculum had a clinical component termed Clinical Correlation. The RIME curriculum has ten half days of family medical clinical experiences. Additionally, there are three Clinical Experience weeks, and clinical experiences throughout the clerkship that cover the organ systems.

ii. Each phase of the human life cycle

The Legacy curriculum provided Clinical Correlation that addressed each phase of the human life cycle. This was also covered in the Family Medicine Clinical Encounter and several clerkship rotations. In the RIME curriculum, this is covered throughout the units, in the Family Medicine Clinical Experience and the clinical clerkship.

iii. Continuity of care

Continuity of care was experienced in the family medicine clinical encounter course in the Legacy curriculum. In the RIME curriculum, the continuity of care is experienced in the family medicine clinical experience throughout the Professional Role course.

iv. Preventative, acute, chronic, rehabilitative and end-of-life care

In the Legacy curriculum, Clinical Correlation and the Family Medicine Clinical Encounter provided adequate coverage of these components. Additionally, preventative, acute, chronic, rehabilitative and end-of-life care is covered in the clinical clerkship rotations. The RIME curriculum covers the noted components in the Family Medicine Clinical Experience and the clinical clerkship rotations.

7.3 SCIENTIFIC METHOD/CLINICAL/ TRANSLATIONAL RESEARCH

The faculty of a medical school ensure that the medical curriculum includes instruction in the scientific method 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.

Requirement 7.3-1
The faculty of the medical school ensure that the medical curriculum includes instruction in the scientific method.

Analysis of evidence for requirement 7.3-1

In both the Legacy and RIME curricula there is heavy focus on instruction in the scientific method. In the Legacy curriculum students completed a mandatory Applied Evidence-Based Medicine course to understand and apply the principles of the scientific method as it applies to evidence-based medicine. Within RIME, these concepts are expanded and distributed throughout the blocks, with an introduction in Block 1 to address the need for and potential pitfalls of relying on traditional evidence-based medicine from a health equity perspective. In Block 2, the Legacy AEBM curriculum has been redeveloped to be patient-centered and integrated into the patient presentations of the week. Students are assessed on asynchronous learning materials by participation in small group journal clubs to critically appraise literature that is pertinent to the presentations and patients they encounter that week.

In clerkship, students are expected to apply these principles of critical appraisal in the diagnosis and management of patients.

Requirement 7.3-2
The faculty of the medical school ensure that the medical curriculum includes instruction in the basic scientific and ethical principles of clinical and translational research, including the ways in which such research is:

- *i. conducted*
- *ii. evaluated*
- *iii. explained to patients*
- *iv. applied to patient care*

Analysis of evidence for requirement 7.3-2

As documented in 7.3-1, both the Legacy and RIME curricula provide instruction on how research is conducted and evaluated. Students in the Legacy curriculum performed a research elective through AEBM and in the RIME curriculum all students are required to perform a scholarly activity project. The ethical principles of research are taught both in medical ethics and throughout the evidence-based medicine curriculum, as well as woven into the patient presentations in the RIME curriculum, when considering health equity in the context of the information used to inform treatment of patients. Clinical and translational research is evaluated and applied to patient care through both dedicated educational events (lectures in legacy curriculum, podcasts and learning activities in RIME) and then integrated into the patient presentations for diagnosis and management. Students were taught and assessed on communicating clinical and translational research to patients in the Integrative Course in the Legacy curriculum.

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.

Requirement 7.4-1
The faculty of the medical school ensure that the medical curriculum incorporates the fundamental principles of medicine.

Analysis of evidence for requirement 7.4-1

The students have multiple opportunities to engage in critical judgement and reasoning throughout the pre-clerkship and clerkship. In the Legacy curriculum, clinical presentations were the medical school curriculum's cornerstone and were intertwined into large group presentations, small groups and clinical experiences.

In the RIME curriculum, clinical critical judgement is emphasized in small group tutorials and in large group in-person sessions. Clinical reasoning and clinical critical thinking are evaluated through the assessment process.

Requirement 7.4-2
The faculty of the medical school ensures that the medical curriculum 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.

Analysis of evidence for requirement 7.4-2

There were several opportunities for clinical decision making throughout the Legacy curriculum including the Clinical Correlation sessions, Physical Examination course, Communications course, small group, Course 8, Clinical Skills/Integrative, AEBM2 and the Family Medicine Clinical Experience. For critical thinking, opportunities were provided in the Clinical Correlation, Introduction to Clinical Practice, Clinical Skills course, Integrative course and clerkship. For the critical appraisal of evidence, this was evident during the integrative, AEBM1 and AEBM2 experiences.

In the RIME curriculum, clinical reasoning is covered in tutorial groups, large group sessions and podcasts. Clinical critical thinking is covered in the above venues. For critical appraisal of evidence, the podcast series, large group sessions, and small group journal club sessions address this topic.

Requirement 7.4-3
These required learning experiences enhance medical students' skills to solve problems of health and illness.

Analysis of evidence for requirement 7.4-3

In the Legacy curriculum, the skill of *solving problems of health and illness* was addressed in the Clinical Correlation sessions, Communication and Physical Examination sessions. This was also covered in the small group sessions and the Family Medicine Clinical Experience. The clerkship rotations have a particular focus of solving problems of health and illness.

In the RIME curriculum, this is covered in tutorials and large group sessions. There are also sessions on critical evaluation of literature.

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.

Requirement 7.5-1

The faculty of the 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.

Analysis of evidence for requirement 7.5-1

Both the Legacy and the RIME curricula examples illustrate the details regarding purposeful instruction in the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of common societal problems.

In the Legacy curriculum, course leaders identified gaps based on MCC objectives or prevalent social issues, and then determined how to include related learning objectives into their courses while also determining other content to be removed to accommodate the new material. Proposed changes were reviewed and voted on at the Pre-Clerkship Committee. Examples involved educational material related to the COVID pandemic and the impact in long-term care facilities as well as a session on the opioid crisis that involved patient and community partners.

The material related to the structural determinants of health and health equity objectives were fully integrated within the small and large group sessions as well as the “patients” of the week in the RIME curriculum, with the curricular map including the integration of all CanMEDS physician roles. The Curriculum Innovation and Oversight Committee (CIOC) reviews all requests for additions to the content, in addition to annual review of program objectives. Examples provided include instruction related to adverse childhood events, the opioid crisis, disability and ableism and others.

The Director of Health Equity and Structural Competency is a member of the RIME Pre-clerkship Committee as well as the Curriculum Innovation and Oversight Committee and has responsibility in overseeing the topic of “racism in medicine and structural barriers to health care”. Given that societal problems, and related concepts of social accountability and structural competency are woven and built upon throughout the RIME curriculum, their involvement in these committees is instrumental in ensuring that adequate time and resources are dedicated to these learning objectives.

7.6 CULTURAL COMPETENCE AND HEALTH CARE DISPARITIES

The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address the unique needs of people of diverse cultures, genders, races and belief systems, in particular the Indigenous peoples of Canada.

The medical curriculum prepares medical students to:

- ***a) recognize and appropriately address the manner in which people of diverse cultures, genders, races and belief systems perceive health and illness and respond to various symptoms, diseases and treatments;***
- ***b) recognize and appropriately address personal biases (cultural, gender, racial, belief) and how these biases influence clinical decision-making and the care provided to patients;***
- ***c) develop the basic skills needed to provide culturally competent health care;***
- ***d) identify health care disparities and participate in developing solutions to address them.***

Requirement 7.6-1

The faculty of the medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address the unique needs of people of diverse cultures, genders, races, and belief systems, in particular the Indigenous peoples of Canada.

Analysis of evidence for requirement 7.6-1

The Legacy curriculum had several examples in various courses where the above requirements were delivered, including Indigenous health. The RIME curriculum also has examples of how this content is woven into the curriculum. There are at least nine half days specific to Indigenous health, which is an increase over the Legacy curriculum. There are several other examples throughout the pre-clerkship that address healthcare delivery in diverse cultures, personal biases and how such biases may impact patient care.

Requirement 7.6-2

The medical curriculum prepares medical students to:

- *a) recognize and appropriately address the manner in which people of diverse cultures, genders, races, and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments*
- *b) recognize and appropriately address personal biases (cultural, gender, racial, belief) and how these biases influence clinical decision-making and the care provided to patients*
- *c) develop the basic skills needed to provide culturally competent health care*
- *d) identify health care disparities and participate in developing solutions to address them*

Analysis of evidence for requirement 7.6-2

The Legacy curriculum included all required components through various curriculum courses. The RIME curriculum also includes these requirements, but they are presented in a longitudinal manner and woven throughout all the small and large group learning experiences, as well as the Community Engaged Learning opportunities.

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 medical students to behave ethically in caring for patients and in relating to patients' families and others involved in patient care.

Requirement 7.7-1
The faculty of the 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.

Analysis of evidence for requirement 7.7-1

The central role of bioethics and human values is emphasized throughout the CSM curriculum. Students are made aware that a knowledge of bioethics is part of the skillset of a competent physician. Its starts in week "0", where, as they prepare to sign an Oath of Confidentiality, students have a session on the importance of privacy and confidentiality in medicine.

In the Legacy curriculum, the pre-clerkship students had a formal bioethics unit which familiarized them with bioethical principles and provided them with tools for dealing with such issues. In both didactic and small group discussions, they were exposed to common ethical dilemmas associated with informed consent, confidentiality, truth-telling, relationships with industry, conflict of interest, end of life decisions, MAID, genetics, genomics, reproductive technologies, pediatrics, capacity and competency. Recent additions to the curriculum included bioethical issues associated with pandemics, cultural pluralism, social media, and physician remuneration. Students were also taught about legal precedents and their legal obligations. Exposure to such topics was not limited to the bioethics unit, but also occurred in units dealing with communication, physical exam and professionalism and physician health and the Integrative Course, where they learned about sensitive and respectful ways of communicating with patients and families. As clinical clerks, these same topics are addressed in actual clinical scenarios and students are encouraged to inquire if they have questions. Overall, the centrality of autonomy and respect for patients and their families is the cornerstone of the bioethics curriculum.

The RIME curriculum addresses the above topics throughout each of the Units, as well as in the Professional Role course. Clerkship experiences are unchanged.

Requirement 7.7-2
The faculty of the medical school requires medical students to behave ethically in caring for patients and in relating to patients' families and others involved in patient care.

Analysis of evidence for requirement 7.7-2

The expectation for professional and ethical behaviour of students permeates the curriculum. From the moment they sign their Oath of Confidentiality, students are reminded of their ethical obligations in caring for patients and their families. Within the pre-clerkship curriculum, students are evaluated each year by their attendance, a short written assignment and a presentation on a contemporary topic in bioethics to their small group.

Objectives, in terms of ethical considerations in specific medical situations, are reviewed and also a component of the ITER assessment in pre-clerkship courses. In the ITER assessments the students are evaluated on their professionalism and respect for patients and the team.

In clerkship, the ITERS in each rotation include assessment of their professional and ethical activities. Students who are identified as having issues with professionalism and ethics meet with a course chair and/or Assistant/Associate Dean.

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.

Requirement 7.8-1

The faculty of the medical school ensure that the medical curriculum includes specific instruction in communication skills as they relate to communication with:

- *i. patients and their families*
- *ii. colleagues*
- *iii. other health professionals*

Analysis of evidence for requirement 7.8-1

Applicable to both the Legacy and RIME Curricula:

i. patients and their families

The longitudinal clinical skills course, during the first 18 months of pre-clerkship, puts emphasis on a patient centered approach to all patient interactions with a trauma informed care lens in all encounters. It emphasizes gender, affirming care principles, as well as exploring the patient's perspective and agenda. Special attention is given to cultural context as a core theme in the communications unit. Several 2-hour small group communication sessions (4-6 students and a preceptor) with standardized patients/families occur longitudinally and in a patten of increasing complexity in a supportive environment. These sessions promote instruction and feedback in the critical area of communication. The one-way mirrors in the healthcare simulation MedSkills Centre allows for students to have observed communications with standardized patients/families, with a follow-up facilitated debrief involving the group.

ii. colleagues

Communication with colleagues is repeatedly emphasized by creating effective and respectful small group interactions throughout the weekly sessions in pre-clerkship. This incorporates the ability to give and receive constructive feedback, which is emphasized in the Communication course. This effective communication modality is further applied in exploring safe patient sign-over and structured case presentations in introduction to clinical practice in pre-clerkship and during clerkship. Once in the clerkship, students are evaluated on communication skills with colleagues through their regular ITER and expect to have clear written and verbal communication with them.

iii. other health professionals

Multiple components of the curriculum highlight the interprofessional interactions that are core aspects of effective patient care, including the family medicine clinical experience, collaborative practice sessions, and community engaged learning. These components emphasize respectful interactions with marginalized populations and process and confront personal biases and stigma.

7.9 INTERPROFESSIONAL COLLABORATIVE SKILLS

The faculty of a medical school ensure that the 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.

Requirement 7.9-1

The faculty of the medical school ensures that the 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.

Analysis of evidence for requirement 7.9-1

Both the Legacy and RIME curricula included/include multiple experiences that enhance interprofessional collaborative skills:

1. Career exploration clinical experiences (three pre-clerkship weeks in total) place students in a clinical environment conducive to working and interacting effectively with physicians and non-physician allied healthcare professionals, and healthcare teams.
2. Team based simulations, focused on interprofessional collaboration, occurs during introduction to clinical practice and involved a physician and an allied healthcare professional.
3. Community engaged learning (CEL) activities, in pre-clerkship exposes students to the role of interdisciplinary teamwork and holistic care that extends to include social work, law, and community services.

Requirement 7.9-2

These required curricular experiences include practitioners and/or students from the other health professions.

Analysis of evidence for requirement 7.9-2

In clerkship, these principles covered above are revisited, and applied in context of clinical encounters.

1. The Family Medicine rotation exemplifies the importance of shared decision-making with patients and collaboration with multiple healthcare providers to offer patient-comprehensive care. (Legacy and RIME)
2. Clerkship interprofessional education (IPE) occurs at the start of clerkship by placing students with allied healthcare professionals to understand the scope of their practice and their respective roles within the healthcare team (Legacy). These allied healthcare professions include social work, optometry, EMS, physiotherapy, occupational therapy and respiratory therapy. All clerkship rotations exist within a multidisciplinary healthcare system.
3. With the University of Calgary Longitudinal Integrated Clerkship (UCLIC) streams students have most of the rotations in rural sites where care teams are crucial to patient care.
4. Clerkship OSCE involves assessment of EPA related to collaborative care.

7.10 PROFESSIONAL AND LEADERSHIP DEVELOPMENT

The curriculum provides educational activities to support the development of each student's professional identity, core professional attributes, knowledge of professional responsibilities and leadership skills.

Requirement 7.10-1

The curriculum provides educational activities to support the development of each student's:

i. professional identity
ii. core professional attributes
iii. knowledge of professional responsibilities
iv. leadership skills

Analysis of evidence for requirement 7.10-1

Table 7.10-1A in the DCI outlines several initiatives in place regarding professional identity, core professional attributes, professional responsibilities, and leadership skills in the Legacy Curriculum. This is comprehensive in nature with some of the concepts noted below:

Legacy Curriculum:

i. Professional Identity: During the orientation block at the start of the medical program there is introduction to the professional role, identity of a physician and potential professionalism concerns. Concepts of integrity and altruism were introduced. A session was also delivered by the College of Physician and Surgeons of Alberta - Serving the Public by Guiding the Medical Profession.

ii. Core Professional Attributes: Concepts related to mindfulness, changing relationships during medical school, resilience building were introduced with several objectives for each session.

iii. Knowledge of professional responsibilities:
   a. Professionalism and physician health course
   b. Orientation week with several sessions related to professional responsibility including social media presence
   c. Student mistreatment awareness
   d. Addressing personal wellness
   e. Dealing with the crisis in medicine and how to be professional and be human

iv. Leadership Skills
   a. Introduced in detail in the professionalism and physician health course
   b. Leaders in medicine initiative allows for a joint degree and additional leadership responsibilities.

RIME Curriculum:

Table 7.10-1A in the DCI outlines several initiatives in place regarding professional identity, core professional attributes, professional responsibilities, and leadership skills in the RIME Curriculum. Small and large group sessions, asynchronous teaching, and CARDS are all strategies used to address and reinforce professional and leadership awareness and development. A comprehensive list of educational opportunities is noted in the DCI, with an example of when/where some of the topics are covered noted below:

a. Teamwork session – Block 1
b. Conflict management – Block 3
c. Balancing balance -- Block 1 & 2
d. Investing in yourself -- Block 1 & 2
e. Time management – Block 1 & 2
f. Know your limits – Block 1 & 2
g. When do behaviors impact care? – Block 1 & 2
h. Avoiding abuse of privilege – Block 1 & 2
i. Doctor as Teacher – Block 1 & 2
j. Dealing with difficult issues – Block 2
k. Altruism – is seemingly impossible ask – Block 1 & 2

<u>Leadership skills</u>: Teachings towards understanding the role of leadership in healthcare are introduced throughout Blocks 2 and 3. These include leadership for patient safety topics and exploring how individual leadership style and professional identity will play into team dynamics.

The joint degree program of Leaders in Medicine (LIM) allows select students to pursue a masters, PhD or MBA concurrently with their MD degree. This program is designed to develop future leaders in clinical and academic medicine.

STANDARD 8: CURRICULAR MANAGEMENT, EVALUATION, AND ENHANCEMENT

The faculty of a medical school engages in curricular revision and program evaluation activities to ensure that that 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.

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8.1 CURRICULAR MANAGEMENT

The faculty of a medical school entrusts 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.

Requirement 8.1-1
The faculty of the medical school entrusts authority and responsibility for the medical education program to a duly constituted faculty body commonly called a curriculum committee.

Analysis of evidence for requirement 8.1-1

There is evidence of a duly constituted faculty body with the authority and responsibility to create and monitor the medical education program. This curricular review body was recently transitioned from the Undergraduate Medical Education Committee to the Curriculum Innovation and Oversight Committee as the medical school implemented the new RIME curriculum. Terms of reference for both committees are provided, and the authority provisions of each committee are clearly stated.

Requirement 8.1-2
This committee and its subcommittees or other structures that achieve the same functionality, oversee the curriculum as a whole and have responsibility for the

- *i. overall design*
- *ii. management*
- *iii. integration*
- *iv. evaluation*
- *v. enhancement of a coherent and coordinated medical curriculum*

Analysis of evidence for requirement 8.1-2

A clear organization chart is provided. The terms of reference for the above-mentioned committees as well as their sub-committees are provided and outline how they oversee i.-v. above. Review of a selection of minutes from these committees provides evidence of oversight of i.-v. Items within the minutes which demonstrate i.-v. above are highlighted and further described in the DCI.

8.2 USE OF PROGRAM AND LEARNING OBJECTIVES

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

Requirement 8.2-1

The faculty of the medical school, through the curriculum committee, ensures that the formally adopted medical education program objectives are used to:

- *i. guide the selection of curriculum content*
- *ii. review and revise the curriculum*

Analysis of evidence for requirement 8.2-1

The medical school has the "Big 10" graduation objectives as well as the AFMC EPAs to both guide the selection of curriculum content as well as review and revise the curriculum. These objectives were reviewed regularly in UMEC and the PCC in the Legacy curriculum. In the RIME curriculum, the same objectives apply, and these are reviewed in UMEC and the RIME Pre-Clerkship Committee. Appropriate quotes relating to changes to curriculum were documented in the DCI.

Requirement 8.2-2

The learning objectives of each required learning experience are linked to the medical education program objectives.

Analysis of evidence for requirement 8.2-2

In the Legacy curriculum, the curriculum was reviewed by UMEC and the PCC to ensure that the content was in line with the objectives.

Within RIME, all new curricular content is additionally scrutinized by the Curriculum Innovation and Oversight Committee to ensure that the objectives and content appropriately align with these principles and objectives. Ultimate approval of large curricular changes then moves to UMEC for further review, discussion and approval.

8.3 CURRICULAR DESIGN, REVIEW, REVISION/CONTENT MONITORING

The faculty of a medical school is 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.

Requirement 8.3-1

The faculty of the medical school is 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.

Analysis of evidence for requirement 8.3-1

In the Legacy curriculum, there was a well-established oversight structure. Courses were led by groups of content experts and educators who oversaw the organization and scheduling of the educational program and established objectives and evaluations for learning events. Instructional methods were planned by the individual course committees and reviewed annually by the Pre-Clerkship Committee. Assessment methods were developed by the course leaders and were reviewed at Student Evaluation Committee, chaired by the Assistant Dean, Evaluations and Research.

A similar structure exists for the clerkship, which has not changed with the initiation of the RIME curriculum. Clerkship rotations are led by content and education experts responsible for the rotation planning, educational methods and development and maintenance of the rotation objectives. Assessment methods are developed and reviewed by the clerkship leaders and approved of by the Student Evaluation committee.

Course and Clerkship leaders are responsible to the Pre-Clerkship and Clerkship Committees, respectively. A detailed annual review of each course and clerkship is completed, presented, and discussed at the relevant committee. These committees are chaired by the Assistant Dean (pre-clerkship/clerkship) who provides updates to UMEC on the functioning of the courses and clerkship at each meeting, with a detailed report provided annually. These multiple levels of oversight allow for input from both content and educational leaders; final authority for management of the curriculum rested with UMEC.

In the RIME curriculum there is further support for curricular development, review and management in both the pre-clerkship and clerkship through the Curriculum Innovation and Oversight Committee; this committee is chaired by the Assistant Dean, Program Evaluation and reports to UMEC, so that the ultimate responsibility for curriculum will continue to rest with UMEC. Changes proposed within the pre-clerkship or clerkship are discussed at the relevant committee for refinement; these proposals are then presented to Curriculum Innovation and Oversight Committee for approval. Minor changes are then implemented; major changes will require UMEC approval.

In all situations, any change to the program's overall design or structure or the course load must be approved by the University.

Requirement 8.3-2

The curriculum committee oversees:

- *i. content and content sequencing*
- *ii. ongoing review and updating of content*
- *iii. evaluation of required learning experiences*
- *iv. teacher quality*

Analysis of evidence for requirement 8.3-2

In the Legacy curriculum, Course Committees were responsible for the consideration of the content to be included in each course, and the order in which topics were presented. Each course was required to complete a detailed evaluation of the course on an annual basis using feedback from both students and teachers and evaluation data, with the course report being presented by the course chair to the Pre-Clerkship Committee for review and approval. Course chairs would also meet directly with the Assistant Dean, Pre-clerkship to discuss the report content. Feedback was collected from students at the end of each learning event and at the end of each course; feedback was collected from all involved course teachers at the end of each course iteration. This allowed for the evaluation of all learning experiences and each course as a whole. The feedback on student perceived teacher quality was determined through the collection of the student data. The Assistant Dean, Pre-Clerkship, provided an update to UMEC at each meeting, with a more detailed report provided annually. As required, poorly performing teachers would be given feedback with the opportunity for improvement; if an improvement was not seen, those teachers would not be invited back to teach in future years. Serious teacher evaluation concerns were addressed in a timely and immediate manner.

In RIME, this process structure has changed significantly. The RIME development process included a very specific intent to provide a spiral curriculum where content is presented sequentially, with clinical presentations represented multiple times; with the depth and complexity increased with each subsequent clinical presentation exposure. The content sequencing reflects this interleaving of subject areas to promote long-term learning and simulate the varied nature of clinical presentations seen by a generalist physician. This avoids the previous constraints of the department-based sequential courses in the Legacy curriculum and is one of the pedagogical strengths of RIME.

The ongoing review and updating of content will be achieved in RIME by targeted surveys of groups of students (rather than the entire class at each time) to increase response rates and to achieve a more balanced input from student feedback. This survey feedback is enhanced by focus groups conducted by the Assistant Dean, Program Evaluation. The Assistant Dean, Program Evaluation, is responsible for reviewing all student feedback and reviewing this with the Curriculum Innovation and Oversight Committee (CIOC). This committee will advise both the RIME Pre-clerkship Committee and UMEC on issues related to curriculum content updates. This student data will also inform the RIME Pre-Clerkship Committee (RPCC) about individual learning events that may require improvement.

In the RIME pre-clerkship curriculum, there is significantly more direct control over individual teachers, as the cadre of teachers in the pre-clerkship is much smaller than in the Legacy curriculum. This allows for more directed opportunities for feedback to individual teachers and opportunities for targeted faculty development; the proportion of teachers accessing these faculty development opportunities is high, as all teachers have been hired into their roles due to their commitment to teaching and personal improvement in that realm.

In the clerkship, the departmental clerkship committees are responsible for providing the rotation structure, including the duration and location of clerkship clinical experiences. This provides the best opportunity for clerks to experience the clinical presentations relevant to that clerkship by structuring the rotations to mimic the work of a practitioner in that clinical area. Students are asked to provide feedback at the end of each rotation and are invited to provide feedback directly on individual preceptors. This feedback is reviewed by the clerkship leaders and the Assistant Dean, Clerkship. The clerkship director and Assistant Dean, Clerkship, meet annually to discuss the feedback and plan for changes in the clerkship. Each clerkship director also presents an annual report to the Clerkship Committee for further review and discussion. The Assistant Dean then reports to UMEC at each meeting and in more detail annually to inform UMEC about ongoing changes in the clerkship. Poorly performing teachers identified through student feedback will meet with the Clerkship Director for feedback on performance; if further negative experiences are reported, the teacher will be removed from clerkship teaching duties. Depending on the nature of the poor performance, a review may occur with the Assistant Dean, Clerkship, the Associate Dean and/or the relevant Department chair.

As described above, the Curriculum Innovation and Oversight Committee will provide a further layer of support to the process of the ongoing review and updating of content.

Requirement 8.3-3

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.

Analysis of evidence for requirement 8.3-3

As described in the above requirements, students in the Legacy curriculum, the RIME curriculum and the clerkship are surveyed regularly for input on the curriculum and assessments in the MD program. This feedback is provided to the relevant Assistant Dean and the course/clerkship leaders. The data are reviewed and discussed to make plans for required changes through the relevant committees. These changes are reported to UMEC for approval on a regular basis. The Curriculum Innovation and Oversight Committee will support this process for curricular content; the Student Evaluation Committee will continue to support the process for evaluation maintenance and development.

8.4 EVALUATION OF PROGRAM OUTCOMES

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 as a whole. These data are collected during program enrollment and after program completion.

Requirement 8.4-1
The 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.

Analysis of evidence for requirement 8.4-1

Data are collected throughout the pre-clerkship and clerkship and reviewed by the Assistant and Associate Deans, as well as the UME management team. These data include results from all examinations, EPA completion rates, results from all mandatory learning experiences, feedback from residency program directors after graduation, as well as MCCQE results and observed trends. The results of all the above are used as a mechanism to potentially modify experiences or, in the setting of the MCCQE, tailor the preparation course that is offered, to ensure that trainee success is paramount in curricular modification.

The information provided in the above outcome measures informs the UME program leadership of the extent by which the medical students are achieving the medical education program objectives, and the potential need for future curricular modification.

Requirement 8.4-2
The medical school collects and uses a variety of outcome data, including national norms of accomplishment, to enhance the quality of the medical education program as a whole.

Analysis of evidence for requirement 8.4-2

A. Data that are collected and viewed by the Assistant and Associate Deans, as well as the management team includes the following: student advancement and graduation rates, student responses on the AFMC GQ, specialty choices of graduates, feedback on residency performance of graduates and MCCQE Part 1. Comparison to national norms for the AFMC GQ, as well as the MCCQE data is reviewed on a yearly basis.
B. MCCQE data has been studied in detail over the years and initiatives have been put in place to address the results, which have historically been below national averages. The SUCCESS (Supplemental UME Course for Competence in Educational Skills and Strategies) program was established and an improvement in scores, often surpassing the national levels, has been achieved.

Requirement 8.4-3
These data are collected during program enrollment and after program completion.

Analysis of evidence for requirement 8.4-3

Specific data collected after program completion include the results of MCCQE Part 1, information regarding specialty choices, as well as feedback on residency performance of graduates.

8.5 MEDICAL STUDENT FEEDBACK

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

Requirement 8.5-1

In evaluating medical education program quality, the medical school has formal processes in place to collect and consider medical student evaluations of their:

- *i. required learning experiences*
- *ii. teachers (other than faculty members)*
- *iii. faculty members*
- *iv. other relevant aspects of the medical education program*

Analysis of evidence for requirement 8.5-1

The quality of the medical education program is evaluated for all mandatory and several optional learning experiences. Collected data regarding the learning experiences are reviewed at the UME Management Committee and the Pre-Clerkship and Clerkship Committees. Red flags are identified and actioned on, and key strengths and weaknesses are discussed with a growth mindset. Course and Clerkship leads are involved in report review and in implementing changes, when necessary.

Feedback is collected both after specific learning experiences, as well as yearly.

Yearly feedback addresses whether students felt that their exposure to certain topics (Indigenous health, anatomy, disease prevention/health promotion, end of life care, inter-professionalism, and physician wellness and self-care) was inadequate, appropriate, or excessive. Yearly feedback also addresses whether students have experienced various forms of mistreatment based on any of the following categories: race or ethnicity, gender, gender identity, religion, physical appearance, other, and where the mistreatment was from (i.e. students, residents, staff, patients or standardized patients, others). Comments about the strengths and weaknesses of the program are explored through early surveys. Readiness for clerkship is explored after the second year, and several dimensions of readiness are explored at that point. At the end of the final year, students are surveyed again, and in addition to several previous questions, students are asked how well they think the training program has prepared them for each of the Big 10 graduation educational objectives.

Feedback for non-faculty members (residents, allied health care professionals etc.) is collected and distributed in a similar manner as faculty feedback. Resident feedback is distributed to Program leadership (i.e. program directors) for review prior to distribution.

Teacher feedback for small group teaching is provided to small group teachers immediately, with narrative data withheld unless requested by teachers.

Clerkship teacher feedback is provided after a delay with the goal of protecting anonymity. Teachers are provided with their feedback, and copies are distributed to those in leadership roles, such as departmental leads. Comments that are egregious in nature are addressed immediately, protecting the anonymity of the trainees, but addressing serious concerns.

The RIME curriculum has introduced an innovative *intermittent sampling* method of feedback collection whereby a subset of students will be surveyed after each learning experience. The objective is to decrease survey fatigue but continue to allow for ongoing feedback collection.

In the ISA survey over 97% of trainees agreed with the statement: *the medical school provided me with opportunities to evaluate my required learning experiences (e.g., courses, clerkship rotations, longitudinal integrated clerkships).* Over 98% agreed with the statement*: the medical school provided me with opportunities to evaluate my teachers.*

Given that the RIME curriculum was implemented in 2023, the first class to learn through RIME (Class of 2026) was invited to participate in a voluntary ISA-style pre-accreditation survey designed to provide data for program evaluation purposes. Survey results and a report from the Calgary Medical Students Association (Class of 2026) are included as *Supplemental Appendix 8.5-1 B*.

8.6 MONITORING OF REQUIRED PATIENT ENCOUNTERS AND PROCEDURES

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.

Requirement 8.6-1
The medical school has in place a system with central oversight that monitors the required patient encounters, clinical conditions, skills, and procedures to be performed by all medical students.

Analysis of evidence for requirement 8.6-1

The system with central oversight is a mandatory online logbook reporting of clinical presentations and procedures/tasks for each clerkship rotation. If a real patient was not encountered, alternatives to learning include simulation or case discussion during the clerkship rotation. Each clerkship rotation also has protected academic time to learn about clinical presentations through self-study or preceptor-facilitated sessions. Several clerkships also host simulations to further expose students to clinical presentations, skills, and procedures.

Requirement 8.6-2
The medical school has in place a system with central oversight that remedies any gaps in the required patient encounters, clinical conditions, skills, and procedures to be performed by all medical students.

Analysis of evidence for requirement 8.6-2

As above, each clerkship rotation has mandatory online logbook reporting of clinical presentations and procedures/tasks. If there is an exposure gap, the student must discuss those clinical presentations as substitute exposure. In addition, during the clerkship year there is a longitudinal course called “Comprehensive Clinical Skills Curriculum for Clerkship” as a “safety net” to ensure that all students have been exposed to clinical conditions, skills, and procedures considered critical for undifferentiated physicians graduating from the MD program. This longitudinal course is reviewed and revised yearly based on several requirements including accreditation requirements, student and faculty feedback, performance on formative and summative evaluations, clerkship online logbook reporting, and changing requirements for the medical school.

Requirement 8.6-3
The medical school has in place a system with central oversight that ensures completion of the required patient encounters, clinical conditions, skills, and procedures to be performed by all medical students.

Analysis of evidence for requirement 8.6-3

Students who have not completed their online logbook for a given clerkship rotation are contacted by the UME program coordinator for that clerkship rotation to alert them of the deficiency. This notice includes a reminder that the student will not be able to complete the clerkship final examination until the logbook is complete. The Clerkship Director or Assistant Dean may need to contact the student with a subsequent reminder or inquiry, as needed.

The online logbook has the students indicate whether clinical presentations were “discussed”, “observed”, “simulated”, or “participated”. Each clinical presentation has a pre-specified level of completion. For example, abdominal pain in emergency medicine clerkship cannot be “discussed” or “observed”, it needs to be “simulated” and “participated”.

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.

Requirement 8.7-1
The medical school ensures that the medical curriculum includes comparable educational experiences across all locations within a given required learning experience to ensure that all medical students achieve the same learning objectives.

Analysis of evidence for requirement 8.7-1

In pre-clerkship, there is only one campus, therefore all learning experiences and objectives are the same.

In clerkship, students attend clinical rotations in more than one location. The school uses multiple ways to ensure educational experiences are comparable across all locations:
- Clear learning objectives for all rotations, regardless of location
- Assigning a clerkship director to each mandatory clerkship rotation, who monitors and ensures that educational experiences across all locations are comparable
- Regularly disseminating clerkship objectives to clinical supervisors
- Re-sending a link to the program's "Big 10 graduation objectives" to all preceptors at the time of ITER completion
- Re-sending a link to the relevant course/clerkship objectives to all preceptors at the time of ITER completion
- Asking preceptors to express their awareness of the "Big 10 graduation objectives" and relevant course/clerkship objectives on ITERs
- Monitoring comparability across sites by the Manager of Academic Technologies, the Assistant Dean-Clerkship, Assistant Dean-Program Evaluation and the UME Associate Dean.

Requirement 8.7-2
The medical school ensures that the medical curriculum includes equivalent methods of assessment across all locations within a given required learning experience to ensure that all medical students achieve the same learning objectives.

Analysis of evidence for requirement 8.7-2

The program has only one campus, and most student assessments are completed centrally on this campus. Multiple choice questions and OSCE exams are administered at Foothills Medical Centre.

Assessments that are completed at more than one location are:
- ITERs as part of mandatory clinical rotations
- EPAs that are completed in workplace environment
- Projects that are completed as part of clinical rotations

There is an Assistant Dean of Evaluations and Research, and with the support from the Student Evaluation Committee, this person ensures there are equivalent assessment methods across all locations.

All the ITER and EPA forms used for each location in clerkship are the same, regardless of where the clerkship rotation is physically completed.

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.

Requirement 8.8-1
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.

Analysis of evidence for requirement 8.8-1

The Pre-Clerkship Student Handbook and Clerkship Work Hours Policy (Appendices 8.1-1 A1 and A2) are circulated to students and include information regarding the time spent in educational and clinical activities.

The Pre-Clerkship Student Handbook further provides links to the Student Timetable which provides an overview of the times that students are expected to participate in clinical and educational activities. There is also a curriculum map which shows how all the courses fit together in the entire medical school curriculum.

The Clerkship Work Hours Policy clearly outlines the work hours expected of clerks. This document was approved by the Undergraduate Medical Education Committee on February 1, 2019.

ISA survey results indicate that, when asked the question *"I am informed of the amount of time that the medical education program expects me to spend in required activities"* the answer was 81.4%, 76.3% and 89.3% of the Class of 2023, 2024, and 2025 respectively responded positively regarding having such information. When asked if they were: "*disappointed by the number of times I was required by a supervisor/teacher to spend more time in required activities than expected by the medical education program" it was noted that 31.9%, 33.3% and 20.1%* of the Class of 2023, 2024, and 2025 expressed disappointment.

Although there are clear policies in place, it is perceived by the medical students that pre-clerkship and clerkship scheduled time was not always respected; educational and clinical activities may go overtime. Examples include rotations like surgery, scheduling after-hour content review and information sessions, and running overtime for lectures or bedside teaching.

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.

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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.

Requirement 9.1-1
In the 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.

Analysis of evidence for requirement 9.1-1

Pre-clerkship
Resident and non-faculty instructors who teach at the medical school are provided with the learning objectives. This is either by email or through one of the online resource management systems (OSLER or Fresh Sheet).

Clerkship
For every clerkship rotation, there is a manual or website that houses the clerkship rotation's learning objectives, and this information is distributed to faculty and residents. If there is no manual or website, clerkship objectives are disseminated by email.

Requirement 9.1-2
In the medical school, residents, graduate students, postdoctoral fellows, and other non-faculty instructors who supervise, teach, or assess medical students are prepared for their roles in teaching and assessment.

Analysis of evidence for requirement 9.1-2

Residents are prepared for their roles in teaching and assessment by undergoing a Resident as Teachers Toolkit (RATTS) workshop hosted by the PGME office. Residency programs can also offer an alternative, equivalent training program within their specialty to replace the RATTS training.

Non-faculty instructors are involved in the teaching and the supervision of the pre-clerks in two specific curricular components. Clear examples of the preparation material provided (course objectives, student expectation) and pre-session on-site briefing are provided for the Interprofessional Education (IPE) sessions. There is no evaluative role for the non-faculty instructors. The second major event where non-faculty instructors supervise or teach medical students is the Community Engaged Learning (CEL) initiative. There are many community partners who engage with the learners for several half-days in the pre-clerkship. The objectives for the sessions are distributed in advance of the student's arrival, and an evaluative component is not expected.

The school does not typically use graduate students or postdoctoral fellows to teach.

Requirement 9.1-3
The medical school provides resources to enhance and improve residents' teaching and assessment skills, with central monitoring of their participation in those opportunities provided.

Analysis of evidence for requirement 9.1-3

The PGME office offers a Resident as Teachers Toolkit (RATTS) workshop. This workshop is mandatory for all residents. When a resident completes this workshop, a report of completion is sent to the resident's residency program for record-keeping. If a residency program has an equivalent training option, that option can be used instead. The residency program would oversee and monitor this training.

Other opportunities to enhance/improve residents' teaching/assessment skills include workshops through the Office of Faculty Development and Performance that residents can register for.

Medical students evaluate residents on their teaching and a year-end teaching performance report is given to the residents via their program director.

9.2 SUPERVISION OF REQUIRED CLINICAL LEARNING EXPERIENCES

A medical school must ensure that the supervision of medical students in required clinical learning experiences is provided by faculty members of the medical school.

Requirement 9.2-1
The medical school ensures that supervision of medical students is provided throughout required clinical learning experiences by faculty members of the medical school.

Analysis of evidence for requirement 9.2-1

All physicians who teach in the program must have a faculty appointment, including clerkship and pre-clerkship clinical learning experiences. Information provided confirms that 100% of clinical supervisors at the University of Calgary hold faculty appointments. The UME Office ensures faculty are clinical supervisors through a database, and any error in this regard would be captured via the UME financial office and faculty performance records.

The ISA indicates that over 94% of students believed that they always had appropriate supervision in clinical learning situations involving patient care.

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 the student's level of training, and that the delegated activities supervised by the health professional are within the health professional's scope of practice.

Requirement 9.3-1
The medical school ensures that medical students in clinical learning situations involving patient care are appropriately supervised at all times in order to ensure:

- *i. patient and student safety*
- *ii. that the level of responsibility delegated to the student is appropriate to the student's level of training*
- *iii. that the delegated activities supervised by the health professional are within the health professional's scope of practice*

Analysis of evidence for requirement 9.3-1

Medical students are supervised in clinical learning rotations. A primary preceptor is assigned for all students and oversees the educational experience in the clinical context. Primary preceptors are given objectives and policies relevant to supervising a medical student. Important safeguards built into clinical supervision include co-signing of notes and orders and feedback mechanisms to address possible concerns with supervision. All tasks delegated to learners are expected to be within scope of practice, and the primary preceptor is tasked with oversight.

Graded responsibility and increasing autonomy for medical students is granted based on individual observation and feedback. This is further cemented by providing objectives and anchors on ITERS and EPA assessments. Appropriate responsibility delegation is monitored via student feedback. The feedback from student ISA confirms that supervision is appropriate with over 97% indicating level of supervision ensured their safety and over 96% of students indicating that level of supervision ensured patient safety.

There are several mechanisms by which concerns about supervision can be brought forward by a student. This includes multiple levels, from directly with their preceptor to the Associate Dean UME or external resources including other offices within the CSM and main campus. Reporting options, pathways and mechanisms with the CSM continue to be evaluated.

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), behaviours, and attitudes specified in medical education program objectives, and that ensures that all graduates achieve the same medical education program objectives.

Requirement 9.4-1

The medical school ensures that, throughout its medical education program, there is a centralized system in place that:

- *i. 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), behaviours, attitudes specified in medical education program objectives*
- *ii. ensures that all graduates achieve the same medical education program objectives*

Analysis of evidence for requirement 9.4-1

The UME program uses various measures for student achievement assessment. Direct observation of students' skills is included as part of the assessment program in all three years of the program. Also, the program uses various tools to assess students in all required domains, including knowledge, clinical skills, behaviors, and attitudes.

In the pre-clerkship component of the program, acquisition of knowledge is assessed using written multiple-choice examinations, peripatetic examinations (for anatomy content in the Legacy curriculum), OSCE examinations (involves direct observation), as well as some assignments and presentations (involves direct observation). Acquisition of core clinical skills in the pre-clerkship program are assessed using OSCE examinations (two in the Legacy curriculum and three in the RIME curriculum) as well as preceptor ITER evaluations and EPAs, both of which involve the direct observation of these skills.

Attitudes are assessed on ITER evaluations as well as through oral and or paper-based assignments and presentations. In the clerkship curriculum, knowledge is assessed using written multiple-choice examinations, a clerkship OSCE (involves direct observation), preceptor ITERs (involves direct observation), and EPA assessments (involves direct observation). Clinical skills are assessed on OSCE examinations (involves direct observation), preceptor ITERs (involves direct observation), EPA assessments (involves direct observation), and observed histories and physical exams which involve direct observation. Attitudes are assessed on the clerkship OSCE (involves direct observation), preceptor ITERS (involves direct observation), and presentations (involves direct observation). Table 9.4 GQ data shows the percentage of students observed and assessed on their performance in history taking and physical examination throughout their clerkship rotations. The percentages are high but not 100%. This may be in part due to recall error. The lowest numbers were consistently observed for the surgery rotation, but interventions have been put in place, and this has improved over the past two years. The UME program has responded to the need for directly observed histories and physical exams by mandating that all students complete an assessment of EPA 1 (history and physical examination) during their surgery rotation.

Although oversight of the assessment program is provided by the Assistant Dean of Evaluations and Research (with support from the Student Evaluation Committee), acquisition of the medical education program objectives (i.e. the Big 10) is ensured by SARC, which is tasked with making progression and graduation decisions. To inform the decisions about progress and promotion, the UME program created a RIME pre-clerkship and clerkship level Competency Committee, which includes various relevant stakeholders. Each committee meets approximately every 6 months to review the assessment data for each student. The committee is tasked with making consensus recommendations regarding students' readiness to progress within the program and to graduate from the program. To recommend graduation from the program, the committee must ensure that each student meets the Big 10 graduation objectives, which it does by reviewing each student's assessment data in detail. When the committee recommends against progression or graduation, the committee provides recommendations for criteria that must be met prior to recommending that student for progression or graduation. These recommendations are provided to the Associate Dean, who then presents them to the SARC which makes final progress and graduation decisions. This process ensures that every student has met the Big10 graduation objectives by the completion of the program.

In the Legacy curriculum, instead of a Competency Committee, students had to pass all evaluation components of the pre-clerkship curriculum before being recommended for progression to clerkship.

9.5 NARRATIVE ASSESSMENT

A medical school ensures that a narrative description of a medical student's performance, including the student's 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.

Requirement 9.5-1
The medical school ensures that a narrative description of a medical student's performance, including the student's 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.

Analysis of evidence for requirement 9.5-1

Narrative assessment is an ongoing part of both the pre-clerkship and clerkship curriculums:

1. Pre-clerkship
   a. Legacy curriculum: narrative feedback is provided for several required components including: 1) Family Medicine clinical experience; 2) Applied Evidence-Based Medicine (clinical, directed study or research); and 3) Career Exploration. In these experiences, In-Training Evaluation Reports (ITERs) are completed at the end of the experience and the midpoint in the family medicine clinical experience. All ITERs contain a narrative comment box. In addition, there are med-skills OSCE's in both years of the pre-clerkship. Rating and comments are provided for each student at each station, by the station examiner. These comments are also released to the students, after review by the UME leadership, to facilitate learning. The volume and quality of these comments are consistently excellent.
   b. RIME curriculum: Narrative feedback is designed to be continuous within the RIME curriculum. EPA assessments that can be either student or preceptor initiated form the basis of narrative assessments in most clinical and educational settings within the pre-clerkship. Forms are linked to a specific encounter or task with an overall assessment and narrative comments. In addition, there are cumulative OSCE exams at the end of each of the three blocks of the RIME pre-clerkship curriculum. As with the Legacy curriculum, narrative comments along with ratings are recorded at each station by the evaluator. Like the Legacy curriculum, it is expected that these are substantial in breadth and depth. These comments are also released to the students, after review by the UME leadership, to facilitate learning.

2. Clerkship: The narrative assessment is a continuous feature of evaluation. Each rotation ITER has two comments sections. One is for comments reflective of the students' performance that the evaluators feel would be appropriate to appear on the MSPR. In addition, a second comments box is provided for constructive feedback/advice to allow for further development in student learning or performance that the preceptors do not feel represent a significant issue that should appear on the MSRP and impact the student's success in the CaRMS match. The purpose of this second box is to enhance the depth or narrative assessment without undue impact on student wellness or success. In addition, the clerkship students must successfully complete a specified number of each of the EPAs for graduating medical students. These forms require a rating of performance on an entrustment scale (O-Score derived) and narrative assessment comments. Finally, the clerkship OSCE includes narrative assessment in addition to overall ratings (mapped to EPAs). Like the OSCEs in the pre-clerkship, the breadth and depth of comments seen on these evaluations is consistently of high value. Narrative assessment comments are available to the Competency Committee in their assessment of students regarding graduation recommendations.

The provision of narrative assessment across the above settings ensures a well-rounded student assessment with emphasis on both cognitive and non-cognitive domains of performance.

The richness of student narrative assessment is enabled by appropriate preparation of preceptors to provide high quality descriptions of student performance. There is focus on this task at the orientation sessions for OSCE examiners. The use of appropriate anchors and descriptors for EPA and ITER forms provides guidance around expectations that narrative assessment comments can be positioned against for comparison. Links to the program objectives provide a further narrative frame of reference against which to judge performance. The provision of the non-MSPR comment box on ITERs allows for rich narrative assessment to guide student learning without undue effects on outcomes related to the residency match. For example, if preceptors feel that a student would benefit further from more focus on "X" but that this does not represent a performance level below what is expected they can make this assessment in the non-MSPR box without significant consequence to the student.

Finally, educational activities for preceptors are available via the Office of Faculty Development and Performance and include topics such as “how to give effective feedback”. Within RIME, all educators were given a mandatory RIME specific faculty development course leading up to the curriculum launch, which included a session on giving effective feedback.

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.

Requirement 9.6-1
The 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.

Analysis of evidence for requirement 9.6-1

The response outlines the oversight of setting achievement standards in all required learning experiences by the Assistant Dean of Evaluations and Research and the Student Evaluation Committee. Specific course exams and assessments are constructed by course faculty and course chairs, and then approved by the Assistant Dean of Evaluations and Research. This Assistant Dean is chosen based on experience and expertise in standard setting, and there is focused faculty development and mentorship when there is change in this position.

Any policy change or procedures enacted by the Assistant Dean of Evaluations and Research must be approved by the Student Evaluation Committee, which includes widespread partner representation from important groups, as well as a Senior Evaluation Advisor and Medical Education and Research Advisor, both of whom have extensive expertise in standard setting.

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

Requirement 9.7-1
The medical school ensures that the medical education program provides timely formative assessment consisting of appropriate measures by which medical students can measure their progress in learning.

Analysis of evidence for requirement 9.7-1

There are clear policies developed detailing expectations. Formative exams exist for all pre-clerkship and clerkship courses. There are clear policies regarding the requirement for providing feedback. There is a required CARDS program for RIME students providing frequent, low-stakes formative assessment.

Requirement 9.7-2
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.

Analysis of evidence for requirement 9.7-2

In the pre-clerkship Legacy curriculum, formative exams were provided at midpoint of each course. For clerkship rotations, formative MCQ exams as well as OSCE are provided at the midpoint. In the RIME curriculum there are pre-clerkship EPA, OSCE and mandatory CARDS assessments.

The addition of a surgical skills day is helpful for formative assessment of surgical skills.

There are formative review exams prior to the final summative exam for medical school (MCCQE).

Requirement 9.7-3
Formal feedback occurs at least at the midpoint of the learning experience.

Analysis of evidence for requirement 9.7-3

There are policies developed regarding mandatory feedback. Feedback during the surgery clerkship has improved by having a specific preceptor designated to give feedback.

Requirement 9.7-4
In medical education programs with longer educational experiences (e.g., longitudinal integrated clerkship, year-long required learning experiences) formal feedback occurs approximately every six weeks.

Analysis of evidence for requirement 9.7-4

There are regular meetings weekly for the first 12 weeks, and then every 6 weeks are an expectation.

Requirement 9.7-5
For required learning experiences less than four weeks in length alternate means are provided by which medical students can measure their progress in learning.

Analysis of evidence for requirement 9.7-5

Specific assessments for shorter learning experiences are outlined in Table 9.7-5A and appear satisfactory.

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.

Requirement 9.8-1
The 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.

Analysis of evidence for requirement 9.8-1

There is a clear policy regarding release of results with 14 working days after each assessment.
There is strong committee oversight of evaluation changes.

Requirement 9.8-2
Final grades are available within six weeks after the end of a required learning experience.

Analysis of evidence for requirement 9.8-2

The school meets expectations for the release of exam scores in written evaluation. Ongoing effort to work on the completion of ITERs for clinical rotations; most are within 6 weeks, but there are some outliers.

9.9 STUDENT ADVANCEMENT AND APPEAL PROCESS

A medical school ensures that the medical education program has a single set of core standards for the advancement and graduation of all medical students across all locations. A subset of medical students may have academic requirements in addition to the core standards if they are enrolled in a parallel curriculum. A medical school ensures that there is a fair and formal process for taking any action that may affect the status of a medical student, including:

- ***a) timely notice of the impending action,***
- ***b) disclosure of the evidence on which the action would be based,***
- ***c) an opportunity for the medical student to respond,***
- ***d) an opportunity to appeal any adverse decision related to advancement, graduation, or dismissal.***

Requirement 9.9-1

The medical school ensures that the medical education program has a single set of core standards for the advancement and graduation of all medical students across all locations. A subset of medical students may have academic requirements in addition to the core standards if they are enrolled in a parallel curriculum.

Analysis of evidence for requirement 9.9-1

Pre-clerkship is centralized with consistent examinations. Promotion standards throughout the medical school curriculum are uniform. There are mandatory reviews of all students by the Competency Committee in both pre-clerkship and clerkship. Approval of graduation is necessary by SARC. There is an annual review of decentralized sites to ensure similar outcomes.

Requirement 9.9-2

The medical school ensures that there is a fair and formal process for taking any action that may affect the status of a medical student, including:

- *a) timely notice of the impending action*
- *b) disclosure of the evidence on which the action would be based*
- *c) an opportunity for the medical student to respond*
- *d) an opportunity to appeal any adverse decision related to advancement, graduation, or dismissal*

Analysis of evidence for requirement 9.9-2

There is a well-defined formal process through SARC with notice, disclosure, pre-committee meeting, opportunity to respond and appeal. Details are made available to all students.

9.10 STUDENT HEALTH AND PATIENT SAFETY

The medical school has effective policies to address situations, once identified, in which a student's personal health reasonably poses a risk of harm to patients. These patient safety policies include:

- ***a) timely response by the medical school***
- ***b) provision of accommodation to the extent possible***
- ***c) leaves of absence***
- ***d) withdrawal processes***

Requirement 9.10-1

The medical school has effective policies to address situations, once identified, in which a student's personal health reasonably poses a risk of harm to patients.

Analysis of evidence for requirement 9.10-1

The UME has a policy on "Student – Injury, Incident, and Exposure Reporting". It states that "after regular hours, a student who is injured during their course of study must go immediately to Emergency or Urgent Care Centre or drop-in clinics for medical support". As well, "special situations should be brought to the attention of UME Management". Students who are injured during their course of study must also communicate with the UME Immunization Specialist, ideally within 24 hours of occurrence, according to this policy.

The UME policy is not clear what "special situations" represent. If someone has a medical or psychological health issue that may pose a risk of harm to patients, it is not clear in the policy what are the exact steps the medical school would take to support the learner and their effectiveness. This is challenging to assess from the data given, because the UME policy does not specifically speak about a health issue that "poses a risk of harm to patients".

The UME is also part of the University of Calgary, so UME students fall under the university's Student Accommodation Policy. There is a policy in place to provide accommodation for students. Examples and effectiveness of accommodations are unclear from this document; it is only noted that accommodations can happen.

Medical students are regulated members of the College of Physicians and Surgeons of Alberta (CPSA). They are subject to the Duty to Report Self policy. This deals with the duty to report, but it does not specify the policy to address the situation.

The Student Academic Review Committee (SARC) Terms of Reference outlines leaves of absence. For medical/personal leave of absences, this is a decision by the Associate Dean, and a SARC appearance is not necessary. There is no particular guidance regarding how the decision is made, and it does not specify any relation to "reasonably poses a risk of harm to patients".

Requirement 9.10-2

These patient safety policies include:

- *a) timely response by the medical school*
- *b) provision of accommodation to the extent possible*
- *c) leaves of absence*
- *d) withdrawal processes*

Analysis of evidence for requirement 9.10-2

a) Students should ideally report their injury within 24 hours to the medical school. However, there is no specification that the medical school would report back in a timely manner. The term "injury" overall seems to apply to physical injury, rather than mental health issues. In the university's student accommodation policy, it notes that the university has a duty to "consider and assess all Accommodation requests on a case-by-case basis and in a timely and responsive manner".

b) In the university's Student Accommodation policy, it notes that the university has a duty to "consider and assess all accommodation requests on a case-by-case basis and in a timely and responsive manner". The student accommodation policy outlines that "The University has a Duty to Accommodate to the point of Undue Hardship in the provision of its services."

c) The policy pertaining to leaves of absence is contained with the UME's Student Academic Review Committee (SARC) Terms of Reference.
d) The policy regarding the withdrawal process is contained with the UME's Student Academic Review Committee (SARC) Terms of Reference. SARC can require a student to withdraw after reviewing all available information and hearing statements by all parties. Also, students can voluntarily withdraw from the Program; these students are invited to meet with the Associate Dean. If the Associate Dean deems that the student has made an informed decision, the Associate Dean will write an approval for the student to withdraw. The student then fills out a Notice of Withdrawal form from the University of Calgary Registrar's Office.

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, enrolment, and assignment.

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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.

Requirement 10.1-1

Through its requirements for admission, the 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.

Analysis of evidence for requirement 10.1-1

The MD program at the Cumming School of Medicine does not have pre-requisite courses. General recommendations are made to potential applicants concerning pre-medical course work, and applicants are encouraged to take a broad-based undergraduate education. These recommendations are communicated within the Applicant Manual.

Requirement 10.1-2

Through its requirements for admission, the medical school confines its specific premedical course requirements to those deemed essential preparation for successful completion of its medical curriculum.

Analysis of evidence for requirement 10.1-2

There are no pre-requisite undergraduate courses as a requirement for admission to the MD program. However, since 2023 all students entering the MD program are required to complete the free online University of Alberta Faculty of Native Studies Indigenous Canada Course Massive Online Open Course (MOOC).

A three-year CQI initiative will be undertaken to determine if a modification to the premedical course requirement may be necessary, based on a change in student wellness or academic support with the RIME curriculum, which began in July 2023.

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10.2 FINAL AUTHORITY OF ADMISSION COMMITTEE

The final responsibility for accepting students to a medical education program 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.

Requirement 10.2-1

The final responsibility for accepting students to the medical education program 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.

Analysis of evidence for requirement 10.2-1

The final authority for admission to the MD program rests formally with the UME Admissions Committee. The authority, composition, rules for operation, voting privileges, quorum are outlined in the *Admissions Committee Terms of Reference*, Required Appendix 10-2.1 A. These were most recently approved by CSM Faculty Council on October 17, 2023.

Requirement 10.2-2

Faculty members constitute the majority of voting members at all meetings.

Analysis of evidence for requirement 10.2-2

Data show that faculty members constitute 7 of 11 members of the Admissions Committee. The Terms of References stipulate that faculty members must represent 50% or more of voting members present at any given meeting for quorum to be met. Data show that the five most recent 2023-2024 admission cycle meetings were attended by over 65% of voting faculty members.

Requirement 10.2-3

The selection of individual medical students for admission is not influenced by any political or financial factors.

Analysis of evidence for requirement 10.2-3

The Admissions Committee employs multiple tools to ensure confidentiality of the admissions process and ensure no influence by any political or financial factors. All individuals involved in admissions sign a confidentiality & conflict of interest form. There is no financial or political influence from those on the Admission Committee or those involved in reviewing applicant files. Applicant files are anonymized through all stages of admissions. Any demographic, parental, or financial information is not visible to individuals scoring applications, nor voting members of the Admission Committee.

10.3 POLICIES REGARDING STUDENT SELECTION / ADVANCEMENT AND THEIR DISSEMINATION

The faculty of a medical school establishes criteria for student selection and develops and implements effective policies and procedures regarding, and makes decisions about, medical student application, selection, admission, assessment, advancement, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, policies, and procedures regarding these matters.

Requirement 10.3-1
The faculty of the medical school establishes criteria for student selection.

Analysis of evidence for requirement 10.3-1

The MD program lists student selection criteria in both the University of Calgary Calendar and in the MD program Applicant Manual.

The admission criteria and process most recently underwent a significant 6-month review in 2018. The most recent changes were approved by Cumming School of Medicine Faculty Council on Oct 17, 2023.

Requirement 10.3-2
The faculty of the medical school develops and implements effective policies and procedures regarding, and make decisions about:

- *i. medical student application*
- *ii. selection*
- *iii. admission*
- *iv. assessment*
- *v. advancement*
- *vi. graduation*
- *vii. any disciplinary action*

Analysis of evidence for requirement 10.3-2

The MD program outlines criteria, policies & processes for i-iii in the University of Calgary Calendar, and Applicant Manual. Alternative admission pathways are clearly outlined in the Calendar & Applicant Manual. Of note, the Cumming School of Medicine does not have a formal MD-PhD stream and applicants interested in graduate work are required to apply to the MD program and the Faculty of Graduate Studies in parallel, with eventual application through the Leaders in Medicine Program, a joint degree process, if accepted into both programs.

Assessment (iv) policies are overseen by the Student Evaluation Committee (Appendix 10-3.2 A3). A procedure exists for appeals, (Appendix 10.3-2 A4). Both of these are available online to students and faculty.

Student advancement (v) & graduation (vi) is under the authority of the Student Academic Review Committee (SARC) (Appendix 10-3.2 A6). Student advancement is guided by the Promotion and Graduation Standards (Appendix 10.3-2 A7). Both are available online to students and faculty.

Disciplinary actions (vii) are outlined in various policies, including the Student Academic Misconduct Policy (Appendix 10.3-2 A8) and Student Non-Academic Misconduct Policy (Appendix 10.3-2 A9). Academic & non-academic misconduct are typically reviewed at SARC. There are formal processes within the Cumming School of Medicine and University of Calgary which are outlined in the University of Calgary Calendar.

Requirement 10.3-3
The medical school makes available to all interested parties its criteria, policies, and procedures regarding these matters.

Analysis of evidence for requirement 10.3-3

The MD program makes available to medical students, applicants and faculty policies and procedures for matters in 10.3-2.

The location of these publicly accessible resources is as follows:

1) Application processes and policies are described in the Applicant Manual, which is revised annually, and available on the Admissions website for the MD program. Any changes from the previous cycle are highlighted as such in the manual (i-iii)
2) Significant changes are highlighted on the Admissions website
3) Additional information is available in the Academic Calendar (i-iii)
4) The Assistant Dean of Admissions maintains a Wordpress blog which is used to communicate and field questions or concerns from applicants.
5) All other UME policies and procedures are found on the UME website. (iv-vii)

10.4 CHARACTERISTICS OF ACCEPTED APPLICANTS

A medical school selects applicants for admission who demonstrate competencies in the following domains: interpersonal, intrapersonal, thinking, reasoning and science.

Requirement 10.4-1
The medical school selects applicants for admission who demonstrate competencies in characteristics in domains of interpersonal, intrapersonal, thinking, reasoning and science necessary for them to become competent physicians.

Analysis of evidence for requirement 10.4-1

The MD program admissions & selection process is holistic, considering both academic & non-academic attributes. Academic attributes are assessed at the file review stage, specifically:

GPA 20% of file review score
MCAT CARS 10% of file review score
Two academic categories in global assessment 10% of file review score
Intellectual curiosity, scholarly activity & research are also 10% of file review score

The following non-academic attributes are assessed as part of the file review stage:
- Communication Skills
- Collaborative Skills
- Leadership
- Professionalism and Maturity
- Commitment to Community

The MD program utilizes a Multiple Mini Interview (MMI) format for the interview stage. This approach allows for a comprehensive assessment of an applicant’s competencies in the domains of interpersonal, intrapersonal, thinking, and reasoning.

10.5 CORE COMPETENCIES FOR ENTERING MEDICAL STUDENTS

A medical school develops and publishes core competencies for the admission of applicants and the retention and graduation of medical students.

Requirement 10.5-1
The medical school develops and publishes core competencies for the admission of applicants and the retention and graduation of medical students.

Analysis of evidence for requirement 10.5-1

The MD program utilizes the Technical Standards for Students in the MD program (Appendix 10.5-1 A). This was most recently revised by UMEC in January 2020, and is reviewed at least every 5 years, if not sooner.

The technical standards are competencies identified for admissions and the successful completion of the MD program.

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 undergraduate medical degree 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.

Requirement 10.6-1

The medical school's calendar and other informational, advertising, and recruitment materials

- *i. present a balanced and accurate representation of the mission and objectives of the medical education program*
- *ii. state the academic and other (e.g., immunization) requirements for the undergraduate medical degree and all associated joint degree programs*
- *iii. provide the most recent academic schedule for each curricular option*
- *iv. describe all required learning experiences in the medical education program*

Analysis of evidence for requirement 10.6-1

The University of Calgary Calendar (on-line only) is the official academic regulation for the MD program.

The MD program mission & objectives (i) can be found on the public UME website. This is not required to be included in the UCalgary Calendar entry.

Academic requirements for the MD program as also known as the Big 10 Educational Objectives and can be found on the UME website. Program requirements (ii) including immunization information and a description for the Leaders in Medicine program are included in the UCalgary Calendar.

The academic schedule (iii) for the RIME curriculum is available online, however the schedule for the Legacy curriculum is no longer available online.

All required learning experiences (iv) are outlined in the Calendar. The RIME requirements are available online in the active Calendar, however Legacy requirements are no longer available on-line.

10.7 TRANSFER STUDENTS

A medical school ensures that any student accepted for transfer or admission with advanced standing demonstrates academic achievements, completion of relevant prior required learning experiences, and other relevant characteristics comparable to those of the school's medical students at the same level. 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.

Requirement 10.7-1

The medical school ensures that any student accepted for transfer or admission with advanced standing demonstrates academic achievements, completion of relevant prior required learning experiences, and other relevant characteristics comparable to those of school's medical students at the same level.

Analysis of evidence for requirement 10.7-1

The MD program has a Medical School Transfers policy (Supplemental Appendix 10.7-1).

The MD program does not accept transfers into the pre-clerkship curriculum. Transfers are only considered for clerkship. Eligibility for transfer is outlined in the above policy. Ultimate review of a transfer application and decision regarding a transfer is made by the Student Academic Review Committee (SARC). This is outlined in Section C.2.a of the SARC Terms of Reference (Required Appendix 10.3-2 A6). Transfers are only accepted in extenuating circumstances, if school capacity permits.

Requirement 10.7-2

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

Analysis of evidence for requirement 10.7-2

The MD program has accepted five transfer students in the clerkship curriculum since the last accreditation visit. These transfers were all due to personal circumstances, and all five learners were from CACMS fully accredited institutions.

10.8 Currently, there is no element 10.8

10.9 VISITING STUDENTS

A medical school oversees, manages, and ensures the following:

- ***a) verification of the credentials of each visiting medical student;***
- ***b) each visiting medical student demonstrates qualifications comparable to those of the school's medical students;***
- ***c) maintenance of a complete roster of visiting medical students;***
- ***d) approval of each visiting medical student's assignments;***
- ***e) provision of a performance assessment for each visiting medical student;***
- ***f) establishment of health-related protocols for visiting medical students.***

Requirement 10.9-1

The medical school oversees, manages, and ensures:

- *a) the verification of the credentials of each visiting medical student*
- *b) that each visiting medical student demonstrates qualifications comparable to those of the school's medical students*
- *c) the maintenance of a complete roster of visiting medical students*
- *d) the approval of each visiting medical student's assignments*
- *e) the provision of a performance assessment for each visiting medical student*
- *f) the establishment of health-related protocols for visiting medical students*

Analysis of evidence for requirement 10.9-1

a) Only students attending schools accredited by CACMS or LCME are supported for visiting electives. These students arrange electives through the centralized AFMC Electives Portal, and student information is collected through the portal.

b) Accepting students only from CACMS and LCME accredited medical schools ensures that all visiting students have qualifications comparable to local students.

c) A roster of visiting medical students can be generated from the AFMC Visiting Electives Portal. The approval process of electives is largely automated using the AFMC Visiting Electives Portal. Any challenges with this process are dealt with by the Visiting Electives Program Coordinator in the UME.

d) Oversight of electives for visiting students is through the Clerkship Electives Course Chair, with administrative support from the UME Visiting Electives Program Coordinator.

e) The performance assessments of visiting medical students are completed through the home school's evaluation process. If there are challenges with assessment completion, UME office can assist by contacting the preceptor involved. This assistance is provided if the UME office is notified of a delay in submitting student performance assessments.

f) Visiting students follow the same health-related protocols as local students. Visiting students receive a welcome email that includes a link to the "Health and Safety" page on the AFMC Visiting Electives Portal. Information is provided regarding safety in the clinical environment, personal support for students through the Student Advocacy and Wellness (SAW) Hub, mistreatment reporting mechanisms, and reporting occupational health and safety exposure. An additional document is provided from Alberta Health Services Workplace Health and Safety with information on Hand Hygiene, Communicable Diseases, N95 Fit Testing, and Workplace Hazards and Incident Reporting. A post-rotation survey also collects information that includes quality of teaching, discrimination, engagement, etc.

10.10 Currently, there is no element 10.10

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.

Requirement 10.11-1
The 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.

Analysis of evidence for requirement 10.11-1

Pre-clerkship students complete the majority of their training at the medical school. There are no other campuses.

There is the possibility of being placed at a rural site for one of the Family Medicine Clinical Experiences in the first or second year. Students are surveyed for their placement preference for an urban or rural site, and they may include other considerations such as transportation issues or extenuating family circumstances. Students are allocated to the site through survey results.

Students can apply to complete their clerkship in the University of Calgary Longitudinal Integrated Clerkship (UCLIC). Applicants are interviewed and applications are reviewed in detail, considering evidence of intellectual perspective, resiliency, empathy, creativity, and passion to change patient care, the health of communities, and the medical profession.

For the non-UCLIC rotation-based clerkship, students are provided with a customized schedule through a clerkship lottery. Students indicate schedule preference by placing “tokens” into each clerkship rotation. A computer algorithm places students into schedules, based on how students distributed their tokens. The clerkship lottery has been successful and, as an example, 100% of the Class of 2024 students received their top three choices of clerkship rotations prior to the MSPR cutoff. After the lottery process is complete, the students can still request trades with colleagues and these requests are communicated to the Clerkship Program Supervisor.

For the Surgery, Internal Medicine, Pediatrics, and Psychiatry clerkship rotations, students are able to rank their site preferences. If there are more requests for a site than spots, students will be randomly allocated to other sites. In other clerkship rotations the students are randomly allocated to sites. Once sites are all assigned the students may trade sites and inform the Clerkship Program Supervisor, who will then adjust the master schedule.

In some rotations (e.g., Family Medicine, Pediatrics), sites may be located outside of Calgary. Students who are assigned these sites may request a change in cases of complex medical conditions requiring close monitoring by subspecialist physicians or access to specialized treatment facilities, as well as extenuating family circumstances.

Occasionally students will discover that their career goals have changed. Students can contact the Assistant Dean, Clerkship, who would then work with the student and Clerkship Program Supervisor to see if it is possible to adjust rotation schedules to align with career goals.

Students are allowed to change preceptors (and potentially sites for training) in order to avoid working with and/or being evaluated by preceptors who have previously provided the student with health care.

Requirement 10.11-2
The medical school considers the preferences of students and uses a fair process in determining the initial placement.

Analysis of evidence for requirement 10.11-2

Described in 10.11-1, there is evidence that the medical school considers the preferences of students and uses a fair and centralized process in determining the initial placement. For Family Medicine Clinical Experiences, students submit a preference survey. For UCLIC applications, students are interviewed. For non-UCLIC rotation-based clerkship, a lottery system is used. For several clerkship rotations, students can rank their site. For other clerkship rotation assignments, they are done by random assignment.

Requirement 10.11-3
A process exists whereby a medical student with an appropriate rationale can request an alternative assignment when circumstances allow for it.

Analysis of evidence for requirement 10.11-3

A policy is in place for "Requests for Different Assignment" as seen in Supplemental Appendix 10.11-1 B. The appropriate rationale for requesting a change is delineated.

Described in 10.11-1 are also examples of when students with an appropriate rationale can request an alternative assignment when circumstances allow for it.

STANDARD 11: MEDICAL STUDENT ACADEMIC SUPPORT, CAREER ADVISING, AND ACADEMIC 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.

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11.1 ACADEMIC ADVISING AND COUNSELLING

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

Requirement 11.1-1
The medical school has an effective system of academic advising in place for medical students.

Analysis of evidence for requirement 11.1-1

The Student Advocacy and Wellness (SAW) Hub has several resources available to assist students and the Faculty Advisors had 584 (2021) and 651 (2022) and 762 (2023) one-on-one appointments with medical students for academic concerns, study strategies and exams.

The SAW Hub ensures the students have access to the Student Union Wellness Health Clinic on the main campus or their own family physician. The SAW Hub provides Psychological Counselling Services with five Counsellors working on contract. The demand for their services has been steadily increasing. They had 111 (2021) and 215 (2022) and 155 (Jan-Aug 2023) appointments with students. The SAW Hub also works with three Psychiatrists, who are available to see students requiring psychiatric services.

Awareness of the SAW Hub is high at > 95%, and the 2023 ISA noted a great appreciation for the multifaceted support available through the resources provided.

Requirement 11.1-2
The academic advising system integrates the efforts of faculty members, directors of required learning experiences and student affairs staff with its academic counselling and tutorial services.

Analysis of evidence for requirement 11.1-2

Faculty members who teach in the pre-clerkship curriculum, as well as the Associate and Assistant Deans, may access the assistance of the SAW Hub members in supporting students with academic counselling and tutorial services. The SAW Hub staff may also tap into programs such as the SUCCESS Program (Supplemental UME Course for Competence in Educational Skills and Strategies) when they are working with trainees in academic difficulty. In the case where accommodations may be required, the SAW Hub supports the student in getting these in place through the Student Accessibility Services on main campus.

Requirement 11.1-3
The medical school ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or advancement decisions about them.

Analysis of evidence for requirement 11.1-3

There is also a formal policy related to conflict avoidance - *Role Conflict: Physicians as Care Providers and Teachers* (Supplemental Appendix 11.1-3 A) - that informs both teachers and students of their professional expectations. The faculty in the SAW Hub function as student advocates and are not involved in student assessment and advancement decisions. The programs on main campus and the Physician and Family Support Program (PFSP) are not involved in student assessment and advancement. These programs are also physically located in a separate space from UME. All student files related to the SAW Hub, PFSP and the main campus services are inaccessible to UME staff.

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, directors of required clinical learning experiences, and student affairs staff to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs.

Requirement 11.2-1
The medical school has an effective and where appropriate confidential career advising system in place.

Analysis of evidence for requirement 11.2-1

There is a comprehensive career exploration program that is introduced to students in the orientation week with a one-hour mandatory session that outlines all the resources available to students. Each student is assigned a Career Coach. This formal program involves the students completing the Careers in Medicine questionnaires that explore the disciplines that align with their interests and values, prior to the first mandatory meeting with their Career Coach. They have a minimum of three meetings with their Career Coach over the first 18 months.

Elective counselling is also provided. In addition to the Career Coach, students have access to the SAW Hub Faculty Advisors who offer personal appointments for confidential career advising and other support throughout medical school. Students rate this resource highly with 274, 326 and 464 appointments for 2021, 2022 and 2023 respectively for career counselling.

The SAW Hub is skilled in directing students to appropriate resources related to CARMS including personal letter and CV review in addition to interview preparation. The UME Assistant Deans are also able to provide career advising for students if requested.

ISA data indicate that the vast majority of students are aware of the career advising services available.

Requirement 11.2-2
The career advising system integrates the efforts of faculty members, directors of required clinical learning experiences, and student affairs staff to assist medical students in:

i. *choosing elective courses*
ii. *evaluating career options*
iii. *applying to residency programs*

Analysis of evidence for requirement 11.2-2

The career advising system assists medical students in choosing elective courses. Elective availability is outlined to students during the Orientation Week. The Career Coaches and SAW Faculty Advisors all provide elective counselling. During pre-clerkship, the three Career Development Weeks and the AEBM MD Course 440 (Legacy curriculum) provided elective opportunities that helped to inform subsequent choices in the formalized clerkship. Many of the same sessions from the Legacy curriculum continue in the RIME curriculum, with some integrated in the Professional Role course.

The SAW Hub Faculty Advisors offer personal appointments for confidential elective counselling throughout medical school. This resource is well-accessed with 264, 240 and 312 appointments for 2021, 2022 and 2023 respectively for elective counselling.

The career advising system gives students the opportunity to explore and evaluate their career options. Meetings with the Career Coach and the SAW Faculty Advisors is an iterative process, with opportunities to debrief after career exploration experiences. Emphasis is placed on how the career choice aligns with their strengths and values.

The career advising system assists medical students in applying to residency programs. Students have the opportunity to discuss the process of applying to different residency programs with their Career Coach and with SAW Faculty Advisors. The SAW Faculty Advisors also provide optional sessions on the clerkship lottery and personal appointments

to discuss strategies for the clerkship lottery that determines the order of their clerkship rotations. The SAW Hub reviews CaRMS applications including personal letters, CVs and assists with interview preparation, if requested.

ISA data indicate that the vast majority of students are aware that they can obtain assistance with choosing elective courses, evaluating career options, and applying to residency programs.

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

Requirement 11.3-1

If a medical student at the 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:

- *i. review the proposed extramural elective prior to approval*
- *ii. ensure the return of a performance assessment of the student*
- *iii. ensure an evaluation of the elective by the student*

Analysis of evidence for requirement 11.3-1

Extramural electives at other Canadian medical schools are assumed to meet educational standards, as they all occur at CACMS accredited medical schools. As such students can apply for extramural electives through the AFMC student portal, and assuming there is availability, students are able to secure an elective experience.

A small number of students perform electives outside of Canada. These electives need specific approval from the UME office, and also need to apply through the office of Risk Management, to ensure the safety to students.

Students distribute an ITER to their preceptor at the end of their elective, and this ITER must be completed by their primary preceptor in order for the elective to be considered complete. Any barriers faced by students in the assessment process are addressed with the CSM UME office.

Students are not required to complete evaluations of their extramural electives; however, they are strongly encouraged to complete evaluations to improve the experience for their classmates and future students.

Requirement 11.3-2

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) availability of emergency care*
- *c) possibility of natural disasters, political instability, and exposure to disease*
- *d) need for additional preparation prior to, support during, and follow-up after the elective*
- *e) level and quality of supervision*
- *f) any potential challenges to the code of medical ethics adopted by the home school*

Analysis of evidence for requirement 11.3-2

For students choosing to do an international elective, they must apply to the UME office and the Department of Risk Management. Electives located in countries of high and extreme risk reviewed on a case-by-case basis, and approval is required from Risk Management and Vice-Provost, International. The protocols in case of emergency, including how to facilitate evacuation, are communicated to all students. Students must also participate in travel briefs, where they are advised about security, travel logistics, crime, other risk, and potential ethical challenges. Prior to their elective, students must have confirmation in writing from a primary physician preceptor overseas. There was no mechanism to confirm the quality and level of supervision prior to the elective; however, students are asked to complete a post-elective survey, and any concerns regarding the educational experience are brought to the attention of the Assistant Dean. The Visiting

Electives Program Coordinator in UME will also now ensure that the primary preceptor is a faculty member of an accredited institution.

For global health electives, students are directly supported by their preceptor. They also need to attend a faculty-led pre-departure training simulation session.

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.

Requirement 11.4-1
The 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.

Analysis of evidence for requirement 11.4-1

The DCI indicates the dates upon which the MD program's Medical Student Performance Record (MSPR) has been released from 2016-2023. All of the dates are after October 1 of the final year.

11.5 CONFIDENTIALITY OF STUDENT ACADEMIC RECORDS

Medical student academic records, unless released by or with the consent of the student, are confidential and available only to the student and duly authorized persons or organizations. A medical school follows procedures based on relevant privacy legislation for the collection, storage, disclosure, disposal, and retrieval of student academic records, and makes these procedures known to medical students.

Requirement 11.5-1
Medical student academic records, unless released by or with the consent of the student, are confidential and available only to the student and duly authorized persons or organizations.

Analysis of evidence for requirement 11.5-1

The Student Files policy clearly outlines the process for the organization, storage and access to student academic and non-academic information. This policy also describes who is able to access the academic and non-academic portions of the student record.

Requirement 11.5-2
A medical school follows procedures based on relevant privacy legislation for the collection, storage, disclosure, disposal, and retrieval of student academic records, and makes these procedures known to medical students.

Analysis of evidence for requirement 11.5-2

The data provided indicate that UME program leadership is aware of and follows the relevant legislation regarding the student records. An explicit description of the duration of maintenance of the files is also described (Appendix 11.5-2 A). It was noted that during the review of policies, a discrepancy between the UME policy and the main campus University of Calgary policy for file retention was identified. Efforts to rectify this discrepancy with the creation of an updated policy to be in compliance with University regulations are ongoing with involvement by senior privacy and legal staff.

The Student Files policy is available on the UME website, which is an open access site and so can be reviewed by students or other interested parties.

The ISA that was administered by the AFMC (in preparation for accreditation) inadvertently excluded several questions, including the relevant question for this section that would allow for an assessment of student knowledge of the policy and processes.

11.6 STUDENT ACCESS TO ACADEMIC RECORDS

A medical school has policies and procedures in place that permit medical students to review and to challenge their academic records, including the Medical Student Performance Record, if the student considers the information contained therein to be inaccurate, misleading, or inappropriate.

Requirement 11.6-1
The medical school has policies and procedures in place that permit medical students to review and to challenge their educational records, including the Medical Student Performance Record, if the student considers the information contained therein to be inaccurate, misleading, or inappropriate.

Analysis of evidence for requirement 11.6-1

The MD program has an established process for students to have access to their student records (both academic and non-academic files) as outlined in the Student Files policy; this policy is available on the MD Program website which is an open access site.

Students can challenge academic assessments as described in the MD Program Reappraisal Policy and the Academic Assessment/Graded Term work policy. Students are reminded of the availability of the reappraisal process when they have unsatisfactory evaluation results; this is included in the letter provided to students with unsatisfactory results in clerkship. Any student who fails examinations meets with the relevant Assistant Dean (Pre-Clerkship or Clerkship) who will also review the reappraisal process.

Students are provided with a copy of their MSPR prior to it being submitted to CaRMS by the school. Students may challenge comments on their MSPR by submitting change requests to the MSPR committee, which meets to review student submissions prior to the finalization of the MSPR for submission. The process and guidelines for the review and/or change of the MSPR is outlined in the MSPR Policy, which is available for review on the open access UME website.

STANDARD 12: MEDICAL STUDENT HEALTH SERVICES, PERSONAL COUNSELLING, 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.

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12.1 FINANCIAL AID / DEBT MANAGEMENT COUNSELLING/ STUDENT EDUCATIONAL DEBT

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

Requirement 12.1-1
The medical school provides its medical students with effective financial aid counselling.

Analysis of evidence for requirement 12.1-1

Financial counselling is centralized on main campus, and the available services are advertised on the UME website. The Student Advocacy and Wellness Hub (SAWH) may alert the UME office of students in dire financial need, and additional support is available at that point. GQ data noted that over 91% of students were satisfied with financial aid and debt management counselling.

A financial literacy consultant is available to provide guidance to students related to budgeting for visiting electives, application and licensing costs, as well as navigating student loan and other financial aid needs.

Requirement 12.1-2
The medical school provides its medical students with effective debt management counselling.

Analysis of evidence for requirement 12.1-2

The Office of the Registrar has resources and information on their website related to one-on-one financial planning, Money Smart, debt management, budgeting, credit, and savings.

The medical debt over the past three years has been high, but stable. Debt is higher than the national average, and may be related to several factors (cost of living difference, inability to have a summer job due to the year-round curriculum, etc.)

Requirement 12.1-3
The medical school has mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) on medical student indebtedness.

Analysis of evidence for requirement 12.1-3

Several programs aim to alleviate the financial burden by providing grants and scholarships based on merit, need, or a combination of both. The three main programs are noted below:

a) Emergency Funding: available: $30,000
b) Special Bursaries available $150,000
c) Tuition Differential Bursaries: $582,000-678,000/year over the past three years

In total for these three programs, CSM contributes approximately $790,000 per year (approximately $760,000 from UME and $30,000 from CSM). There is some variation in this number from year to year, with increases as overall funding permits. This amount represents approximately 65% of the total bursary and scholarship funding awarded to UME students annually. The remaining 35% in comes from scholarships and awards funded by the University of Calgary itself.

Approximately 25% of the student body benefits from the above support each year.

Items that are necessary for personal safety, such as masks, gloves, gowns, operating scrubs, are provided free of charge to students.

12.2 TUITION REFUND POLICY

A medical school has clear 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).

Requirement 12.2-1
The medical school has clear 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).

Analysis of evidence for requirement 12.2-1

The University of Calgary has clear policies related to the refund of a medical student's tuition, fees and other allowable payments. Tuition for the UME program is administered by the University of Calgary Office of the Registrar. Because the UME is a program rather than a collection of individual courses, medical students cannot take or drop individual courses. For this reason, the UME tuition due date falls the day before the course drop date for all other students at the University of Calgary.

Tuition reassessments are only made in extenuating circumstances, and a leave of absence does not guarantee a tuition reassessment. If a tuition reassessment has been approved, students will receive a credit note for a future tuition. General fees are not adjusted and must be paid in the term that the reassessment is being made.

UME helps to support students who might be subjected to unnecessary tuition through a MDCN 500 course which provides official student status but does not trigger tuition. Students are enrolled in this course for periods of 1-2 months prior to re-starting medical school studies full-time to allow them to re-integrate.

The University of Calgary Academic Calendar describes the policies and procedures surrounding tuition refunds and is available to all UME students via the UCalgary website. It clearly describes the following relevant information:

a) Refund eligibility
b) How to request a refund
c) Fees charged as part of the admission process, including the application fee and admission deposit, are non-refundable.
d) Refunds on payments made to the student account by external third parties (such as external award agencies, parents, and family members)
e) Handling of credit present on an account, and
f) Application of payment towards a future term

12.3 PERSONAL COUNSELLING / WELL-BEING PROGRAMS

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

Requirement 12.3-1
The medical school has in place an effective system of personal counselling for its medical students that includes programs to promote their well-being and to facilitate their adjustment to the physical and psychosocial demands of medical education.

Analysis of evidence for requirement 12.3-1

The medical school's system of personal counselling for its medical students is well received by the student body, and clearly responsive to the needs of the student body. There are five dedicated therapists who work in the Student Advocacy and Wellness (SAW) Hub. Support is free of charge, is confidential with personal counselling and resources provided to CSM learners. Appointment times are flexible and tailored to meet the needs of the local and rural students. A variety of in-person and virtual appointments are available during early mornings, lunchtime, evening, and weekends. An on-line booking system exists.

In addition to the above, students and their immediate family members can access free, confidential, and personal counselling through the Physician and Family Support Program run by Alberta Medical Association (AMA). Additionally, students can also access free, confidential, and personal counselling through Wellness Services on main campus.

Students are informed of the personal counselling system and its programs by way of a "Survival Guide" prior to their first day of classes which provides information regarding SAW Hub supports and resources, in addition to a letter from the SAW Hub at the time of acceptance encouraging them to book a one-on-one meeting with as SAW Hub.

The medical school monitors the effectiveness of its system of personal counselling by way of annual anonymous feedback surveys and direct feedback from students in one-on-one meetings. The Graduate Questionnaire noted 95% of respondents commenting that they were satisfied or very satisfied (aggregated) with the academic advising/counselling offered.

A culture of wellness and support is created at the CSM. This is evidenced by the existence of several informal, student led, and faculty supported initiatives including: a grief and loss Peer Support Program, student run Buddy System, the Student Advocacy and Wellness Hub Committee chaired by the SAW Student Representative, workshops to support student's wellness such as Journaling Workshops, Mindful Meditation, Yoga, Wellness Weekends, and a variety of other initiatives.

Additionally, there are robust sessions on intro to clerkship - How to Succeed and Thrive in Clerkship panel discussion with senior clerks, the CaRMS preparation curriculum, Personal Letter Power Hour, Resident Led CaRMS Mock Interviews, and a CaRMS Match and Unmatched Review Process.

Students are extremely satisfied with the services and supports provided and the ISA has recognized the exceptional support provided by the members of the SAW Hub

The ISA has noted gaps in adequate support for racism and the wellness impacts of racial discrimination.

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.

Requirement 12.4-1

The 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.

Analysis of evidence for requirement 12.4-1

Although formal health care services are not provided to medical students by or within the CSM itself, the students are strongly encouraged to obtain a personal family physician. Students are introduced to three options to access a Family Medicine physician: 1) Student Wellness on main campus through U of C Student Health Services Clinic, 2) through Alberta Medical Association (AMA) Physician and Family Support Program (PFSP) and 3) AHS website.

Requirement 12.4-2

The medical school has policies and procedures in place that permit students to be excused from these experiences to seek needed care.

Analysis of evidence for requirement 12.4-2

The pre-clerkship students, clerks and those on rural clerkships can be excused for medical reasons, as per the absence policy. For those on their UCLIC rotation, a local physician could be found, or they can be excused to return to Calgary to seek medical attention. All students are made aware of policies that permit time away from classes, and clinical work, if required.

12.5 PROVIDERS OF STUDENT HEALTH SERVICES / LOCATION OF STUDENT HEALTH RECORDS

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

Requirement 12.5-1
The health professionals who provide health services, including psychiatric/psychological counselling, to a medical student have no involvement in the academic assessment or advancement of the medical student receiving those services, excluding exceptional circumstances.

Analysis of evidence for requirement 12.5-1

The policy regarding non-involvement of a student's treating physician in their evaluation was referred to and included in the DCI (Appendix 12.5-2 B2). Since the MD program does not require its students to disclose the details of their personal medical history, it is the responsibility of the student to ensure that they are not placed on rotations with previous treating physicians by informing UME leadership of their desire to be moved or assigned to a different learning experience. This policy is on the UME website. The SAW Hub and UME managers send email reminders to this effect to communicate with students.

UME leadership does not provide direct care to medical students except under emergency circumstances. If necessary, a referral to an appropriate colleague is made. The psychiatrists who accept student referrals through the SAW H are not actively involved in the medical school other than episodic bedside teaching. Students receive periodic email reminders to this effect.

Requirement 12.5-2
The medical school ensures that medical student health records are maintained in accordance with legal requirements for security, privacy, confidentiality, and accessibility.

Analysis of evidence for requirement 12.5-2

Medical care is not provided within the confines of the medical school itself, therefore there are no medical records. Health records at the University of Calgary Student Health Services Clinic are stored securely at that facility (see Appendix 12.5-2 B1 Student Files policy). The only physicians who have access to those records are the physicians who work within that clinic, and none are significantly involved in the MD program.

12.6 STUDENT HEALTH AND DISABILITY INSURANCE

A medical school ensures that health insurance is available to each of its medical students and their dependents, and that each medical student has access to disability insurance.

Requirement 12.6-1
The medical school ensures that health insurance is available to each of its medical students and their dependents.

Analysis of evidence for requirement 12.6-1

All Alberta residents have Alberta insurance coverage, and medical students from outside of the province are eligible for this after three months. It is strongly recommended that all international students have coverage through a private organization.

Students are informed at orientation every year of health insurance options provided by the University Student Union and the process to enroll in the extended health and dental coverage plan. All information in relation to extended health and dental insurance including what benefits are in the program, costs, adding family members, etc. is available on the University website.

Requirement 12.6-2
The medical school ensures that each medical student has access to disability insurance.

Analysis of evidence for requirement 12.6-2

Disability insurance is not provided by the medical school. Students can discuss disability insurance with private insurance companies during orientation. Some private disability insurance is available through the Students' Union plan and is also offered to medical students through the Alberta Medical Association.

Disability insurance, and the importance of holding it, is emphasized during financial literacy presentations and information is on the University of Calgary website. Students are made aware that if something happened to them that causes injury or mental health issues and requires that they step out of the program for more than six months, then their student loans would change to repayment status.

12.7 IMMUNIZATION REQUIREMENTS AND MONITORING

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

Requirement 12.7-1
The medical school follows accepted guidelines that determine immunization requirements.

Analysis of evidence for requirement 12.7-1

The immunization guidelines are determined by two factors. Firstly, the Alberta Health Services (AHS) Standard for Immunizations of Post-Secondary Health Care Students and Students in other High-Risk Occupational Programs (Supplemental Appendix 12.7-1 A1). These are then compared to the requirements set out by the AFMC Student Portal Immunization and Testing Form (Supplemental Appendix 12.7-1 A2). The most stringent requirements from these documents have been used to create the UCalgary Immunization Worksheet-MD Program (Appendix 12.7-1 C) which students are sent at admission. The students meet the highest standard so that when they apply for and are accepted to carry out a visiting elective, no additional immunizations that may be non-Alberta specific should be required.

Requirement 12.7-2
The medical school ensures compliance of its students with these requirements.

Analysis of evidence for requirement 12.7-2

The Immunization Specialist, who is a registered nurse employed by the CSM, ensures all students have completed the testing and immunization requirements. If the requirements are not met, the Immunization Specialist follows-up/tracks the student until all requirements have been met.

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) education of medical students about methods of prevention***
- ***b) procedures for care and treatment after exposure, including a definition of financial responsibility***
- ***c) 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.

Requirement 12.8-1

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

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

Analysis of evidence for requirement 12.8-1

The Cumming School of Medicine has the policies in the appendices to address medical student exposure to infectious and environmental hazards:

Appendix 12.8-1 A1 – Student – Injury, Incident and Exposure Reporting (b. procedures)
Appendix 12.8-1 A2 – Protocol for Injuries, Incidents and Exposures – UME Students (b. procedures)
Appendix 12.8-1 A3 - Safety Policy Medical Students (a. prevention + b. procedures + c. effect on learning activities)
Appendix 12.8-1 A4 - Operating Procedures - Role of Learners During Health Care Emergencies (b. procedures)

In addition to contact information included under Procedures in the Safety Policy in Appendix A3, the Student Advocacy and Wellness Hub is a resource that all students are made aware of through both the CSM website and during orientation.

Requirement 12.8-2

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

Analysis of evidence for requirement 12.8-2

The information is available on the homepage of the UME website.

Important curricular material related to infectious diseases and personal protection is included in the orientation week where they view a PPE training followed by a mandatory practical practice session on infection prevention and control procedures. Students are introduced to the Alberta Health Services policies on hand hygiene, infection prevention and control, PPE and needlestick injuries before setting up any clinical shadowing experiences.

The information and policies are available on the homepage of the UME website. This training is tracked by the Immunization Specialist. All clinical learning, including shadowing and clinical core, cannot be scheduled until the training is complete. The ISA indicates that 92.4% of first year students are aware of the steps to take following exposure to infectious or environmental hazards prior to attending any educational activities that could place them at risk.

For visiting students, the information is posted on the UCalgary AFMC portal page under the Health and Safety Incident Reporting tab.

Requirement 12.8-3
All visiting students are informed of these policies before undertaking any educational activities that would place them at risk.

Analysis of evidence for requirement 12.8-3

Information is available on the AFMC portal and an email is sent at the time the elective is confirmed. There is a Health and Safety section of the AFMC portal that applies specifically to CSM and relates to incident reporting of Blood and Body Fluid Exposure (BBFE) or Communicable Disease Exposure (CDE).

ACCREDITATION STEERING COMMITTEE SUMMARY STATEMENT

The Accreditation Steering Committee (ASC) met monthly from September 2022 – June 2024. This was led by the Faculty Undergraduate Accreditation Lead (FUAL) and included 13 members. Each of the six sub-committees (UME, Dean's Office – Academic, Dean's Office – Non-Academic, Student Affairs, Admissions, Equity/Diversity/Inclusion & Indigenous Engagement) and the Independent Student Analysis sub-committee chairs were also members of the ASC. The entire student body was invited to participate in the process and the 50+ student volunteers, spanning all three years, who expressed interest were invited to join a sub-committee. Each subcommittee had representation from each of the three classes (Classes of 2023-25).

Element distribution amongst and within the sub-committees was determined based on the expertise of sub-committee members, and regular meetings occurred from Fall 2022 – Fall 2023. Students were welcome to join some or all of their respective sub-committee meetings, and if unable to attend the sub-committee chair was asked to ensure that their voices were represented. The sub-committee chairs presented the completed Data Collection Instrument (DCI) Elements to the ASC from March to September 2023 until all were reviewed. The FUAL and Accreditation Administrator reviewed all of the DCI data and compiled the information. The level of participation of sub-committee members ranged from an advisory capacity to direct involvement in providing content for the DCI, and varied by the needs of the sub-committee. The students on the sub-committees participated in an advisory capacity.

The Independent Student Analysis survey (ISA) was distributed by the AFMC from January – March 31, 2023. This involved town hall meetings between the FUAL and the student body, with protected time for survey completion. The ISA raw data was distributed to the FUAL and the student sub-committee chair in early April 2023. In May 2023, the quantitative data was distributed to each sub-committee chair to allow for inclusion of relevant tables into the DCI. By mid-June 2023, the qualitative data had been analyzed and presented at the ASC for review and discussion.

The first draft of the ISA report was prepared by the ISA sub-committee, and prior to distribution to the ASC in October 2023, was reviewed by UME and CSM leadership (the Dean and Vice Dean, Senior Associate Dean of Education, as well as the Associate and Assistant Deans of the UME) for factual errors. The FUAL and Accreditation Administrator reviewed the ISA to ensure that it followed CACMS guidelines regarding report preparation. The ISA was also distributed to the entire student body for review and comment. Minor factual changes were made after discussion with faculty leadership. During the ISA survey administration by the AFMC, 16 questions were inadvertently removed. CACMS agreed that the tables related to the omitted questions could be deleted from the DCI with narrative responses used instead. It was also suggested that school-reported data could be collected and added to the DCI.

As noted in the *Introduction – Description of the Self-Study Process*, the Medical School Self-Study (MSS) Elements were completed June – November 2023 by 35 faculty members and 8 medical students. The ASC reviewed the MSS Elements in Fall 2023. First drafts of the MSS and DCI were finalized in December 2023 for distribution to the external reviewers conducting the pre-accreditation review in January 2024. The pre-accreditation report was distributed to the ASC in February 2024 and included recommendations regarding specific Elements to be addressed prior to finalizing the documents for the Fall 2024 accreditation review. The recommendations were referred to the specific sub-committees responsible, and revisions to the DCI and MSS were made from February-June 2024. In the Spring of 2024, after discussion with the ASC and student leadership, a decision was made to distribute a supplemental student survey that included a subset of questions from the ISA to the Class of 2026. The goal was to capture many of the questions that were excluded with the formal ISA survey, and also ensure that the Class of 2026 voice was represented in the accreditation process. This data was included in the DCI and the MSS where relevant.

Two contextual factors impacted the accreditation preparation process and are important to acknowledge. The RIME curriculum, which began in July 2023, involved a fundamental shift in many aspects of the medical program. Although this was a planned curricular shift, the complexity of preparing for an accreditation in the midst of these monumental changes, and the challenge of administering two simultaneous curricula, cannot be underestimated. Engagement of stakeholders and educational leaders from both the Legacy as well as the RIME curriculum was necessary.

Second, significant leadership changes have occurred in the CSM program over the past few years, including a transition in the UME Associate Dean position in January 2024. The timing of this change was intentional, with the previous Associate Dean stepping down 6 months prior to the end of his term to allow for his successor to familiarize herself with her position far in advance of the Fall 2024 Accreditation. Fortunately, she previously held several UME leadership positions as well as a leadership role with the RIME curriculum prior to her transition to the Associate Dean of Undergraduate Medical Education.

APPENDIX A – SELF-STUDY TASK FORCE COMMITTEES

Accreditation Steering Committee & MSS Review Committee

Member	Role/Position/Affiliation
Dr. Marcy Mintz, Chair	Faculty Undergraduate Accreditation Lead
Dr. Bev Adams	Vice-Dean
Dr. Richard Leigh	Senior Associate Dean, Faculty Affairs
Dr. Lisa Welikovitch	Senior Associate Dean, Education
Dr. Chris Naugler (June 2022-December 2024)	Associate Dean, UME
Dr. Amy Bromley (January 2024-present)	Associate Dean, UME
Dr. Pamela Chu	Associate Dean, Precision Equity & Social Justice Office
Dr. Carolyn Hutchison	Assistant Dean, Student Advocacy & Wellness Hub
Dr. Remo Panaccione	Assistant Dean, UME Admissions
Dr. Sonya Lee	Department Head, Family Medicine
Rose Yu	CSM Senior Director
Dr. Michael Spady (April 2023-present)	Associate Zone Medical Director, AHS Calgary Zone
Dr. Peter Jamieson (June 2022-March 2023)	Associate Zone Medical Director, AHS Calgary Zone
Mathieu Chin	Medical Student, Class President, Class of 2023
Jusnoor Aujla	Medical Student, Class President, Class of 2024
Eddie Guo	Medical Student, Class President, Class of 2025
Rafael Sanguinetti	Medical Student, Class President, Class of 2026

Undergraduate Medical Education Sub-Committee

Member	Role/Position/Affiliation
Dr. Chris Naugler (June 2022-December 2024)	Associate Dean, UME
Dr. Amy Bromley (January 2024-present)	Associate Dean, UME
Dr. Sarah Weeks	Assistant Dean, Pre-clerkship
Dr. Kevin Busche	Assistant Dean, Clerkship
Dr. Janeve Desy	Assistant Dean, Evaluation and Research
Dr. Adrian Harvey	Assistant Dean, Program Evaluations
Dr. Antonia Stang	Department Head, Pediatrics
Dr. Martina Kelly	Course chair FM-clerkship and FM curriculum
Dr. Rahim Kachra	Director, Teaching Innovations
Dr. Sarah Anderson	Director, Anatomy
Dr. Murray Lee	Block Director, RIME
Dr. Theresa Wu	Block Director, RIME
Dr. Fariba Aghajafari	Course Chair - AEBM
Mike Paget	Manager, Academic Technologies
Shannon Leskosky	Senior Manager, UME
Emily Macphail	Medical Student, Class of 2023
Siavash Zare-Zadeh	Medical Student, Class of 2023
Simi Juriasingani	Medical Student, Class of 2024
Kathy Fu	Medical Student, Class of 2024
Mohamed Bondok	Medical Student, Class of 2024
Vakkachen Joe	Medical Student, Class of 2025
Jason Kreutz	Medical Student, Class of 2025

Dean's Office – Non-Academic Sub-Committee

Member	Position/Affiliation
Dr. Richard Leigh	Senior Associate Dean, Faculty Affairs

Rose Yu	CSM Senior Director
Peter Romeo	Director, Educational Operations
Jeannie Shrout	Administrative Services Manager, AHS
Leah Johnston	Medical Student, Class of 2023
Jennifer Lee	Medical Student, Class of 2024
Iqra Rahamatulla	Medical Student, Class of 2025
Lucy Yang	Medical Student, Class of 2025

Dean's Office – Academic Sub-Committee

Member	Position/Affiliation
Dr. Bev Adams, Chair	Vice-Dean
Dr. Lisa Welikovitch	Senior Associate Dean, Education
Dr. Chandra Thomas	Deputy Department Head, Medicine
Dr. Dianne Mosher	Associate Dean, Indigenous, Local & Global Health
Dr. Gerald Zamponi	Senior Associate Dean, Research
Dr. David Keegan	Associate Dean, Office of Faculty Development & Performance
Kristy Potter	Senior Specialist, Academic Affairs and Operations
Caitlin McClurg	Associate Librarian - Medicine
Mike Paget	Manager, UME Academic Technologies
Peter Romeo	Director, Educational Operations
Fazeela Mulji	Medical Student, Class of 2023
Mr. Chaim Katz	Medical Student, Class of 2024
Omer Mansoor	Medical Student, Class of 2024
Sadaf Ehklas	Medical Student, Class of 2025

Admissions Sub-Committee

Member	Position/Affiliation
Dr. Remo Panaccione, Chair	Assistant Dean, UME Admissions
Dr. Rabiya Jalil	Associate Director, UME Admissions
Dr. Chip Doig	Chair, UME Admissions Committee
Dr. Pamela Roach	Director, Indigenous Health Education
Dr. James Fewell	Professor, Physiology & Pharmacology
Dr. Richard Buckley	Clinical Professor, Surgery
Shannon Cayer	Manager, UME Admissions
Tharsini Sivananthajothy	Medical Student, Class of 2023
Navpreet Langa	Medical Student, Class of 2024
Aanchel Gupta	Medical Student, Class of 2024
Parth Patel	Medical Student, Class of 2025
Matthew Hobart	Medical Student, Class of 2025
Jasmine Nguyen	Medical Student, Class of 2025

Student Affairs Sub-Committee

Member	Position/Affiliation
Dr. Carolyn Hutchison, Chair	Assistant Dean, Student Advocacy & Wellness
Dr. Teresa Killam	Associate Director, SAW Hub
Dr. Keisha Afflick	Therapist, SAW Hub
Dr. Amy Bromley	Course Director, The Professional Role
Johanna Holm	Manager, SAW Hub

Shannon Leskosky	Senior Manager, UME
Tania Pander	Program Coordinator, UME
Michelle Krbavac	Immunization Specialist, UME
Alex Stephenson	Medical Student, Class of 2024
Ella Krane	Medical Student, Class of 2025
Jing Han	Medical Student, Class of 2025

Equity, Diversity, Inclusion & Indigenous Engagement Sub-Committee

Member	Position/Affiliation
Dr. Pamela Chu, Chair/Co-Chair	Associate Dean, Precision Equity & Social Justice Office (PESJO)
Dr. Jack Janvier, Co-Chair	Chair, UME EDI Committee
Ms. Deborah Book	Legal Counsel, University of Calgary Legal Services
Ms. Sarah Hall	Medical Consultant, Office of the Chief Medical Officer, AHS
Dr. Amy Gausvik	Health Equity Structural Competency Lead - RIME
Dr. Aaron Johnston	Associate Dean, Distributed Learning & Rural Insistiatives
Dr. Jadine Paw	Vice-Chair Education, Department of Obstetrics & Gynecology
Ms. Gauri Taneja	EDI Education Specialist, PESJO
Ms. Margot Scullen (June 2022-August 2023)	EDI Specialist - Policy & Communication, PESJO
Arden Chan (Fall 2023-present)	EDI Specialist - Policy & Communication, PESJO
Mursal Mohamud	Medical Student, Class of 2023
Whitney Ereyi-Osas	Medical Student, Class of 2023
Amira Kalifa	Medical Student, Class of 2024
Mohamed Jama	Medical Student, Class of 2024
Fasika Jembere	Medical Student, Class of 2025
Ife Adepipe	Medical Student, Class of 2025
Sean Bristowe	Medical Student, Class of 2025

Independent Student Analysis Sub-Committee

Member	Position/Affiliation
Mathieu Chin	President, Class of 2023
Jusnoor Aujla	President, Class of 2024
Eddie Guo	President, Class of 2025
Rafael Sanguinetti	President, Class of 2026
Katherine Yu	Medical Student, Class of 2023
Jenny Krahn	Medical Student, Class of 2023
Jill Laurin	Medical Student, Class of 2024
Sravya Kakumanu	Medical Student, Class of 2024
Kayleigh Yang	Medical Student, Class of 2024
Marissa Zhang	Medical Student, Class of 2024
Tali Glazer	Medical Student, Class of 2025
Zorana Lynton	Medical Student, Class of 2025
Harshil Shah	Medical Student, Class of 2025
Sydney Yee	Medical Student, Class of 2025

Class of 2026 Pre-Accreditation Survey Analysis Sub-Committee

Member	Position/Affiliation
Rafael Sanguinetti	President, Class of 2026
Kerry Yang	Medical Student, Class of 2026

Genevieve Pinnington	Medical Student, Class of 2026
Khushi Arora	Medical Student, Class of 2026
Shiva Ivaturi	Medical Student, Class of 2026
Lexyn Iliscupidez	Medical Student, Class of 2026

APPENDIX B – ACRONYMS & DEFINITIONS

ACHRI	Alberta Children's Hospital Research Institute
ADAPT	A Doctor's Appointment Prep Tool
AEBM	Applied Evidence-Based Medicine
AFMC	Association of Faculties of Medicine of Canada
AH	Alberta Health
AHFMR	Alberta Heritage Funding for Medical Research
AHP	Aboriginal Health Program
AHS	Alberta Health Services
AMA	Alberta Medical Association
AMHSP	Academic Medicine and Health Services Program
APR	Academic Performance Report
ARO	Academic Report On-line
ASC	Accreditation Steering Committee
AT	Academic Technologies
ATSSL	Advanced Technical Skills Simulation Laboratory
AUPE	Alberta Union of Provincial Employees
BAAP	Black Applicant Admissions Process
BHSc	Bachelor of Health Sciences
BTSC	Biomedical Technical Support Centre
CACMS	Committee on the Accreditation of Canadian Medical Schools
CAME	Canadian Association for Medical Education
CaRMS	Canadian Residency Matching Service
CAT	Critically Appraised Topic
CC	Clerkship Committee
CCCMG	Clara Christie Centre for Mouse Genomics
CEL	Community Engaged Learning
CERC	Canada Excellence Research Chair
CFPC	College of Family Physicians of Canada
CHIN	Calgary Health Improvement Network
CIOC	Curricular Innovation and Oversight Committee
CME & PD	Continuing Medical Education & Professional Development
Course 1	Intro to Medicine/Blood/Gastrointestinal
Course 2	Musculoskeletal and Skin
Course 3	Cardiology/Respirology
Course 4	Renal/Endocrinology/Obesity
Course 5	Neurosciences/Aging/Special Senses
Course 6	Children's and Women's Health
Course 7	Psychiatry and Family Violence
Course 8	Clerkship longitudinal "half-day back"
CPAC	Libin Cardiovascular Institute's Community and Partners Advisory Committee
CPSA	College of Physicians and Surgeons of Alberta
CSM	Cumming School of Medicine

CSS	Central Sanitation & Sterilization
CWPH	Cal Wenzel Precision Health building (formerly TRW building)
DAB	Dean's Advisory Board
DEC	Dean's Executive Committee
DLRI	Distributed Learning and Rural Initiatives
EFC	Executive Faculty Council
FC	Faculty Council
FMCE	Family Medicine Clinical Experiences
FCOI	Financial Conflict of Interest
FMEC-MD	Future of Medical Education in Canada (AFMC)
GFC	General Faculty Council
GFT	Geographic Full-Time (faculty)
GQ	Graduation Questionnaire (AFMC)
GHIP	Global Health and International Partnerships
GRIP	Group for Research with Indigenous Peoples
HBI	Hotchkiss Brain Institute
HEST	Health Equity & Systems Transformation
HMRB	Heritage Medical Research Building
HRIC	Health Research Innovation Centre
HSARC	Health Sciences Animal Resource Centre
HSC	Health Sciences Centre
HSL	Health Sciences Library
IAP	Indigenous Applicant Process
ICP	Introduction to Clinical Practice
ILGHO	Indigenous, Local & Global Health Office
IHD	Indigenous Health Dialogue
IHP	Indigenous Health Program
IHPAC	Indigenous Health Program Advisory Committee
IPAC	Indigenous Physicians Association of Canada
ISA	Independent Student Analysis
IST	Independent Study Time
ITER	In Training Evaluation Reports
KidSIM	simulation centre and program at Alberta Children's Hospital
LCME	Liaison Committee on Medical Education
LIM	Leaders in Medicine
LMS	Learning Management System
MaPS	Management and Professional Staff
MCC	Medical Council of Canada
MEO	Medical Education Office (AHS)
MIF	Microscopy & Imaging Facility
MPAS	Master of Physician Assistant Studies
MSAC	Medical Student Appeals Committee
ODEPD	Office of Diversity, Equity and Protected Disclosure
OFDP	Office of Faculty Development and Performance

OHMES	Office of Health and Medical Education Scholarship
OIPH	O’Brien Institute for Public Health
One45	software used to collect electronic evaluations of and from students
OPED	Office of Professionalism, Equity & Diversity (now PESJO)
OSCE	Objective Structured Clinical Examination
OSLER	UME learning management system
PaCER	Patient and Community Engagement Research
PARA	Professional Association of Resident Physicians of Alberta
PCC	Pre-Clerkship Committee
PDA	Protected Disclosure Advisor
PESJO	Precision Equity & Social Justice Office (formerly OPED)
PFSP	Physician & Family Support Program (Alberta Medical Association)
PGME	Post Graduate Medical Education
PLC	Peter Lougheed Centre
PSLA	Post Secondary Learning Act
PPC	Planning and Priorities Committee
RCPSC	Royal College of Physicians and Surgeons of Canada
RMETC	Rural Medical Education Training Centres
RhPAP	Rural Health Professions Action Plan
RPCC	RIME Pre-Clerkship Committee
RVH	Rockyview Hospital
SaaS	Software as a Service
SAC	Student Affairs Committee
SACRI	Southern Alberta Cancer Research Institute
SADE	Senior Associate Dean, Education
SAIT	Southern Alberta Institute of Technology
SAMF	Southern Alberta Mass Spectronomy Facility
SARC	Student Academic Review Committee
SCM	Sunrise Clinical Manager
SEC	Strategic Education Council
SEC-UME	Student Evaluation Committee
SHINE	Students for Health Innovation and Education
SHC	South Health Campus
SPC	Student Professionalism Committee
SPL	Special Procedures Lab
SSHRC	Social Sciences and Humanities Research Council
SRC	Strategic Research Council
STRIVE	Simulated Training for Resilience in Various Environments
SU	Student Union
TI	Taylor Institute for Teaching & Learning
TKK	Traditional Knowledge Keepers
TRW	Teaching Research and Wellness building
TSIMP	Teaching Scholars in Medicine Program
UCDNA	University Core DNA Services

UCIT	University of Calgary Information Technologies
UCLIC	University of Calgary Longitudinal Integrated Clerkship
UC	University of Calgary
UCMG	University of Calgary Medical Group
UMEC	Undergraduate Medical Education Committee
UMERC	Undergraduate Medical Education Research Committee
W21C	Ward of the 21st Century