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**TEAM REPORT
OF THE
SITE VISIT OF**

**UNIVERSITY OF TORONTO
FACULTY OF MEDICINE**

Toronto, Ontario

NOTE: This visit, originally scheduled to be carried out as an in person on-site visit on May 3-7, 2020, was postponed as a result of the COVID-19 pandemic and rescheduled as a two-step virtual visit on November 2-4, 2020 and December 7, 2020. The use of the word “visit” throughout the report refers to the virtual process.

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

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MEMORANDUM

TO: Committee on the Accreditation of Canadian Medical Schools

FROM: The Secretary of the *ad hoc* Site Visit Team that visited the University of Toronto, Faculty of Medicine on November 2-4, 2020, and December 7, 2020.

RE: Report of the Site Visit Team

On behalf of the *ad hoc* CACMS Site Visit Team that visited the University of Toronto, Faculty of Medicine on November 2-4, 2020, and December 7, 2020 the following report of the team's findings is provided.

Respectfully submitted,



Dr. Gurdeep Parhar, MD CCFP CCBOM CIME, Secretary

The schedule of the visit is included in Supplemental Appendix S-1.

SITE VISIT TEAM COMPOSITION

Team Chair:	Dr. David Eidelman Dean, Faculty of Medicine & Vice-Principal (Health Affairs) M ^c Gill University Montreal, QC	RESPIROLOGY
Team Secretary:	Dr. Gurdeep Parhar Faculty of Medicine University of British Columbia Vancouver, BC	FAMILY MEDICINE
Field Secretary:	Dr. Sheila Harding College of Medicine University of Saskatchewan Saskatoon, SK	HEMATOLOGY
CACMS Member:	Dr. Albert Ng Schulich School of Medicine & Dentistry University of Western Ontario, Windsor, ON	FAMILY MEDICINE
Student Member:	Christian Farrell Faculty of Medicine University of British Columbia Vancouver, BC	STUDENT
Faculty Fellow:	Dr. Evelyn Sutton Faculty of Medicine Dalhousie University Halifax, NS	RHEUMATOLOGY
Faculty Fellow:	Dr. Regina Taylor-Gjevre College of Medicine University of Saskatchewan Saskatoon, SK	RHEUMATOLOGY

ACKNOWLEDGEMENT

The team expresses its sincere appreciation to Dean Trevor Young and the staff, faculty, and students of the University of Toronto Faculty of Medicine for their many courtesies and accommodations during the visit. Dr. Patricia Houston and Mr. Christopher Jones merit special recognition and commendation for their thoughtful visit preparations and generous support during the conduct of the visit.

DISCLAIMER: This report summarizes the findings and professional judgments of the *ad hoc* site visit team that visited the University of Toronto Faculty of Medicine on November 2-4, 2020, and December 7, 2020, based on the information provided by the school and its representatives before and during the accreditation visits, and by the CACMS. The CACMS may come to differing conclusions when they review the team's report and any related information.

FINAL SITE VISIT TEAM ELEMENT RATING SUMMARY TABLE

Site Visit Team CACMS Element Rating Summary Table 2019-2020 University of Toronto Faculty of Medicine

Standard	1	2	3	4	5	6	7	8	9	10	11	12
Element	1.1	2.1	3.1	4.1	5.1	6.1	7.1	8.1	9.1	10.1	11.1	12.1
	1.1.1	2.2	3.2	4.2	5.2	6.2	7.2	8.2	9.2	10.2	11.2	12.2
	1.2	2.3	3.3	4.3	5.3	6.3	7.3	8.3	9.3	10.3	11.3	12.3
	1.3	2.4	3.4	4.4	5.4	6.4	7.4	8.4	9.4	10.4	11.4	12.4
	1.4	2.5	3.5	4.5	5.5	6.4.1	7.5	8.5	9.5	10.5	11.5	12.5
	1.5	2.6	3.6	4.6	5.6	6.5	7.6	8.6	9.6	10.6	11.6	12.6
	1.6				5.7	6.6	7.7	8.7	9.7	10.7		12.7
					5.8	*	7.8	8.8	9.8	*		12.8
					5.9	6.8	7.9		9.9	10.9		
					5.10		7.10		9.10	*		
					5.11					10.11		
					5.12							

*Currently there is no element 6.7, 10.8 and 10.10

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory monitoring	
Unsatisfactory	

SUMMARY OF SITE VISIT TEAM FINDINGS

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

Element Rating SM, U	Standard
	Standard 2 Leadership and Administration
SM	2.5 Responsibility of and to the Dean
	Finding: The school affirms, and the Team confirmed evidence of a close and effective collaboration between the Vice Dean, Medical Education and the ADME (Regional). Although both positions report to the dean, this triangulated governance structure is inherently problematic and risks undermining the delegated Chief Academic Officer's authority should the incumbents' successors prove to be less collegial.
	Standard 3 Academic and Learning Environments
U	3.4 Anti-Discrimination Policy
	Finding: While the school has a system for intake/disclosure of discrimination allegations and also has a process to report breaches of the anti-discrimination policy, the site visit team heard that the mechanisms and pathways to disclose and report such complaints are confusing. Likely as a result of the newness of some of the initiatives, the majority of students, faculty members and academic leaders interviewed during the site visit did not report an understanding of the processes that corresponded to those in the provided documentation.
U	3.6 Student Mistreatment
	Finding: The school has made laudable efforts in response to students reporting mistreatment (ISA – 25.0-44.9%), lacking confidence in the reporting system, remaining concerned about retaliation (ISA – 41.1%), and being confused or unaware about reporting processes (2019 GQ – 52.5% at MAM; 66.7% at Fitzgerald; ISA <60% years 1&2). Related mistreatment intake/disclosure and reporting procedures described in official documents did not match the processes described by students, faculty members and academic leaders with whom the team met. Given the newness of these initiatives, their diffusion, socialization, and effectiveness remain to be determined.
	Standard 8 Curricular Management, Evaluation and Enhancement
SM	8.4 Program Evaluation
	Finding: The 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.

	<p>ISA data indicate that student satisfaction (% <i>satisfied/very satisfied</i>) with the effectiveness of the pre-clerkship curriculum “in preparation for clinical learning” is low in both years at FitzGerald (69.8% and 76.5%), and in Year 4 at the Mississauga Academy (62.5%). Follow up internal survey data from January 2020, albeit with a modified question, showed improved satisfaction.</p> <p>When discussing this during the visit, students reported that they are not currently well positioned to assess the impact/sustainability of changes that have been made to the pre-clerkship curriculum to address this concern, because those are the very aspects of the Foundations Curriculum most disrupted by the pandemic.</p>
SM	8.5 Medical Student Feedback
	Finding: “In response to student response rates as low as 20% in evaluating the new Foundations Courses, the school implemented new approaches to increase student participation.”
	Standard 9 Teaching, Supervision, Assessment and Student and Patient Safety
U	9.4 Assessment System
	<p>Finding: This element was cited (as Standard ED-27) in 2012.</p> <p>ISA data indicated that rates of students having observed histories were low for Year 3 OBGYN (68.2%) at Mississauga, Year 4 Surgery at all four academies (69.9% to 77.1%) and Year 4 OBGYN at FitzGerald, Mississauga and Wightman-Berris.</p> <p>ISA data also demonstrate low rates of observed physical examinations in Year 4 Surgery at FitzGerald (70.6%), Years 3 & 4 Surgery at Peters-Boyd (74.1 and 78.0%), and Years 3 & 4 Surgery at Wightman-Berris (73.3 and 79.5%).</p>
SM	9.8 Fair and Timely Summative Assessment
	Finding: On average, most Clerkship courses provided final grades to students at both campuses within the six week maximum. There are still rare outliers for the maximum time to receive grades, but numbers of students who fall into this category are quite low. Data for Otolaryngology (a one-week rotation) still shows that > 16% of students do NOT receive grades within 6 weeks (maximum time 7.9 weeks), but most Clerkships are at 0-3% for this measure. In response to the school’s close attention to these data, escalating measures that have been implemented have been successful for most Clerkships, while improvements for Otolaryngology are in progress.
	Standard 11 Element Rating Table and Element Evaluations Forms
SM	11.1 Academic Advising
	Finding: The school has a system of academic advising in place for medical students and ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or advancement decisions about them. In response to variable student satisfaction with academic advising (ISA as

	low as 69.1% at the Fitzgerald Academy), the school implemented a more robust system of designated faculty advisors at each academy. Although the system is new, students with early experience spoke of it favourably.
SM	11.2 Career Advising
	<p>Finding: This element was cited (as Standard MS-19) in 2012.</p> <p>The school has a 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. GQ data show student satisfaction with guidance when choosing electives has fluctuated over the last three years, but has remained low, between 35.3% (Wightman-Berris, 2017) to 69.2% (Mississauga, 2018). The ISA survey found that the aggregated satisfaction with guidance when choosing electives for Year 3 is 57.8% and for Year 4 is 49.5%. During the visit, students spoke positively of their early experiences with a new robust system of advising that has been developed with designated faculty advisors at each campus.</p>

HISTORY OF THE SCHOOL

Note that campus maps are Core Appendix C-2.

Selected Milestones Focused on Medical Education

1843 – School of Medicine is established at the University of Toronto (U of T), one of a number of local medical colleges.

1887 – The Faculty of Medicine at U of T emerges as the single medical school with closure of all others medical colleges in Toronto. First Dean of Medicine, W. T. Aikins, is appointed.

1910 – Flexner Report claims the Faculty of Medicine at U of T (along with McGill) to be of the highest quality in Canada and among the best in North America.

1967 – Institute of Medical Sciences (the graduate unit for the Clinical Departments) is opened to enable academic physicians to supervise graduate (MSc and PhD) students. Today, this is the largest single graduate unit at the University of Toronto and home to the majority of MD/PhD trainees.

1968 – Medical Sciences Building opens on the St. George Campus, providing new research and education facilities.

1984 – Bernard Langer, Professor and Chair of Surgery, establishes the Surgical-Scientist Program, with graduate research training for surgical residents. This was the forerunner of the Royal College of Physicians and Surgeons Clinical Investigator Program.

1984 – Herbert Ho Ping Kong, Chief of Internal Medicine at the Toronto Western Hospital, establishes the first Clinical Teaching Units in Toronto, which continue to play a central role in general internal medicine teaching and learning.

1984 – Launch of the MD/PhD Program, the first in Canada.

1992 – Undergraduate Medical Education Academies established in the fully-affiliated acute care hospitals. These become the home for medical students and emerge over the next two decades as hubs of infrastructure support for undergraduate medical education. The MD Program curriculum is significantly restructured: the Clerkship is expanded to span the third and fourth years instead of Year 4 alone; problem-based learning is introduced into the Preclerkship; clinical skills teaching is brought into first year; and a four-year longitudinal community health course is implemented.

1997 – Wilson Centre for Research in Education is founded as a collaboration between the University Health Network and the Faculty of Medicine, and over the past 15 years become one of the foremost health education centres in the world.

2002 – Centre for Faculty Development is founded as a collaboration between St. Michael's Hospital and the Faculty of Medicine and becomes a world leader in the training of physician-teachers and other health professions educators; in 2011, it hosts the first 1st International Conference on Faculty Development in the Health Professions.

2005 – The Governing Council of U of T establishes the *Policy for Clinical Faculty* that enables academic physicians who are members of academic practice plans to have full (continuing) appointment to U of T.

2011 – Mississauga Academy of Medicine (MAM) opens, the first satellite campus of the Faculty of Medicine, in partnership with the University of Toronto Mississauga and the Credit Valley Hospital and Trillium Health Centre (now Trillium Health Partners).

NOTE: The student body is grouped into four Academies; MAM at the Mississauga Campus, and FitzGerald, Peters-Boyd, and Wightman-Berris at the St. George Campus.

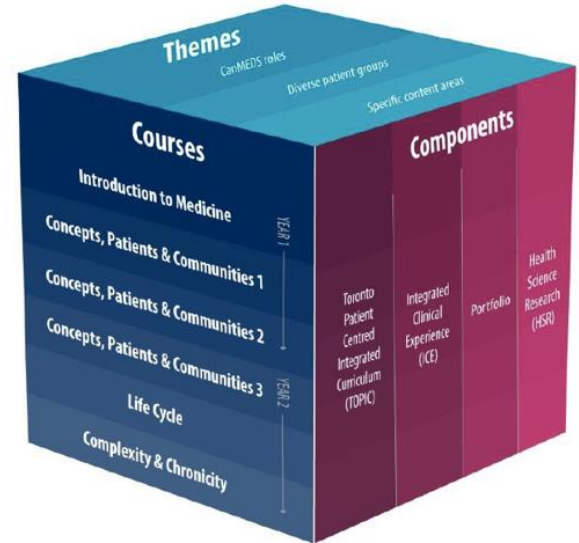
2016 – Launch of the revised pre-clerkship program known as the Foundations Curriculum.

ACCREDITATION HISTORY OF THE SCHOOL

University of Toronto, Faculty of Medicine				
Standard/ Element	Old Standard	Full survey Oct 2012	Status Report Oct 2013	Status Report Oct 2015
<i>Standard 3</i>				
3.3	IS-16	NC	CM	C
3.3	MS-8	CM	CM	C
3.5	MS-31-A	CM	CM	C
<i>Standard 8</i>				
8.3	ED-35	CM	CM	C
8.8	ED-38	NC	CM	C
<i>Standard 9</i>				
9.4	ED-27	NC	CM	C
9.7	ED-30	CM	C	
<i>Standard 11</i>				
11.2	MS-19	CM	CM	C
<i>Standard 12</i>				
12.1	MS-23	CM	CM	C
Follow-up 1		SR	SR	no follow-up
Due Date		Aug 15, 2013	Apr 15, 2015	
Follow-up 2				
Due Date				
Accreditation Status		Continue accreditation	Continue accreditation	Continue accreditation
Next Full Survey		8-year term (2019-2020)	2019-2020	2019-2020

CURRICULUM DESCRIPTION

The two pre-clerkship years comprise the recently introduced (2016) *Foundations Curriculum*. It includes six sequential *courses* (*Introduction to Medicine; Concepts, Patients and Communities 1, 2, & 3; Life Cycle; and Complexity & Chronicity*) integrated with four concurrent *components* (*Toronto Patient-Centred Integrated Curriculum; Integrated Clinical Experience; Portfolio; and Health Science Research*) and three *themes* (*CanMEDS roles; Priority Population Groups; and Specific Content Areas*).



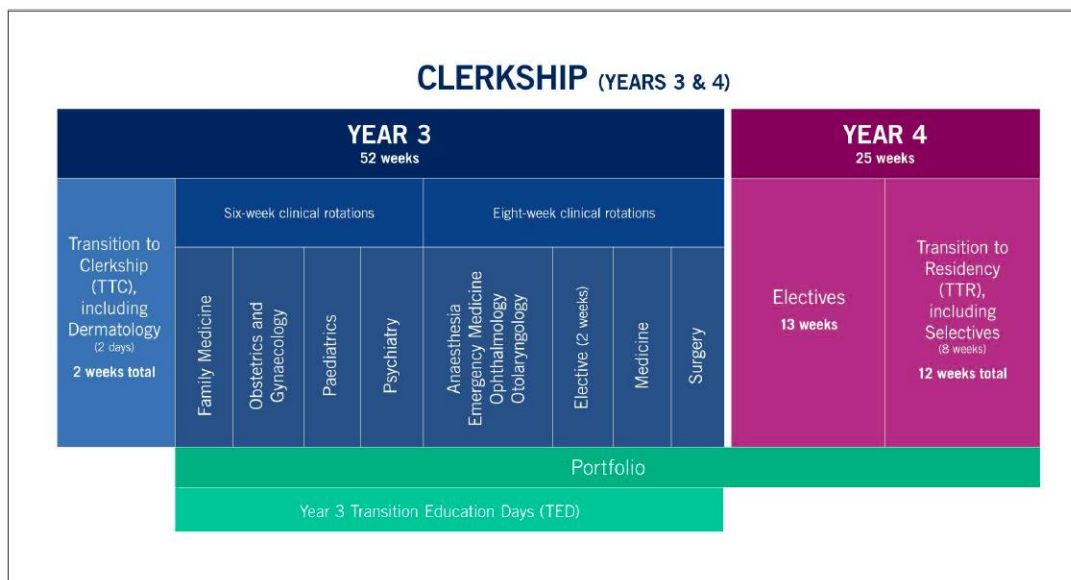
A central feature of the curriculum is the integration of basic science, psychosocial concepts, and clinical concepts; basic science and psychosocial content is closely integrated with the relevant clinical skills. A variety of instructional formats are used, as outlined in DCI Tables 6.0-1 and 6.0-2.

Clerkship begins with a two-week *Transition to Clerkship* course that includes Dermatology, followed by core clinical rotations in Anesthesia (2 weeks), Emergency Medicine (4 weeks), Family and Community Medicine (6 weeks), Internal Medicine (8 weeks), Obstetrics and Gynaecology (6 weeks), Ophthalmology (1 week), Otolaryngology (1 week), Paediatrics (6 weeks), Psychiatry (6 weeks), and Surgery (8 weeks). *Transition Education Days* focus on a longitudinal resiliency curriculum and career planning.

The *Portfolio* course continues throughout clerkship. The *Electives* course (13 weeks) comprises the first term of fourth year, followed in term two by the *Transition to Residency* course, including 8 weeks of selectives.

In 2019/20 a new two-week home-school elective was introduced at the end of Year Three to assist with career exploration. Students are required to complete 13/15 weeks allotted to electives across both years of clerkship, using the remaining time for vacation.

Elentra is the online learning management system used by the program. There is no parallel curriculum.



OVERVIEW DATA

Table 6.0-1 | Academic Year 1 -
Instructional Formats

Source: School-Reported

Using the most recently completed academic year, list each required learning experience from year one of the curriculum and provide the total number of instructional hours for each listed instructional format. Note that “small group” includes case-based and problem-solving sessions. Provide a definition of “other” if selected. Add rows as needed for each campus if there are differences between campuses.

Campus (specify only if differences exist between campuses)	Required learning experience	Weeks	Number of formal instructional hours per required learning experience					Total
			Lecture	Lab	Small group	Patient contact	Other (describe)	
	MED100H1F: Introduction to Medicine	1-11	77	28	85.5	8 (standardized patients) & 6 (real patients)	4 (Loblaw’s Community Session)	208.5
	MED120H1Y: Concepts, Patients and Communities 1	12-25	91	27	107.5	4 (standardized patients) & 20 (real patients)	16 (Community visits) & 0.5 (individual meeting with Portfolio Academy Scholar)	266
	MED130H1Y: Concepts, Patients and Communities 2	26-36	66.5	18	82	6 (standardized patients) & 10 (real patients)	4 (ICE: MP GPS) & 0.5 (individual meeting with Portfolio Academy Scholar)	187
TOTAL		36	234.5	73	275	54	25	661.5

Note: Student-led CBL hours (90 hours total – small group, independent), pre-week preparation (108 hours), as well as self-learning modules (108 hours) are not included in *Table 6.0-1*.

Table 6.0-2 | Academic Year 2 - Instructional Formats

Source: School-Reported

Using the most recently-completed academic year, list each required learning experience from year two of the curriculum and provide the total number of instructional hours for each listed instructional format. Note that “small group” includes case-based or problem-solving sessions. Provide a definition of “other” if selected. Add rows as needed for each campus if there are differences between campuses.								
Campus (specify only if differences exist between campuses)	Required learning experience	Weeks	Number of formal instructional hours per required learning experience					Total
			Lecture	Lab	Small group	Patient contact	Other (describe)	
	MED200H1F: Concepts, Patients and Communities 3	37-52	76	37	140	2 (standardized patients) & 20 (real patients)	20 (CBSL) & 0.5 (individual meeting with Portfolio Academy Scholar)	295.5
	MED210H1S: Life Cycle	53-61	45	3	83.5	6 (standardized patients) & 8.5 (real patients)	16 (CBSL) & 3 (Blanket Exercise)	164
	MED220H1S: Complexity and Chronicity	62-72	67.5	0	91	4 (standardized patients) & 12 (real patients)	16 (CBSL) & 0.5 (individual meeting with Portfolio Academy Scholar)	191
TOTAL		36	187.5	40	314.5	52.5	56	650.5

Note: Student-led CBL hours (90 hours total – small group, independent), pre-week preparation (108 hours), as well as self-learning modules (108 hours), Enriching Educational Experiences (24 hours over 2 years), Pain Week (in MED220), and Family Medicine Longitudinal Experience (24 hours in either the Fall or Winter) are not included in Table 6.0-2.

Table 6.0-3 | Academic Year 3 and Year 4 (where applicable) - Weeks/Formal Instructional Hours

Source: School-Reported

Provide data from the most recently-completed academic year on the total number of weeks and formal instructional hours per week (includes lectures, conferences, teaching rounds, clinical and procedural skills teaching/workshops) for each required learning experience in years three and four (where applicable) of the curriculum. Provide a range of hours if there is significant variation across weeks. Note that hours devoted to patient care activities should NOT be included. Add rows as needed for each instructional site if there are differences between sites.			
Instructional site (specify only if differences exist between instructional sites)	Required learning experience	Total weeks	Typical hours per week of formal instruction
	Anesthesia	2	8
	Dermatology	0.4 (in TTC)	16
	Emergency Medicine	4	2-21
	Family Medicine	6	3-14
	Internal Medicine	8	8-10
	Obstetrics & Gynaecology	6	9-11
	Ophthalmology	1	4
	Otolaryngology	1	3
	Paediatrics	6	3-7
	Psychiatry	6	2-21
	Surgery	8	1.5-33
	Transition to Clerkship (TTC)	2	20-26
	Transition to Residency	10	0-24

KEY PARAMETERS OVERVIEW SUMMARY TABLE

Since the last full visit, the total medical student enrollment is about 8% higher, although the current entering class size is actually 3% lower than in 2012. Residents and fellows have increased by 26%. Overall faculty numbers have increased by 15% (basic science faculty reduced by 7%; clinical science faculty increased by 18%).

Reported revenues have increased by about 6%. Note that this report does not include the recently announced \$250M gift to the medical school from the Temerty Foundation.

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

Table 1.0-1 | Faculty and Enrollment

Source: AFMC CFQ

These data are from the AFMC Canadian Financial Questionnaire (CFQ) for the academic year (AY) of the program's previous full site visit self-study, and for the academic year relevant to the current full site visit.		
	Data from the last full site visit report (2012)	AY 2018-19
Entering class size	267	259
Total medical student enrollment	1000	1079
Number of residents and fellows	2937	3698
Number of full-time basic science faculty	274	255
Number of full-time clinical faculty	2628	3094

Table 1.0-2 | Financial Overview

Source: AFMC CFQ

These data are from the AFMC Canadian Financial Questionnaire (CFQ) for the academic year (AY) of the program's previous full site visit self-study, and for the academic year relevant to the current full site visit.		
Revenue sources	Data from the last full site visit report (2012)	AY 2018-19
Visa student and trainee fees	13.7	24.9
University (excluding allied health and other programs)	103.2	106.0
Federal government	7.5	5.9
Provincial government	43.8	41.9
Practice plan/alternate funding plan/billing group	0.0	0.0
Hospital or health authority	19.3	11.8
Research awards, grants, and contracts	153.5	128.9
Research grants overhead funds	5.9	3.5
Gifts, donations, and interest earned on endowments/investments	0.0	0.0
Other	39.5	86.1
Total revenues (\$Millions)	386.6	409.0

EVALUATION OF THE DCI

The DCI was thoughtfully written, thorough and internally consistent. The few minor omissions and discrepancies were quickly and thoroughly addressed, as were requests for additional information and/or clarification. Pre-visit updates were clear and helpful. Issues with the collation of the Core Appendices were helpfully managed by the CACMS Secretariat staff.

EVALUATION OF THE MSS

The MSS Steering Committee was appropriately constituted, including key faculty, student, and administrative leaders, together with two co-chairs from each of five subcommittees. In turn, subcommittee membership reflected the diversity of the MD Program's educational partners and clinical affiliates, with good representation from each of the four Academies and student representatives from both pre-clinical and clinical years.

The MSS documented careful, well-informed consideration and reflection on the elements and their associated findings. Due consideration was given to the findings of the ISA, such that the MSS comprehensively addressed student concerns identified therein. Except for the unavoidable disruptions imposed by the COVID-19 pandemic, the DCI and MSS together accurately portrayed the usual circumstances of the school; those meeting with the team were able to distinguish between how things are usually done as compared to how things had been modified to manage pandemic-related realities.

The MSS findings and associated CQI recommendations were largely congruent with team's findings, with some variance in perspective, weight and/or emphasis. The school was already aware of most of the concerns identified by the team and appropriate steps had been taken/initiated to address them; the one exception is that the school did not/does not share the team's concern regarding the reporting relationship of the Associate Dean, Regional.

EVALUATION OF THE ISA

The ISA Task Force had a suitable structure and appropriately broad student representation. As documented in the ISA, "the ISA [survey] response rate was a resounding success, with 942 of 1080 students completing the entirety of the survey, resulting in an 87.2% response rate...[with] strong representation from students of all genders, years (including MD/PhD), academies, and campus sites" (p.9). The team found the ISA to be a helpful resource in evaluating the school and its MD program.

Overall, the students are positive about the school and their educational experiences. They report adequate representation and voice in decision-making bodies and processes.

Strengths identified in the ISA and during the visit include:

- effectiveness of the Office of Health Professions Student Affairs (OHPSA) and the Office of the Vice-Dean MD Program regarding accessibility, responsiveness, and inclusion of students on key working groups and medical school committees;
- high student awareness of mistreatment policies, excellent respect in learning environments, and high quality of overall learning experience and satisfaction with class diversity;
- availability of student services to support student well-being; financial, and debt management counselling;
- guidance from Faculty in preparing students for the CaRMS process and providing support in booking electives and selectives;
- ability to care for individuals from diverse backgrounds, broad exposures to generalist care and family medicine, and broad settings in which clinical experiences take place;
- sufficient time spent in educational and patient care activities in pre-clerkship and clerkship, appropriate preceptor expectations in clerkship, appropriate amount of feedback received in pre-clerkship and clerkship, and appropriate integration of student feedback overall;
- ample opportunities for service learning, scholarly research activities, and extracurricular activities.

The most worrisome issues identified in the ISA and during the visit pertain to student mistreatment: the significant number of students experiencing mistreatment; poor accessibility of student mistreatment reporting systems; and lack of student comfort with reporting mistreatment. This is despite the high student awareness of the relevant policies and of the enormous efforts being made by the school to address it. Similarly, there is low student comfort with contesting evaluations, taking personal days and/or asking for accommodations. Other identified areas for improvement include:

- financial concerns (tuition, living expenses, commuting costs, conference funding, cost of electives and CaRMS, etc.);
- low perceived socioeconomic (SES) diversity and poor integration across the St. George and MAM campuses; high levels of stress and/or anxiety experienced by students regarding not matching in the CaRMS process.

EVALUATION OF ELEMENTS BY STANDARD

STANDARD 1 ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 1: MISSION, PLANNING, ORGANIZATION AND INTEGRITY

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

1.1 STRATEGIC PLANNING AND CONTINUOUS QUALITY IMPROVEMENT

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

Requirements

- 1.1 a The medical school has a written statement of its mission and goals for the medical education program.
- 1.1 b The medical school engages in ongoing planning and continuous quality improvement that establish short- and long-term goals for the medical education program.
- 1.1 c The strategic plan for the medical education program is reviewed and revised at appropriate intervals.
- 1.1 d The outcomes of the strategic plan for the medical education program are monitored to ensure that the strategic plan is effective.
- 1.1 e The medical school monitors ongoing compliance with CACMS Standards and Elements and takes steps to maintain compliance.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

1.1a The mission and goals of the education program are found in Core Appendix 1 (C-1), which summarizes the strategic plan of the school. The mission and goals are clearly articulated in the document *Academic Strategic Plan: Leadership in advancing new knowledge, better health and equity (2018-2023)*.

1.1b There is an ongoing process for the ongoing plan and continuous quality improvement, built around a strategic plan established after widespread consultation and approved by Faculty Council in October 2018 (C-1).

1.1c The program is reviewed annually by the MD Program Executive Committee based on annual performance assessment review reports submitted to the Vice Dean, MD Program. This review is considered to be part of the ongoing strategic planning process. Initiatives identified by senior academic and administrative leaders are reviewed in the spring and fall by the MD Program Executive Committee.

1.1d The DCI describes a process whereby the findings from annual reviews are used to inform and drive the ongoing evolution of the MD Program. This process is managed by the Program Evaluation Committee, a subcommittee of the MD Program Curriculum Committee, which also uses external data sources such as MCCQE results, AFMC GQ results and CaRMS match results. There is further oversight in the form of annual review by the Faculty Education Committee, which is led by members elected from Faculty Council according to the terms of reference on the Faculty website. This committee is intended to serve as an additional safeguard of standards and quality of the programs regarding Curriculum and Evaluation among other topics.

1.1e Elements are reviewed for compliance on an ongoing basis.

The DCI presents examples of this, including an item in the current strategic plan, “Implement changes to admissions requirements and processes approved in Spring 2019”, which was listed as a short-term goal under Diversity (Admissions). The school has a specific framework for monitoring and iterative development of that short-term goal. The School has used the framework to move its plan forward – recommendations were endorsed by the MD Program Curriculum Committee and Faculty of Medicine Education Committee in Spring 2019, with implementation of the first stage of changes to the Admissions requirements as of September 2019. In addition, the MD Program reviews all the accreditation standards formally at least once every four years during interim and full accreditation reviews. The most recent interim review took place during the 2016-2017 academic year. This process mirrored the entire CaCMS accreditation process including the development of a DCI for each Standard and Element.

1.1.1 SOCIAL ACCOUNTABILITY

A medical school is committed to address 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.*

Requirements

- 1.1.1 a The medical school has identified the priority health concerns of the populations it has a responsibility to serve.
- 1.1.1 b The medical school’s social accountability is:
 - i. articulated in its mission statement.
 - ii. fulfilled in its educational program through admissions, curricular content, and types and locations of educational experiences.
 - iii. evidenced by specific outcome measures.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

1.1.1a The school has identified 3 groups as priorities for social responsibility consideration. These are detailed in the DCI as being Indigenous peoples, Black people, and LGBTQ2S+ people. Teaching about these groups is overseen by respective theme leads. The DCI lists specific sources of input into the identification of priority health concerns, such as the Indigenous Physicians Association of Canada competencies, the UN report of the Working Group of Experts on People of African Descent and Medical Council of Canada Objective 94-1, “Gender and Sexuality”.

1.1.1b:

i) The school’s social accountability is articulated in the guiding vision of its strategic plan (Appendix C-1) and on the Faculty’s website, which highlights inclusion and diversity in numerous places, including the home page.

ii) According to the DCI, the Faculty has well defined processes for inclusion and assessment of issues related to social accountability in its curriculum. Specific programs have been established for Indigenous Student Applications and Black Student Application. Information about these programs is on the Faculty website. The DCI includes a table that specifically identifies all the places in the curriculum, across the 4 years where cultural safety, health equity, indigenous health and LGBTQ2S+ health are taught. The DCI describes a variety of experiences ranging from community-based service-learning to lecture to opportunities for clerkship placements. The mandates for the offices related to indigenous health and equity, diversity and inclusion are well described.

iii) Specific outcome measures related to social accountability are monitored as part of the strategic planning process. There is clear articulation regarding which committees review the various aspects of the plan, generally on an annual basis or when there is a proposed curricular change.

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.

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

1.2a There are applicable conflict of interest policies for all individuals noted in the element.

1.2b The medical school informs the relevant individuals about these policies and procedures. The team reviewed a sample letter to lecturers concerning commercial conflicts of interest and the standard template for conflict of interest disclosure during talks to students. There is relevant information on the website of the Faculty, including a policy on Relationship with Industry and the Educational Environment in Undergraduate and Postgraduate Education. Additional information is posted on research and policies webpages of the Faculty. According to the DCI, administrators send a document regarding procedures for disclosure of conflicts to all who are responsible for preparing or delivering lectures. This document is also available on the Faculty website. The procedures are also referenced in the MD Program academic calendar and can be accessed from the Faculty's learning management platform.

1.2c. Based on the DCI and material available on the Faculty's website, the policies address research, faculty with academic and teaching responsibilities, as well as commercial support for continuing medical education. All of these policies are available on the Faculty's website in relevant locations. It was possible to independently confirm that the documents are publicly accessible by searching the internet.

1.2d There are well-defined strategies for managing actual or perceived conflicts of interest, which are outlined in a publicly available document, approved by the MD Curriculum Committee, and last amended in 2015.

1.3 MECHANISMS FOR FACULTY PARTICIPATION

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

Requirements

- 1.3 a Faculty are voting members on the majority of standing committees in the medical school.
- 1.3 b There is an effective process used to select faculty members for standing committees that takes into account the need to have members whose perspectives are independent of departmental leadership and central administration.
- 1.3 c Faculty are made aware of proposed changes in the medical education program, its policies and procedures, and provided opportunity to provide input.
- 1.3 d There is at least one general faculty meeting each year (in person or audio/visual conference) where faculty are notified of the agenda and the outcomes of the meeting.
- 1.3 e The medical school uses an effective system to inform the faculty of important issues at the medical school.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

1.3a According to the By-Laws of the Faculty Council, faculty members are voting members on the majority of standing committees of the medical school. The By-Laws are publicly available on the Faculty's website.

1.3b. According to the DCI and the By-Laws, membership on standing committees is determined by a striking committee chaired by the "Speaker" of the Faculty Council. There are elected at-large members on all standing committees to ensure representation independent of the departmental leadership and central administration.

1.3c. The Faculty has several mechanisms to make members aware of policy and other changes. According to the DCI, there is a system of consultation primarily at the department chair level. Feedback is also obtained through clerkship site directors and course directors in the Foundations component of the course (Years 1 & 2). According to the DCI, major changes involve review first by either the Foundations (Years 1 & 2) or the Clerkship (Years 3 & 4) Committees and then the Curriculum Committee. The DCI provides a specific example of how this works by describing the consultation process surrounding the latest Strategic Plan, ratified in 2018.

1.3d. The Faculty Council meets at least three times per year. Notifications of meetings are sent via MedEmail and meeting materials, including the agenda, are posted in advance on the Faculty Council webpage. The last meeting minutes available online are from October 2019. There is an agenda posted for February 10, 2020. More recent meeting agenda and minute documents were received upon request.

1.3.e. According to the DCI, in addition to the methods related to Council and committees described above, there is a twice monthly newsletter to all faculty, staff and students. Additional information is on the Faculty of Medicine website, which showed recent stories regarding issues in the Faculty. The Dean issues an annual report, which is available on-line.

1.4 AFFILIATION AGREEMENTS

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

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

Definition taken from CACMS lexicon

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

Requirements

- 1.4 a The medical school has signed affiliation agreements with all clinical facilities at which medical students complete the inpatient portions of required clinical learning experiences including longitudinal integrated clerkships.
- 1.4 b These agreements have explicit language as indicated in **a-e** in the element.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

1.4a. Signed affiliation agreements with the school's clinical partners were provided for the team's review. All agreements were signed in 2017 or 2018.

1.4b. Explicit language for each component (a-e) above is present in each of the agreements.

1.5 BYLAWS

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

Definition taken from CACMS lexicon

- *Senior administrative staff: Individuals in high-level positions responsible for the operation of the medical school e.g., finances, information technology, and facilities.*

Requirements

- 1.5 a There are bylaws or similar policy documents that describe the responsibilities and privileges of the dean and those to whom he or she delegates authority (e.g., vice, associate, assistant deans), department heads, senior administrative staff, faculty, medical students and committees that are made known to faculty members.

RATING

- Satisfactory
- Unsatisfactory

Evidence to support the above rating

1.5a The bylaws and policies related to the dean and his delegates, which describe the responsibilities and privileges of the dean and those to whom he delegates authority, are available on the Faculty Council website. This document is publicly available.

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.*

Definition taken from CACMS lexicon

- *University: The university or universities of which the medical school is a part.*

Requirements

- 1.6 a The medical school and its campuses are located in Canada.
- 1.6 b Students complete all required learning experiences in the medical school.
- 1.6 c The medical school is part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

1.6a The medical school has two campuses, St. George and Mississauga. These are located in the greater Toronto area in Ontario, Canada.

1.6b. Students complete all required learning experiences in the medical school.

1.6c. The school is part of the University of Toronto, which has the legal authority to grant the degree of Doctor of Medicine.

STANDARD 2
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 2: LEADERSHIP AND ADMINISTRATION

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

2.1 SENIOR LEADERSHIP, SENIOR ADMINISTRATIVE STAFF AND FACULTY APPOINTMENTS

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

Definitions taken from CACMS lexicon

- *Senior administrative staff: Individuals in high-level positions responsible for the operation of the medical school e.g., finances, information technology, and facilities.*
- *University: The university or universities of which the medical school is a part.*

Requirements

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

RATING

- Satisfactory
 Unsatisfactory

Evidence to support the above rating

As outlined in the DCI and in the University of Toronto's Policy on Appointment of Academic Administrators, which is available on the Secretariat's website and for which a link was provided, the appointment of the Dean, Vice Deans and other officials are ultimately appointed by the Governing Council, which serves as the governing board for this institution.

Appointment of faculty members is done by the Faculty but ultimately must be approved by the Academic Board of the Governing Council.

Appointment of administrative staff is made based on the publicly available policy on the HR and Equity website of the university.

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.

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

As stated in the DCI, the current Dean, Dr. Trevor Young, has been in this position since 2015. He is an internationally known authority in mental health research, with an interest in depression research. Dean Young has extensive experience as an academic leader, having served as Chair of Psychiatry prior to the present appointment. He has also served as Physician-in-Chief and Executive Vice President, Program at the Centre for Addiction and Mental Health in Toronto, as well as Head of Psychiatry at the University of British Columbia. Dean Young holds a medical degree from Manitoba and a PhD from the University of Toronto. He completed his residency at McGill University and Johns Hopkins University.

As Dean, Dr. Young is responsible for all missions of the school in accordance with the University of Toronto policy on Appointment of Academic Administrators, which was linked in the DCI and is posted on the Secretariat website.

2.3 ACCESS AND AUTHORITY OF THE DEAN

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

Definition taken from CACMS lexicon

- *University: The university or universities of which the medical school is a part.*

Requirements

- 2.3 a The dean has appropriate access to the university president or other university official charged with final responsibility for the medical education program in order to fulfill his or her responsibility for the medical education program.
- 2.3 b The dean has appropriate access to other university officials in order to fulfill his or her responsibilities for the medical education program.
- 2.3 c The dean has appropriate access to officials in the hospitals or health authorities in order to fulfill his or her responsibilities for the medical education program.
- 2.3 d The position description of the dean clearly identifies his or her authority and responsibility for the medical education program.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

2.3a At the University of Toronto, the Dean of Medicine has a dual role, fulfilling the duties of Vice-Provost Relations with Health Care Institutions, report to the Vice President and Provost. This role is confirmed in the organizational charts in Appendix C-7. It is also a part of the position description provided in Appendix C-8. According to the DCI, in his role as Vice Provost, the Dean meets both with the Provost as well as the University President, the latter in matters relating to health care and medical education.

2.3b As a member of the university's senior leadership, the Dean has access to Vice Presidents and other officials in matters related to advancement, communication and government relations.

2.3c The Dean is a member of the boards of four fully affiliated hospitals and one community affiliate. He represents the University of Toronto at the Toronto Academic Health Sciences Network committee of hospital Presidents/CEOs and serves on its standing committee on research. This network includes all of the major healthcare partners of the university.

2.3d The position description (Appendix C-8) confirms that the dean has authority and responsibility for the medical education program.

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.

Definition taken from CACMS lexicon

- *Senior administrative staff: Individuals in high-level positions responsible for the operation of the medical school e.g., finances, information technology, and facilities.*

Requirements

- 2.4 a There are a sufficient number of vice, associate or assistant deans; senior administrative staff (e.g., CFO), and leaders of other organizational units who have the time necessary to fulfill their responsibility for the mission(s) of the medical school for which they are responsible.
- 2.4 b Vacant positions are filled in a timely manner that ensures appropriate leadership in these areas.
- 2.4 c Student survey data show that the vast majority of respondents are satisfied/very satisfied (aggregated) with the accessibility and responsiveness of the office of the vice/associate/assistant dean or director of the medical education program (academic) to address their problems and include them on key medical school committees and working groups.
- 2.4 d Student survey data show that the vast majority of respondents are satisfied/very satisfied (aggregated) with the accessibility and responsiveness of the office of the vice/associate/assistant dean or director of student affairs to address their problems and include them on key medical school committees and working groups.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

2.4a The deanery includes 5 Vice Deans, 5 Associate Deans, a Senior Advisor on Clinical Affairs, the Chief Administrative Officer, the Director of Physician Scientist Training Programs and the Chief Financial Officer. There are no interim appointments at this level. The DCI lists 40%-100% efforts in these roles, although it is noted that recently the time devoted to administrative vs clinical or teaching is no longer specified. During the site visit, leaders at all levels indicated that they had sufficient protected time.

2.4b At the time of the site visit, the position of Vice Dean, Research and Innovation was filled on an interim basis. Among department chairs at the time the DCI was submitted, there were 4 (of 26) interim positions, all vacant for less than one year except for Physiology, which has had an interim leader since December 31, 2018. Searches were said to be underway at the time of submission.

2.4c Based on GQ and ISA data, students are very satisfied with accessibility of and collaboration with the Vice Dean MD Program. The GQ data tends to show a lower score (75% in 2019) than the ISA (74.5% to 88.7%, varying by year) for responsiveness to student problems.

2.4d Based on GQ and ISA data, students are very satisfied with accessibility, responsiveness and collaboration with students by the Associate Dean, Student Affairs. Although the percentages vary by year, the ISA shows 86.4-96.0% satisfaction with these criteria across the four years.

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 the adequacy of faculty 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.

Definition taken from CACMS lexicon

- *Campus: An instructional site that offers a complete pre-clerkship academic year.*

Requirements

- 2.5 a The dean himself /herself or through a delegated chief academic officer (vice/associate/assistant dean), is administratively responsible at each campus for the:
- i. conduct and quality of the medical education program
 - ii. adequacy of faculty
- 2.5 b The principal academic officer (regional/vice/associate/assistant dean or site director) at each campus reports (organizational charts/position descriptions) to the chief academic officer of the medical school.
- 2.5 c The faculty and administrative staff who participate or oversee the medical education program at each campus report to the principal academic officer at that campus.
- 2.5 d The adequacy of faculty at each campus is monitored and the chief academic officer works with the principal academic officer to remedy any deficiencies.
- 2.5 e The conduct and the quality of the medical education program are monitored at each campus and the chief academic officer works with the principal academic officer to remedy any deficiencies.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

2.5a As stated in the DCI, the Dean is responsible for all missions of the school. The role of chief academic officer for the MD program has been delegated to the Vice Dean, MD Program. There are two campuses, Mississauga Academy of Medicine (MAM) and St. George campus, the latter being geographically distributed within Toronto. The oversight of the medical education program delivery at MAM has been delegated to both the Vice Dean, MD Program and the Associate Dean, Medical Education (ADME) (Regional). The ADME (Regional) also holds the title of Vice President, Education at Trillium Health Partners (THP), which is MAM's anchor hospital.

The ADME (Regional) position reports to the Dean of Medicine, (rather than to the Vice Dean, MD Program, who nevertheless has delegated responsibility for MD Program delivery at MAM), while the Vice President position reports to an Executive Vice President at THP. According to the position description (Supplemental Appendix S-2) the ADME (Regional) is to work jointly with the Vice Deans for the MD Program and PGME and share responsibility for both MD and residency education.

In the documents provided, the ADME (Regional) does not have any reporting relationship to the Vice Dean MD Program on the organizational chart (Appendix C-9). During the site visit, the school explained that there was close collaboration between the Associate Dean, Regional and the Vice Dean, MD Program. This collegial relationship works well at present but appears to be dependent on the individuals occupying the positions. In the site visit team's judgment, this triangulated governance structure is inherently problematic and risks undermining the authority of the delegated Chief Academic Officer, should the incumbents' successors prove to be less

collegial. (SM)

2.5b Both the ADME (Regional) and the Vice Dean, MD Program report to the Dean and Vice Provost. The ADME (Regional) collaborates with, but does not formally report to, the Vice Dean, MD Program, who is the delegated Chief Academic Officer for the MD Program.

While during the site visit, the school explained that there was close collaboration and collegiality between the ADME and the Vice Dean, MD Program, this appears to be dependent on the individuals occupying the positions and further evidence of sustainability needs to be confirmed.(SM)

2.5c As reported in the DCI, all faculty and administrative staff in the MD Program report to the principal academic officer at their respective campus (MAM or St. George).

2.5d As reported in the DCI, the monitoring of the adequacy of the faculty is managed through the Office of Evaluation, which prepares an annual report for each of the affiliated teaching hospitals. The DCI reports that this is provided to the Vice Dean MD Program, the Associate Dean (Regional) and the MAM academy director. The Vice Dean, the ADME (Regional) and the MAM academy director receive ongoing feedback from course directors and students. It was clear from interviews with the leadership and with faculty members that there is adequate faculty at both MAM and St. George campuses.

2.5e The mechanisms used to monitor the conduct and quality of the medical education program, and to address any deficiencies therein, are as described in 2.5d.

2.6 FUNCTIONAL INTEGRATION OF THE FACULTY

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

Definition taken from CACMS lexicon

- *Campus: An instructional site that offers a complete pre-clerkship academic year.*

Requirements

- 2.6 a There are medical school policies or bylaws that assure the participation of faculty based at all campuses in medical school governance (e.g., committee membership).
- 2.6 b The principal academic officer(s) (regional/vice/associate/assistant dean or site director) at each campus or their designate currently serve as members of some of the medical school's standing committees (e.g., curriculum committee, admissions committee, the executive committee of the medical school).
- 2.6 c Faculty at the departmental level at each campus are functionally integrated into the medical school by appropriate administrative mechanisms.
- 2.6 d Directors of required learning experiences at each campus are functionally integrated with the directors of the required learning experiences at the main campus.
- 2.6 e There is documentation (for example, minuted meetings in person or audio/visual conference or periodic visits to each campus) that the following points are reviewed, and steps taken to address deficiencies:
 - i. student required patient encounters and procedural skills
 - ii. student performance data
 - iii. student evaluation data or required learning experiences
 - iv. faculty performance related to their educational responsibilities

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

2.6a Committees include members from both campuses. Links are provided to the terms of reference, which include dedicated seats to assure the involvement of MAM faculty and staff in major committees, including the Executive Committee; the Curriculum Committee; the Academy Directors Committee; the Foundations, Clerkship and Admissions Committees. All faculty at MAM are eligible to sit on any MD Program Committee. The participation of faculty from both campuses in key committees was confirmed during the site visit.

2.6b The DCI includes links to the terms of reference of the above standing committees, which confirm that the ADME (Regional) and the MAM Academy director both participate on standing committees.

2.6c According to the DCI, the medical school makes use of the Academy Directors Committee to ensure functional integration of all campuses in the delivery of the MD program across both campuses.

2.6d At the departmental level, the DCI states that each course has a single director responsible for the delivery and evaluation of the course at both campuses. The MAM faculty lead for each course represents MAM on the

respective content/theme-based or course committees. These committees report up to the Foundations of Clerkship Committees as appropriate. These report up to the Foundations or Clerkship Committees as appropriate.

2.6e The school reports that the following student data are collected and reviewed:

i.) Case Logs (also addressed in Element 6.2), are monitored centrally in MedSIS (described in Element 8.6) by course directors and the Clerkship Director. The Case Logs are the same for all students, regardless of campus or affiliated clinical site.

ii., iii.) Annual course reports, which include both performance and evaluation data, are compiled by Course Directors and reviewed by the MD Program Evaluation Committee (MDPEC). These reports include site-specific data across all academies and sites, regardless of campus affiliation. The Office of Assessment and Evaluation analyzes student performance data and student evaluation data to determine any statistically significant differences in performance among all four academies. Course directors must submit responses to the MDPEC, which are reported to the MD Curriculum Committee with action plans to address cases where such differences exist.

iv.) The above course reports also include faculty performance data. Evaluations of faculty members are aggregated and reported to Course Directors, Academy Directors, Department Chairs and Vice Chairs Education, and Clinical Department Chiefs, as appropriate. See Element 8.3 for information regarding the approach to identifying and addressing deficiencies in faculty members' teaching performance. See also Element 4.4.

STANDARD 3
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 3: ACADEMIC AND LEARNING ENVIRONMENTS

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

3.1 RESIDENT PARTICIPATION IN MEDICAL STUDENT EDUCATION

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

Definition taken from CACMS lexicon

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

Requirements

- 3.1 a Every medical student in the last three graduating classes worked with a resident in a healthcare setting in a required clinical learning experience of at least a four-week duration.
- 3.1 b The residents who worked with medical students as described above are or were enrolled in accredited programs of postgraduate medical education.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

- 3.1a As stated in the DCI, there are no students who have graduated in the last three years who did not work with a resident in a required clinical learning experience for at least four weeks. During the visit, students in clerkship confirmed that this requirement is met.
- 3.1b There is no parallel curriculum at this school.
- 3.1c The DCI reports that all postgraduate medical education programs at the University of Toronto are fully accredited.

3.2 COMMUNITY OF SCHOLARS/RESEARCH OPPORTUNITIES

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

Requirements

- 3.2 a The medical school informs medical students about and encourages them to participate in research and other scholarly activities of the faculty.
- 3.2 b The medical school supports medical student participation in research and other scholarly activities of the faculty (e.g., coordination of student placements, development of opportunities, or provision of financial support).
- 3.2 c Student survey data show that respondents who wanted to participate in a research or other scholarly activities with a faculty member had the opportunity to do so.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

3.2a Based on the DCI, the school employs a number of mechanisms to encourage students to participate in research and other scholarly activities of the faculty, including compulsory scholarship experiences such as the Practicum Exercises as well as well-structured opportunities such as the Comprehensive Research Experience for Medical Students (CREMS) program or its successor, the graduate diploma in health research (GDipHR). There is also a MSc in System Leadership and Innovation. Information about these opportunities is made available in/through the Academic Calendar, information sessions, periodic notifications about research opportunities from departments and institutes and information posted on the student learning platform.

3.2b Based on the DCI, the school provides considerable organizational supports for student opportunities to participate in scholarly activities. In addition to the opportunities described in 3.2a, there is some financial support such as stipends to MDPHD and GDipHR students.

3.2c The University of Toronto provides an exceptionally rich environment for students to explore research opportunities. The ISA and the GC show a high degree of satisfaction with the opportunities to participate in research. The lowest rate (80% on the ISA) occurred at the Peters-Boyd Academy. The rate at the other academies was at 88% or higher. However, on the ISA at both Peters-Boyd and Mississauga Academies, 6% of students stated they did not have enough opportunities for scholarly activity. In contrast the GQ supports the notion that students are generally satisfied, since no students stated they did not have an opportunity except at Peters-Boyd, where 2.4% of the students said they had no opportunity.

3.3 DIVERSITY/PIPELINE PROGRAMS AND PARTNERSHIPS

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

Definition taken from CACMS lexicon

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

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

3.3a The medical school has well-defined categories of diversity reported in the DCI and forming part of the Faculty's strategic plan (see Standard 1). The categories include: the Indigenous peoples of Canada, people of African ancestry (Black), the economically disadvantaged, people self-identifying as being members of sexual-orientation or gender minorities, racialized persons and persons with disabilities. According to the DCI

(Appendix C-10), the same categories apply for medical students and the same categories, with the exception of economically disadvantaged, also apply to faculty, and to academic and educational leadership. There is special attention paid to the first three groups: Indigenous, Black, and economically disadvantaged.

3.3b The school has developed specific programs for the recruitment of students, with specialized programs for Black and Indigenous students, which are present in the Strategic Plan, on the school's website, and in program-specific documents that were reviewed by the visiting team. These programs include bursary and grant support. The school reports similar support for LGBTQ2S students and those from low socioeconomic status, including programs aimed at potential candidates before application.

In addition, students from all identified diversity groups can access support through a Community of Support (CoS), a longitudinal and collaborative initiative that enables prospective medical students who are Indigenous, Black, Filipino, economically disadvantaged, or who self-identify with having a disability that attend/attended any University to receive support at any stage of their medical school journey to the University of Toronto and elsewhere. CoS operates by providing its participants with access to various supports and opportunities, including: admissions information, including one-on-one advising and access to admissions events; access to mentors (medical students and physicians) and experiences (e.g. enrichment courses, and leadership, research and volunteer opportunities); and, support at each stage of the application process, including MCAT preparation, medical school application preparation, and school-specific interview preparation.

With respect to hiring, there are specific policies regarding employment equity that are established at the university level, which include instruction on *Better Practices in Recruitment* for the conduct of searches. The Academic Strategic Plan lists as a goal to “transform our Faculty to be fully inclusive of the communities we serve.”

3.3c The school has developed specific programs for the support and retention of students from diversity categories. As stated in the DCI and the website, there is a summer mentorship program, a community of support longitudinal program and a school supported Black Medical Students Association. There is also a Diversity Mentorship Program administered by the Office of Inclusion and Diversity. In addition, student mistreatment protocols have been adapted to more explicitly discrimination based on minority status. Diversity is also supported through the office of indigenous medical education, the accessibility services and the personal counselling office. As stated in the updated DCI, as of August 28, 2020 the Office of Health Professions Student Affairs has posted a job opportunity for a part-time counsellor with experience working in anti-oppression/anti-racism framework with individuals from the identified priority groups, with will further strengthen this work.

The school has appointed faculty leads and advisory groups for indigenous medical education, Black health and LGBTQ2S health, who provide input into recruitment and retention activities and curriculum. There is a group known as “Out in Medicine”, which is dedicated to advocacy, community education and development of LGBTQ+ initiatives.

There are events such as academic promotion sessions for women and sessions in partnership with the Black Physicians Association of Ontario. According to the updated DCI, as of September 2019, there are specific events targeted at supporting the career advancement of faculty members from underrepresented minorities, including encouraging their participation in leadership training such as the *New Emerging Academic Leaders* program. Similar activities are ongoing, despite the disruption of the pandemic.

3.3d Based on the DCI and the MSS, as well as the school's website and documents associated with the Strategic Plan, the school monitors the diversity of students, staff and leadership and uses this information to guide its planning.

3.3e Based on the DCI, the website, the Strategic Plan, the approaches taken by the school regarding student admission are appropriate and, in the case of a specific pathway for Black students, are ahead of most other schools in Canada.

3.3f As noted above, the school has included monitoring of diversity as one of the goals of its strategic plan. Methods used include a “Voice of [group] Survey” and regular program quality assurance reviews both of which

have sections related to equity, inclusion and diversity.

3.3g According to the DCI, the programs aimed at improving the diversity of the applicant pool has shown modest growth in the number of applications to the Black Students Application Program, and stable numbers of indigenous students. Despite the many efforts of the school, the number of applications from Indigenous students has declined between 2014 and 2019. Additional information provided in September 2020 indicates a marked increase in the number of Black students accepted, increasing from 15 in 2019 to 26 in 2020. There has been no change in the number of indigenous students. The recently introduced, biannual “Voice of the Faculty Survey” is to be used to monitor progress at the faculty level – there are, at present, only baseline data available, against which future progress will be assessed.

The school-identified diversity categories for all faculty members include: Female (52.7%), Indigenous Peoples of Canada (0.6%), People of African ancestry (1.5%), Sexual orientation and gender minorities (6.6%), Racialized people (31.3%) and People with disabilities (18.3%).

The school-identified diversity categories for academic and educational leadership include: Female (48.0%), Indigenous Peoples of Canada (0.3%), People of African ancestry (1.4%), Sexual orientation and gender minorities (5.2%), Racialized people (23.7%) and People with disabilities (18.5%).

As already noted, there are specific policies regarding employment equity that are established at the university level, which include instruction on *Better Practices in Recruitment* for the conduct of searches. The Academic Strategic Plan lists as a goal to “transform our Faculty to be fully inclusive of the communities we serve.”

3.4 ANTI-DISCRIMINATION POLICY

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

Requirements

- 3.4 a The medical school and its clinical affiliates have anti-discrimination policies that are made available to faculty, students and other members of the medical school community.
- 3.4 b The medical school and its clinical affiliates foster an environment in which all individuals are treated with respect and takes steps to prevent discrimination.
- 3.4 c There is a safe mechanism for reporting incidents of known or apparent breaches of the anti-discrimination policy.
- 3.4 d Allegations are investigated in a fair and timely manner.
- 3.4 e There is prompt resolution of documented incidents with a view to preventing their repetition.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

3.4a The University of Toronto has well-defined policies against discrimination and harassment, which were provided to the team for review and are found on the website. The school makes the community aware of this policy through its Academic Calendar, its policies web page and references it in the *Student Mistreatment Protocol*. At the time of completing the DCI, work was underway to enhance the current standards. The School appointed a Director, Learner Experience in May 2020, who has specific responsibility in this area.

Documentation provided by the school in the September 2020 DCI update refers to a Faculty Council meeting held on April 13, 2020 at which an update to the standards of professionalism was approved to include microaggressions as a form of mistreatment.

3.4b It is clear from reviewing the Faculty's website, the DCI and associated documents that the school endeavors to promote an environment in which all individuals are treated with respect and steps are taken to prevent discrimination.

3.4c On paper, the school has a well-defined process to report incidents of apparent breaches of the anti-discrimination policy. Students may use a *Disclosure Form (DF)* on the MD Program's student mistreatment web page, and which can be reached by a Student Assistance button on all student-facing MD Program web pages as well as the learning management system (Elentra). According to the updated DCI, as of March 17, 2020, the MD Program Committee has designated the following leaders to receive and discuss disclosures: Director, Learner Experience; Associate Dean, Health Profession Student Affairs and Academy Directors.

The school's *Student Mistreatment Protocol* draws a distinction between disclosure and reporting. Recent changes have been made in an effort to ensure that intake, disclosure of incidents, is safe for learners, and that students can speak with a trusted advisor in order to make a well-informed decision about whether or not to report the incident formally to the University. As outlined in the *Protocol*, it is not the role of the designated program

leader to escalate, investigate, and/or resolve the case.

If a student decides to report an incident, then oversight of management of the process to review and find resolution to the complaint would involve the relevant department and hospital-based education leaders in collaboration with university leadership.

However, in meetings with senior leadership, faculty members, and students, the site visit team heard that many mechanisms exist to receive and discuss disclosures, which ought to be helpful, but students find confusing. The majority of students, faculty members and academic leaders interviewed during the site visit, did not report an understanding of the disclosure and reporting processes that corresponded to those in the provided documentation.

While the school's efforts to improve the reporting of discrimination breaches is laudable, the newness of the procedures and processes may have caused some confusion during this period of transition. The diffusion, education, socialization and effectiveness of the new initiatives remain to be determined. (U)

3.4d According to the DCI, the school commits to immediate confirmation of submission of a Disclosure Form (DF), which is reviewed by the designated MD Program leader within 3 business days. All DF submissions are immediately notified to Director, Learner Experience. Each DF is reviewed and subsequent action determined on a case-by-case basis.

3.4e The school has put in place a solid protocol and provided a clear pathway for handling reported incidents. The 2019 Professionalism Report describes aggregate and de-identified data regarding the types of mistreatment concerns disclosed or reported by students in the 2019 calendar year.

Some aspects of Anti-Discrimination are also described in Element 3.6.

3.5 LEARNING ENVIRONMENT

A medical school ensures that the learning environment of its medical education program is:

- a) conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations.*
- b) one in which all individuals are treated with respect.*

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

- 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 correct violations of professional standards*

Requirements

- 3.5 a The medical school and its clinical affiliates collaborate in the periodic evaluation of the learning environment using appropriate methods and share the results of these evaluations to identify positive and negative influences on the professional development of medical students.
- 3.5 b The medical school and its clinical affiliates have implemented appropriate strategies to a) enhance the positive influences and b) mitigate the negative influences of the learning environment on the professional development of medical students.
- 3.5 c The medical school and its clinical affiliates identify and promptly correct violations of professional standards in the learning environment.
- 3.5 d Student survey data show that the vast majority of respondents in years 1- 4 at each campus agree/strongly agree (aggregated) that the medical school fosters a learning environment in which all individuals are treated with respect, and that is conducive to learning and to the professional development of medical students.
- 3.5 e Student survey data show that the vast majority of respondents in years 3 and 4 at each campus agree/strongly agree (aggregated) that the medical school's clinical affiliates foster a learning environment in which all individuals are treated with respect, and that is conducive to learning and to the professional development of medical students.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

3.5a The DCI reports on collaboration between the medical school and its affiliates in the handling of regular reports from students. Each required learning activity is rated by students and low scores are investigated by faculty leaders. These evaluations are analyzed as part of the annual review of each course. There has also been a learner engagement survey through the Toronto Academic Health Sciences Network, which is analyzed in aggregate form. There is careful analysis of the AFMC-GQ. There is an active Toronto Academic Health Sciences Learning Environment Working Group, and documents were provided that demonstrated activity and work product of this working group.

This work is being further enhanced by the establishment of a Learner Experience Advisory Council (LEAC), chaired by the recently hired Director, Learning Experience, to develop strategies to qualitatively and quantitatively understand the experiences of medical students and post-graduate medical trainees.

3.5b The DCI describes examples of enhancing a positive element and mitigating a negative element:

The former involved the establishment of a duty hours working group to ensure that the standards (*Standards for call duty and student workload in the Clerkship*) were in place. When problems with compliance on the Medicine rotation were identified, they worked successfully to improve this performance, reducing the reported rate of non-compliance from 68/255 to 39/237 between 2013 and 2016.

The latter involved the identification of barriers to the reporting of mistreatment, which led to significant changes to the standards of professional behavior (*Standards of Professional Behaviour for Medical Clinical Faculty*) in the protocols for handling such issues. This work is ongoing. (See Element 3.6.)

3.5c The school has a well-defined protocol for the identification and correction of violations of professional standards.

3.5d e ISA (Appendix C-1) identified “excellent respect in the learning environment” as a core strength of the program. The students’ survey data (which asked students across all years about both the MD Program and the affiliated academy training sites/hospitals, together in the same survey questions) regarding the learning environment is generally very positive across all 4 years at each of the academies. Two questions were asked:

1. University of Toronto MD Program and affiliated academy training sites/hospitals foster learning environments conducive to learning and to the professional development of medical students; and
2. The University of Toronto MD Program and affiliated academy training sites/hospitals foster learning environments in which all individuals are treated with respect.

For the responses Agree/Strongly Agree, no score was below 81.6% for any year at any academy; scores at all four academies were generally above 90%, and there were four instances of scores of 100%, three from Year 1 students and one from Year 2 students.

3.5e See response to 3.5d. Agree/strongly agree scores from students in Years 3 and 4 ranged between 81.6% (the response by Year 4 students at Mississauga to statement #2; all other scores were > 88%) and 96.2%.

3.6 STUDENT MISTREATMENT

A medical school documents and publicizes its expectations of how medical students and visiting medical students should be treated by those individuals with whom they interact as part of the medical education program. These individuals include, but are not limited to, faculty members, physicians, residents, and other health professionals, other students, and administrative and support staff. The medical school develops written policies that address violations of these expectations, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing inappropriate behaviors. Mechanisms for reporting incidents of harassment or abuse are understood by medical students and visiting medical students and ensure that any incident can be registered and investigated without fear of retaliation.

Requirements

- 3.6 a The medical school has documented its expectations of how medical students and visiting medical students should be treated by those individuals with whom they interact as part of the medical education program.
- 3.6 b There are formal policies or procedures for responding to allegations of medical student and visiting medical student harassment or abuse including the venues for reporting and mechanisms for investigating reported incidents.
- 3.6 c Medical students and visiting medical students, residents, faculty responsible for required learning experiences and those who teach or assess medical students and other individuals who interact with students in the medical school or clinical environment are informed about the medical school's expectations of how medical students and visiting medical students should be treated while participating in the medical education programs.
- 3.6 d Mechanisms for reporting and investigating incidents of harassment or abuse protect students from retaliation.
- 3.6 e Medical students are informed of the procedures for reporting and investigating incidents of harassment or abuse.
- 3.6 f Student survey data show that the vast majority of respondents agree/strongly agree (aggregated) that they are aware of the school's policies regarding student harassment and abuse.
- 3.6 g Student survey data show that the vast majority of respondents agree/strongly agree (aggregated) that they know the procedures for reporting incidents of harassment or abuse.
- 3.6 h Allegations of medical student and visiting medical student harassment or abuse are investigated and resolved in a timely manner.
- 3.6 i Student survey data and other reports of medical student and visiting medical student harassment or abuse collected by the school are reviewed by individuals/committee(s) in the medical school and clinical learning environments with the authority to take steps to reduce the level of harassment or abuse while at the same time minimizing the likelihood of retaliation.
- 3.6 j The medical school monitors the reasons why students do not report harassment or abuse and has taken steps to reduce barriers to reporting.
- 3.6 k The medical school implemented appropriate educational activities aimed at reducing and preventing student harassment or abuse at instructional sites where mistreatment has occurred.
- 3.6 l Student survey data show that the level of student harassment and abuse are decreasing.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

3.6 a The school has a well-defined set of standards for professional behavior by medical clinical faculty with respect to their treatment of medical students (*Standards of Professional Behaviour for Medical Clinical Faculty*), which applies to all students including visiting students. These were updated in April 2020.

3.6 b The procedures for dealing with allegations of medical student and visiting medical student harassment or abuse are detailed in Appendix 3.6a2.

Faculty members seemed confident that a clear process was in place but the procedures they described did not correspond to those explained in the documents provided. Some departments reported that they have developed their own, parallel approaches to addressing student mistreatment that are not yet fully integrated with the new, central process. Some of this confusion may relate to the many recent efforts and programming to address this issue, with educational, awareness and socialization initiatives ongoing at the time of the site visit. (U)

3.6 c The DCI presents a narrative explaining how students and faculty are informed about the school's expectations in this area. Methods include inclusion in the Academic Calendar, email messages to medical students, MD Program teachers (including residents) and administrative staff. The ISA confirms high student awareness of these expectations.

3.6 d The school has well-defined mechanisms for reporting and investigating incidents of harassment or abuse that are intended to protect students from retaliation.

The *Student Mistreatment Protocol* draws a distinction between disclosure and reporting. Recent changes have been made in an effort to ensure that intake, disclosure of incidents, is safe for learners, and that students can speak with a trusted advisor in order to make a well-informed decision about whether or not to report the incident formally to the University. As outlined in the *Protocol*, it is not the role of the designated program leader to escalate, investigate, and/or resolve the case.

If a student decides to report an incident formally, then oversight of management of the process to review and find resolution to the complaint would involve the relevant department and hospital-based education leaders in collaboration with university leadership.

However, as noted in 3.6i below, the ISA indicates that students do not have a high level of confidence in the system. At the site visit, while students were aware of and appreciated the many efforts of the school to improve the system, there remained uncertainty about confidentiality and the possibility of retribution. Students were worried that complaints about someone in a specialty they were interested in would be prejudicial to their ability to pursue their career choice. According to both school leaders and faculty members, allegations of harassment are typically directed to a departmental Vice Chair of Education or the Vice President for Education in the relevant healthcare authority.

It was clear during the site visit that, while great effort is being made to correct the shortcomings of the previous system, this remains a work in progress and students did not feel safe from retaliation when reporting incidents of abuse or harassment. (U)

3.6 e Medical students are informed about the procedures for reporting through a variety of mechanisms. These include the academic calendar, the learning management system (Elentra), the Faculty's website, email, orientation sessions for incoming students and those beginning clerkship. There are mandatory sessions during clerkship which address this issue and all students are required to review a module on the website that discusses workplace violence/harassment. As noted elsewhere, the school's efforts to effectively address mistreatment,

while laudable, have created confusion for some students during this period of transition. (U)

3.6 f Appendix C-12 shows data from the AFMC GQ indicating that between 84.6% and 96.6% of students reported awareness of school policies in this area, in the last three years and across the four academies. This is mirrored in the ISA data (Appendix C-14), which shows generally high levels of awareness.

3.6 g In Appendix C-13, the GQ data show evidence that the percentage of students who know the school reporting procedures is variable. While the rate was 84.9% or higher in 2017, this declined to 52.5% at the Mississauga Academy and 66.7% at the FitzGerald Academy in 2019. The numbers at the other two academies were higher (73.8% and 73.2%) but also lower than in 2017. Of note, the rate in the Wightman-Berris Academy improved from 2018 when it was 45.8%. (U)

The data from the ISA (Appendix C-15) were generally more positive, although scores in Years 1 & 2 were generally below 60%. For year 4, the data were above 63% at all sites. Questions are raised in the narrative component of the ISA (Appendix C-1, page 46, *Accessibility*) regarding the effectiveness of the communication strategy employed. (U)

3.6 h According to the DCI, the school commits to immediate confirmation of submission of a Disclosure Form (DF), which is reviewed by the designated MD Program leader within 3 business days. All DF submissions are immediately notified to Director, Learner Experience. Each DF is reviewed and subsequent action determined on a case-by-case basis. The concerns of students, as expressed in the ISA narrative, relate to the possibly excessive speed with which less severe allegations are pursued, which may result in revealing the origin of confidential complaints.

3.6 i According to the ISA (Appendix C-1, ISA Appendix p. 122), 41.1% of students either strongly disagreed or disagreed with feeling comfortable reporting mistreatment. The level of disagreement was particularly high for year 4 students at the Mississauga Academy of Medicine (66.7%).

As a result of the acknowledgement that learners have not felt comfortable coming forward, the school has implemented changes to the intake of complaints in the new Protocol to ensure the safety of those who choose to discuss/disclose and report mistreatment.

Appendix C-16 provides information from the AFMC GQ on the rates of different forms of harassment or abuse experienced by students at each of the four academies over the last 3 years. At the time the DCI was written this information was reviewed by the Associate Dean, Health Professions Student Affairs, who is primarily responsible for their review. The data were analyzed by the Associate Dean in conjunction with the Vice Dean, MD Program, the Director of Evaluations and members of the student leadership.

Since April 2020, these issues are reviewed by the Director, Learner Experience; Associate Dean, Health Professions Student Affairs (HPSA); Academy Directors. Some disclosures are reviewed by the respective course director as part of the review process overseen by the Program Evaluation Committee. There is also an internal "Voice of the Student" survey, which is used to inform changes in the management of harassment or abuse. Specific examples are provided of how this was done in the past.

Nevertheless, at the time of the site visit academic leadership recognized that the "Narratives are disturbing and shocking; learners have not felt empowered to come forward." Despite the efforts of the school to address this issue, the site visit confirmed that students remain hesitant to provide feedback because of concerns about retribution. The effectiveness of the school's initiatives in addressing this remains to be determined by the collection of further data. (U)

3.6j As stated in the DCI, the Protocol for addressing incidents of discrimination, mistreatment and other unprofessional behaviours was revised over the 2018-2019 academic year with the intention to reduce barriers to reporting. The new protocol was approved by the MD Program Committee on March 17, 2020 and by Faculty Council on April 13, 2020. (SM)

3.6k In addition to orientation sessions, the Faculty has undertaken a number of specific events, which include a

“We All Belong” communication and awareness campaign launched in 2018, a concerted effort by the Vice Dean, MD Program to share learner mistreatment data with both school leadership and affiliated hospital partners, and a Physician Health Symposium held on June 11, 2019. There was a student-led Diversity in Medicine Conference for trainees in August 2019. The Vice Dean’s presentations are tailored to site/audience, so that site-specific issues are addressed.

Education and remediation is also provided at the level of the department, division, and/or individual faculty member when circumstances warrant. Explicit examples were provided for review by the team.

3.6l According to the AFMC GQ, the levels of student mistreatment have been generally stable (Peters-Boyd, Wightman-Berris) or rising slightly (FitzGerald, Mississauga). ISA data show that, by Year 4, 25.0% - 44.9% of students report having experienced mistreatment. (U)

STANDARD 4
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

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

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

4.1 SUFFICIENCY OF FACULTY

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

Requirements

- 4.1 a The medical school has a sufficient number and types of faculty members to deliver the medical education program at each campus.
- 4.1 b The directors of required learning experiences, hospital site directors, campus site directors (includes longitudinal integrated clerkship site directors) and the chair of the curriculum committee (or equivalent committee) have the appropriate amount of protected time (time with salary support or release from other responsibilities) to fulfill their responsibilities in the medical education program.
- 4.1 c The medical school anticipates faculty retirements and plans recruitment activities to minimize any negative impact on the delivery of the medical education program at each campus.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

<p>4.1a The school has a very large faculty covering all pertinent disciplines. In the 2018-2019 year, the DCI reports 1449 basic science faculty and 7331 clinical faculty. According to the DCI, 2739 are active in the medical education program, primarily in the departments of Family Medicine (726), Medicine (580), Surgery (259), Pediatrics (239), Psychiatry (235) and Obstetrics and Gynecology (192). The DCI provides extensive detail on the composition of each department or unit, as well as its role within the MD Program, if any.</p> <p>4.1b Protected time is offered to the various directors of learning experiences, in a manner which appears to align with the level of responsibility. According to Appendix C-19, this ranges from 0.1 to 0.5 FTE. At the site visit, faculty members and school leaders reported adequate protected time.</p> <p>4.1c Specific information was provided at the site visit regarding faculty retirements and recruitment plans. Faculty members and school leaders reported no difficulty in identifying successors for any position in the MD Program given the size of the faculty complement. There is intentional succession planning for educational leadership roles.</p>

4.2 SCHOLARLY PRODUCTIVITY

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

Requirements

- 4.2 a The scholarly productivity (articles in peer-reviewed journals, published books/book chapters, co-investigators or PIs on extramural grants, or other peer-reviewed scholarship) of the medical school's faculty, as a whole, over the last three years is consistent with its research/scholarly mission and characteristic of an institution of higher learning.
- 4.2 b The medical school fosters and supports faculty members' development as scholars by appropriate means.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

4.2a The total scholarly productivity of the Faculty of Medicine of the University of Toronto is the highest in Canada and among the highest in the world. This is confirmed by a review of the synopsis of the research activities provided by the school for the team's review. The Faculty lists 1922 funded principal investigators in 2018.

4.2b The Faculty has well defined procedures for appointments, recruitment and promotions. These were reviewed by the team and are listed on the Faculty's website. The Faculty has a Research and Innovation Office under the direction of a Vice Dean which, as reported in the DCI, provides a variety of services. The Faculty website has many links to relevant support including guides for new researchers, funding opportunities, grant development, core facilities and ethics issues. There is also support at the level of the Toronto Academic Health Science Network, which maintains a research committee. Information in the DCI also refers to a variety of initiatives at the department level to encourage and promote the scholarly careers by appropriate means.

4.3 FACULTY APPOINTMENT POLICIES

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

Requirements

- 4.3 a The medical school’s or university’s policies and procedures for faculty appointment, renewal of appointment, promotion, granting of tenure, remediation, and dismissal are clear.

- 4.3 b Each faculty member is given written information about his or her term of appointment, responsibilities, lines of communication, privileges and benefits, performance evaluation and remediation, terms of dismissal, and if relevant, the policy on practice earnings.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

<p>4.3a The school has clear policies and procedures governing academic appointments for clinical faculty and for regular appointments. There is also clear policy related to promotions. These policies are available on the Faculty’s website and include all pertinent information regarding academic appointments.</p> <p>4.3b The policies and procedures governing academic appointments are outlined in the policies noted above. Each faculty member receives a letter from the Department Chair indicating their privileges, benefits and responsibilities. Example appointment letters were provided and reviewed by the team. Based on the information provided and available through the university website, expectations for performance as well as the manner of its evaluation are well defined. The site visit confirmed that faculty have annual evaluations. The site visit team was told that at all sites teaching is considered an element of their job description along with clinical work and serves as part of the annual evaluation and promotion process.</p>
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4.4 FEEDBACK TO FACULTY

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

Definitions taken from CACMS lexicon

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

Requirements

- 4.4 a A faculty member, consistent with the terms of his or her appointment, receives regular and timely feedback from departmental and/or educational program or university leaders on his or her academic performance, and, when applicable, progress toward promotion or tenure.
- 4.4 b The provision of feedback on academic performance to faculty members is monitored to ensure it occurs.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

4.4a The school has a well-established system for appointment review and feedback. This includes a formal three-year review after appointment, which includes education as a criterion. Faculty also receive feedback from students through standardized teacher evaluation forms as well as feedback from department chairs. Completion of annual reviews is mandatory to maintain both university and hospital appointments.

4.4b The Office of Assessment and Evaluation of the MD Program is specifically tasked with preparing feedback reports. The DCI states that beginning in the 2018-19 academic year, departmental chairs are required to submit a report of the actions taken for each member of the department flagged as being below the 10th percentile. This report is submitted to the Vice Dean, MD Program and the Director of Program Evaluation.

4.5 FACULTY PROFESSIONAL DEVELOPMENT

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

Definition taken from CACMS lexicon

- *University: The university or universities of which the medical school is a part.*

Requirements

- 4.5 a There are individuals with the requisite expertise and time who assist faculty in improving their teaching and assessment skills.
- 4.5 b The medical school identifies faculty development needs.
- 4.5 c Faculty at all instructional sites and all campuses are informed about and have access to faculty development activities.
- 4.5 d When problems are identified with the teaching or assessment skills of a faculty member, the faculty member is provided with support to remediate the deficiencies.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

4.5a The MD Program has a dedicated Office of Faculty Development. According to its website, it provides a variety of services to support teachers in the MD Program. According to the DCI, there is a full-time director who reports to the Vice Dean, MD Program and works with senior leaders, including the Foundations and Clerkship Directors, course directors, theme, and component leads. There is a test committee supporting faculty members who development assessment tools. In addition, the University has a Centre for Faculty Development (CFD). The MD Program's faculty development director collaborates with the University's CFD. The university also supports a Centre for Teaching Support and Innovation (CTSI) as a central resource, which provides access to experienced teaching faculty who can serve as consultants. According to its website, the CTSI also provides opportunities for self-guided learning and course design events or webinars. These resources are typically supplemented by additional resources in departments. Faculty who met with the site visitors uniformly commented on the high quality and quantity of faculty development materials.

4.5b According to the DCI, the director of the Office of Faculty Development works in collaboration with senior leaders of the MD Program to identify faculty needs. Once needs are identified, the Office works to identify the necessary resources. Needs are reassessed annually. The Director of the Office also participates on a number of course, MD Program and departmental committees. The DCI provides a specific example of how this works in practice citing the development of the first year of the Foundations Curriculum. After a consultation process, gaps in terms of faculty knowledge, skills and attitudes were identified. This analysis formed the basis for the focus and objectives of the faculty development sessions and helped determine the appropriate teaching modality.

4.5c) Faculty members involved in teaching in the MD Program are informed of the availability of faculty development opportunities by emails, promotional flyers and direct communication from course directors and other curriculum leads. Input from site directors and Academy coordinators is used to create programs tailored to local needs. Faculty development activities are held at both campuses and all four academies.

4.5d There are several ways in which the difficulties pertaining to an individual faculty member are identified by the MD Program. These include self-identification, input from course directors and input from chairs or clinical site chiefs. Several modes of remediation are available, including meeting with senior colleagues for mentoring or

input, referral to specific faculty development activities or, in severe cases, meeting with the course director to work out a specific remediation plan. The latter may also involve a meeting with the director of the Office for Faculty Development for consultation. Significant behavioural issues are dealt with by higher authorities, usually the Department Chair and the Vice Dean, MD Program.

As noted in 4.4b, beginning in the 2018-19 academic year, departmental chairs are required to submit a report of the actions taken for each member of the department flagged as being below the 10th percentile in academic performance. This report is submitted to the Vice Dean, MD Program and the Director of Program Evaluation.

4.6 GOVERNANCE AND POLICY-MAKING PROCEDURES

The dean and a committee of the faculty at a medical school determine the governance and policy-making procedures of the medical education program.

Requirements

- 4.6 a There is a committee or other similar medical school leadership group responsible for working with the dean to determine the governance and policy-making procedures of the medical education program.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

According to the DCI and information available on the Faculty website, the school has a well-defined governance structure with respect to the MD Program. Within the program there is an Executive Committee and a Curriculum Committee both of which have well defined roles. At the Faculty level there is a Dean's Executive Committee as well as the Faculty Council, which have roles in oversight of the program.

STANDARD 5
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 5: EDUCATIONAL RESOURCES AND INFRASTRUCTURE

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

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.

Requirements

- 5.1 a The trends in past and present financial resources of the medical school indicate that they are stable and adequate to sustain the medical education program and to accomplish other goals of the medical school.
- 5.1 b The anticipated financial resources of the medical school appear to be adequate to sustain the medical education program and to accomplish other goals of the medical school.
- 5.1 c If there is an anticipated decrease in the financial resources of the medical school, there is a plan to address the shortfall.
- 5.1 d The dean engages in effective financial planning that addresses the operating budget, current and projected capital needs and financing deferred maintenance of medical school facilities.
- 5.1 e The key findings resulting from an external financial audit are consistent with the other financial data provided by the medical school and indicate that the medical school has adequate operating funds.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

<p>5.1a Based on the table of Revenues/Expenditures (Appendix C-20) there is an upward trend in in operating revenues over the least three fiscal years. The university allocation, which is the largest source of operating revenue, increasing from \$94.9 million in 2016-17 to \$109 million in 2018-19.</p> <p>5.1b It is projected that Faculty operating funds will increase by 2.3% from 2019-2020 to 2022-2023 while research revenues will remain stable. Debt service payments will decrease from \$2.2 million in 2019-2020 to \$2.1 million in 2022-2023.</p> <p>5.1c There is not anticipated to be any decreases in the financial resources of the medical school. The school recently received a gift of \$250M from the Temerty Foundation, which is expected to be realized over the next seven years.</p> <p>5.1d By reviewing and approving all revenue/expense budgets for every academic and administrative unit in the Faculty of Medicine, the Dean has full authority over the Faculty budget. Capital needs and maintenance of</p>
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medical school facilities are addressed through the Department of Facilities Management and Space Planning (FMSP) with review and approval by the Dean and the central University's departments of Academic and Campus Events, Campus Planning, Facilities and Services and Project Management. These central University's departments, with input from the FMSP, also manage deferred maintenance of medical school facilities.

5.1e The MD Program and the Faculty of Medicine do not have separate audited financial statements from those of the University of Toronto. The University of Toronto's audited financial statements are provided which indicate increasing annual revenues, increasing expenses and increasing net income for the university as a whole for the time period 2016-2019.

5.2 DEAN'S AUTHORITY/RESOURCES

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

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.2a The Dean has authority for the budget of the Faculty of Medicine as a whole and has delegated budgetary responsibility for the MD Program to the Vice Dean, MD Program. The Vice-Dean represents the MD Program in the annual budget review and approval process within the Faculty of Medicine.

5.2b The Vice Dean, MD Program acts as the Chief Academic Officer (CAO) for the MD Program and has a 60% FTE position to fulfill these administrative duties. The Vice-Dean, MD Program serves on the Dean's Executive Committee, All Chairs Committee, Basic Sciences Chairs Committee and Clinical Chairs Committee. She is also a member of the Faculty of Medicine Faculty Council, the Faculty of Medicine Education Committee and the Academy Directors Committee. She chairs the MD Program Executive Committee, co-chairs the MD Program Curriculum Committee and is an *ex officio* member of the subcommittees of the Curriculum Committee.

5.2c The Vice-Dean, MD Program submits an annual budget with a five-year projection for revenues and expenses. By being a member of the Dean's Executive Committee – which meets weekly and has overarching responsibility for strategic planning, financial management, and space and resource infrastructures needed to deliver the mandate of the Faculty of Medicine as a whole – the Vice-Dean has the ability to ensure there are adequate resources for the MD Program.

5.2d There are 79 individuals, both faculty and administrative leaders, with FTE's ranging from 0.025 to 1.0, who report directly or indirectly to the Vice Dean, MD Program to support the delivery and evaluation of the MD Program.

5.2e There is a broad diversity of personnel with FTE's ranging from 0.025 to 1.0 who support the planning, implementation, evaluation of the curriculum and student assessment. The protected time has been negotiated with the faculty members' departments. During the site visit, faculty members reported have sufficient protected time.

5.2f Funds in the annual budget are distributed by the Dean to individual departments for their contributions to teaching in the MD Program. The Chief Administrative Office, Chief Financial Officer, Vice Dean, MD Program and MD Program Operations Director meet quarterly to ensure that the MD Program needs are being met.

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.

Requirements

- 5.3 a In setting the size of the medical school entering class, medical school resources, such as space, faculty numbers, and teaching responsibilities are taken into account such that the quality of educational program is not compromised.
- 5.3 b The pressures to generate revenue from tuition, clinical care, and/or research are managed to ensure the ongoing quality of the medical education program.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.3a The size of the medical school entering class is determined by a formal process, initially determined by the Ontario Ministry of Training, Colleges and Universities in cooperation with the Ministry of Health and Long-Term Care. The Dean, with MD Program leadership then submits an enrolment plan to the University of Toronto which takes into account teaching and space capacity.

5.3b Supernumerary seats are capped and the percentage of incoming students without government funding has been 1.5% or less. Supernumerary tuition sources are not a significant source of funding for the MD Program. Full time clinical faculty have practice plans which provide compensation for both clinical work and academic duties. Part time clinical faculty receive teaching stipends. During the visit faculty reported that, contrary to any pressure to support the clinical mission, they are sometimes actively encouraged by their departmental leaders to reduce their clinical commitments to ensure their ability to meet educational and/or other scholarly commitments.

5.4 SUFFICIENCY OF BUILDINGS AND EQUIPMENT

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

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.4a At the St. George Campus, the MD Program has priority for the scheduling of space. At the University of Toronto Mississauga site, the ample space is now shared with the Occupational Therapy program and the priority is shared. No challenges have been identified in scheduling teaching space at either campus.

5.4b There is a centralized office for scheduling at the St. George Campus called Academic and Space Events (ACE). No recent scheduling challenges at either campus have been identified.

5.4c The current incoming class size has not increased over that of 2011-2012. Slight year-to-year fluctuations have not been large enough to impact the need for teaching space.

5.4d There is no anticipated increase in the incoming class for the next three years.

5.4e There are multiple research sites for research that support the research mission of the medical school including: Medical Sciences Building which includes Central Sterilization Services, Combined Containment Level 3 Unit; Diet, Digestive Tract & Disease Facility; the Division of Comparative Medicine; Faculty of Medicine Flow Cytometry Facility; Microscopy Imaging Lab; and MedStore. Extensive clinical research facilities are available and utilized by virtue of the clinical faculty who are located at the sites of the Toronto Academic Health Science Network (TAHSN).

5.4f The vast majority of students (mostly 90% and higher) were satisfied/very satisfied with the adequacy of

lecture halls and large group classroom facilities at each campus of the medical school. More than 80% at both campuses were satisfied/very satisfied with the adequacy of small group teaching space with the exception of Years 1 and 4 at Peters-Boyd (75.85; 74.0%). Students at this Academy report that some of this dissatisfaction is due to the additional travel time required to reach some of the Peters-Boyd sites.

As stated in the ISA, student satisfaction (*satisfied/very satisfied*) with the adequacy of space for clinical skills teaching at all sites was well above 90% for all years, except for Year 2 FitzGerald, where it was 89.5%.

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).

Requirements

- 5.5 a There are appropriate resources for the clinical instruction of medical students in ambulatory and inpatient settings, including numbers and types of patients.
- 5.5 b Student survey data show that the vast majority of respondents at each campus agree they had sufficient access to the variety of patients and procedures required for the encounter log in the required clinical learning experiences listed in the survey.
- 5.5 c Student survey data show that the vast majority of respondents at each campus are satisfied with the adequacy of space in ambulatory care clinics used for required clinical experiences.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.5a Each required clerkship rotation has multiple inpatient teaching facilities. There are combinations of university-affiliated hospital and community-affiliated hospital ambulatory teaching sites. The one exception is the psychiatry rotation at the Mississauga site which only uses the community-affiliated hospital ambulatory clinic. By using a Case Log system, the Clerkship Committee is able to ensure the required number and types of clinical encounters. No concern has been noted about finding placements for students in ambulatory settings.

5.5b AFMC GQ from 2019 found that most students (over 90%) agreed or strongly agreed that they had “sufficient access to the variety of patients and procedures required” across clerkship rotations and academies. The lowest agreement score (87.2%) was in Family Medicine at Peters-Boyd. There was 100% agreement in Family Medicine at both FitzGerald and MAM, and in Psychiatry at Wightman-Berris. This level of satisfaction has remained high over the last three years.

ISA data (Appendix C-1) confirm that students had sufficient access to the variety of patients and procedures required to complete the Case Logs. In Year 3, agreement ranged from 83.9% in Surgery at Wightman-Berris Surgery to 100% in several rotations and academies.

5.5c ISA data identified high satisfaction with space in ambulatory care clinics among students of all years. FitzGerald students report 88.4% to 98.0% satisfaction; Peters-Boyd students report 92.2% to 97.8%, and Wightman-Berris students report 91.4% to 97.2% satisfaction. Mississauga Academy of Medicine (MAM) Year 2 reported 77.4% satisfaction while using the same facilities as Year 1 students (83.3% satisfaction), Year 3 students (100% satisfaction), and Year 4 students (89.6%). During the visit, MAM students in all years reported satisfaction with the adequacy of space ambulatory care clinics.

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.

Definition taken from CACMS lexicon

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

Requirements

- 5.6 a There are sufficient information resources and instructional facilities at the key clinical facilities used for required clinical learning experiences.
- 5.6 b Student survey data show that the vast majority of respondents are satisfied/very satisfied (aggregated) with the space used for clinical skills teaching and education/teaching space (conferences, rounds, academic half-days) at clinical facilities used for required learning experiences at each campus.
- 5.6 c Student survey data show that the vast majority of respondents are satisfied/very satisfied (aggregated) with access to information resources (computers and internet) at clinical facilities used for required learning experiences at each campus.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.6a The faculty leadership oversee the annual completion of a Clinical Site Checklist, which ensures that each site has sufficient teaching space and access to information technology resources. Student evaluations of required courses have identified no major problems with information resources or instructional facilities at the anchor clinical facilities associated with each academy.

5.6b ISA data (Appendix C-1) found high student satisfaction with academy-based education/teaching space in all academies and years: FitzGerald 97.7% to 100%; MAM 87.5% to 97.9%; Peters-Boyd 88.7% to 100%; Wightman-Berris 92.8% to 100%).

5.6c ISA data (Appendix C-1) found high student satisfaction with accessibility of information resources at academy-based facilities: FitzGerald 94.7% to 98.1%; Peters-Boyd 88.7% to 96.5%; Wightman-Berris 87.7% to 95.8%. Satisfaction at MAM was more variable: Year 1 - 74.1%; Year 2 - 87.5%; Year 3 - 97.8%; Year 4 - 93.8%. Students in the MSS indicated that this may be due to the fact that Wi-Fi access at those clinical facilities involved extra steps of which the Year 1 students may not yet have been fully aware.

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.

Requirements

- 5.7 a There are security systems in place to ensure student safety in each of the following situations:
- i. on campus during regular classroom hours
 - ii. on campus outside of regular classroom hours
 - iii. at clinical teaching sites used for required learning experiences
- 5.7 b There are protections available to medical students at instructional sites that may pose special physical dangers (e.g., during interactions with potentially violent patients).
- 5.7 c The medical school's or university's policies and procedures to ensure student safety are communicated to students and faculty.
- 5.7 d The medical school or university has disaster preparedness policies, procedures, and plans that are communicated to students, faculty and staff.
- 5.7 e Student survey data show that the vast majority of respondents are satisfied/very satisfied (aggregated) with the adequacy of safety and security at all instructional sites.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

5.7a There are adequate security systems in place on campus during and outside regular classroom hours as well as at clinical teaching sites. These include a combination of programmed access to buildings, 24/7 patrol, campus police, video surveillance, perimeter security alarms and restricted card access.

5.7b Students are provided training on potentially unsafe patient encounters during the Transition to Clerkship Course and at the start of the Emergency Medicine rotation. In addition to the safety and protection provided to all staff at clinical sites, the students are also provided personal alarms and panic buzzers during their psychiatry rotation.

5.7c Policies and procedures for safety are communicated to students by way of the Academic Calendar and the faculty website. An email message reminding the students to submit a statement of acknowledgement and confirmation that they have reviewed the Academic Calendar is an MD student registration requirement.

5.7d The policy for disaster preparedness is communicated by the Academic Calendar, which the students must acknowledge and confirm that they have reviewed.

5.7e ISA data (Appendix C-1) found that the vast majority of students, ranging from 92.9% to 100%, are satisfied with safety and security at all instructional sites.

5.8 LIBRARY RESOURCES / STAFF

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

Requirements

- 5.8 a The library staff are familiar with regional and national information resources and data systems to extend library access to information resources for the medical school.
- 5.8 b Library staff support the medical education program by being involved in curriculum planning; participation in the curriculum committee or its subcommittees; or in the delivery of any part of the medical education program.
- 5.8 c Medical students and faculty have access to electronic and other library resources across all instructional sites both on and off campus(es).
- 5.8 d Student survey data show that the vast majority of students at each campus are satisfied/very satisfied (aggregated) with the ease of access to the library resources and holdings (includes virtual access both on and off campus).
- 5.8 e Student survey data show that the vast majority of students at each campus are satisfied/very satisfied (aggregated) with the quality of library support and services.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.8a University of Toronto Libraries (UTL) librarians are current on available information resources and data systems. For complex questions there are GIS analysts and a statistical support specialist employed at the Maps and Data Library (part of UTL) who specialize in providing support for finding and using data and statistics. The Gertstein (GSIC) and Mississauga (UTM) libraries are members in the University of Toronto's network of 41 libraries that offer a free interlibrary loan service for print materials.

5.8b A librarian participates in curriculum planning, curriculum development, educational material development and teaching as the Information Literacy Theme Lead. Information Literacy is taught and assessed in the MD Program in various areas across all four years. The librarian also attends other committees as needed including: Health Science Research Committee, Curriculum Committee, Transition to Clerkship Committee.

5.8c Medical students and faculty have remote access to electronic and other library resources both off and on campus.

5.8d ISA data show that more than 89.6% of all students were satisfied/very satisfied with their ease of access to the library resources, across all years and academies. Most scores were over 93% and the aggregate score for all students was 96.8%. The least satisfied students were in Year 2 at MAM, at 89.6%.

5.8e ISA data show that more than 84.6% of all students were satisfied/very satisfied with the quality of the library support and students, across all years and academies. Most scores were over 95% and the aggregate score for all students was 97.2%. The least satisfied students were in Years 1 & 2 at MAM (84.6%; 87.1%).

5.9 INFORMATION TECHNOLOGY RESOURCES / STAFF

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

Requirements

- 5.9 a There is a wireless network in classrooms and study spaces at each campus or there are adequate internet access points in large classrooms, small group classrooms and student study spaces.
- 5.9 b Information technology resources are sufficient in scope to support the educational program, including meeting the needs for distributed education.
- 5.9 c The IT services staff members support the medical education program in at least one of the following ways:
- i. being involved in curriculum planning and delivery.
 - ii. assisting faculty in developing instructional materials.
 - iii. assisting in developing or maintaining the curriculum database or other curriculum management applications; or
 - iv. assisting faculty to learn to use the technology for distance education.
- 5.9 d Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with access to computers and the internet at the medical school.
- 5.9 e Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with:
- i. ease of access to electronic learning materials.
 - ii. adequacy of wireless network in classrooms.
 - iii. study spaces in the medical school.
 - iv. availability of electrical outlets in teaching and study space at the medical school.
 - v. adequacy of audio-visual technology used to deliver educational sessions (e.g., lectures, academic half-days).

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.9a There is a wireless internet network on each campus, and it is available in all classrooms and study spaces.

5.9b The MD Program utilizes information (IT) resources for curriculum planning, delivery, developing instructional materials, curriculum management and supporting faculty. There are 15.5 FTE staff that provide IT services used by the MD Program, of which 5 FTE supporting videoconferencing.

5.9c The Discovery Commons (DC), the Faculty of Medicine IT service, is engaged in planning and delivery of curriculum, the production of instructional materials, curriculum mapping and videoconference for distance education.

5.9d Based on the AFMC GQ 2017-2019 data, the average student satisfaction for access to computers was more than 90% for students at all sites. Access to the internet from the same survey found an average satisfaction of more than 93% for students at all sites. The lowest satisfaction for any one site was above 80% for access to

computers and the internet.

5.9e The vast majority of students, an average of more than 80%, were satisfied with ease of access to electronic learning materials, adequacy of wireless network in classrooms, study spaces in the medical school, availability of electrical outlets in teaching and study space at the medical school, adequacy of audio-visual technology used to deliver educational sessions. The exception to this was at Wightman-Berris, where the students were less satisfied (71.1%-84.9%) with regards to the adequacy of wireless networks.

5.10 RESOURCES USED BY TRANSFER / VISITING STUDENTS

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

Requirements

5.10 a The medical school has a process that ensures its resources are adequate to support students already enrolled in its medical education program and i) transfer students and ii) visiting students that are accepted.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The MD Program does not admit transfer students into any year of the program. Visiting students for electives are accepted based on capacity, which is ensured through defined electives application processes.

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.

Definition taken from CACMS lexicon

- *Campus: An instructional site that offers a complete pre-clerkship academic year.*

Requirements

- 5.11 a Adequate study space is available at each campus and affiliated clinical site. If study space is not available in the medical school at a campus, or in an affiliated clinical facility, study space is available to students at another accessible location.
- 5.11 b Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with the adequacy of student study space at the medical school.
- 5.11 c Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with the adequacy/availability of relaxation space at the medical school.
- 5.11 d Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with storage space at the medical school.
- 5.11 e In required clinical learning experiences in which students are required to stay overnight, secure on-call rooms are available for their use at each campus.
- 5.11 f Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with on-call rooms for required clinical learning experience.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.11a Both campuses and all hospital teaching sites have small rooms for group study and space for individual study when not occupied.

5.11b The 2019 AFMC GQ indicated that at least 89.7% all students were satisfied/very satisfied with their study space at the medical school campus. The 2019 ISA identified that the lowest satisfaction rate of 76.8% was noted for Year 3 students at the FitzGerald Academy.

5.11c The 2019 AFMC GQ indicated that at least 81.6% of all students were satisfied/very satisfied with their relaxation space at the medical school campus. The 2019 ISA identified that the satisfaction rate of 75.8% was noted for Year 1 students at the Wightman-Berris Academy, 75.5 % for Year 1 students at the FitzGerald Academy and 74.5 % for Year 4 students at the FitzGerald Academy.

5.11d The 2019 AFMC GQ found that students from all years were satisfied/very satisfied with adequacy of secure storage space in the medical school buildings. The exception was Year 4 students from FitzGerald Academy (79.6%). The 2019 ISA found that students from all years and academies were satisfied/very satisfied with adequacy of secure storage space at clinical sites. The exception was Year 3 students from the Peters-Boyd Academy (79.2%).

5.11e In required clinical learning experiences in which students are required to stay overnight, secure on-call rooms are available for their use at each hospital.

5.11f In the 2019 ISA, it was noted that most students (84.0%-94.1%) were *satisfied/very satisfied* with on-site call rooms for required clinical learning experiences. The exceptions were Year 3 and 4 students from Wightman-Berris Academy (78.9% and 74.0%, respectively).

5.12 REQUIRED NOTIFICATIONS TO THE CACMS

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

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

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

Definition taken from CACMS lexicon

- *Campus: An instructional site that offers a complete pre-clerkship academic year.*

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

5.12a Since 2012, the medical school has not increased the number of medical students admitted to the program above a threshold of 10 percent on any campus or 15 medical students in one year or 20 percent in three years, without notifying CACMS. Small increases in admission numbers over recent years have decreased again, such that the incoming class in 2019 was smaller than in 2012. The student body as a whole has increased about 8% since the last visit.

5.12b The MD Program did a major reorganization of one of more years of the program with the introduction of the Foundations Curriculum (pre-clerkship – Years 1 and 2). The MD Program notified CACMS, and the transmittal letters were provided and reviewed by the team.

The MD Program also initiated a trial Longitudinal Integrated Clerkship, which has since been discontinued. The relevant transmittal letters regarding the introduction of the LInC were provided and reviewed by the team.

STANDARD 6
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 6: COMPETENCIES, CURRICULAR OBJECTIVES, AND CURRICULAR DESIGN

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

6.1 PROGRAM AND LEARNING OBJECTIVES

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

Definitions taken from CACMS lexicon

- *Learning objectives: Statements of what medical students are expected to be able to do at the end of a required learning experience (see lexicon).*
- *Medical education program objectives: Statements of what medical students are expected to be able to do at the end of the educational program i.e., exit or graduate level competencies.*
- *Required learning experience: An educational unit (e.g., course, block, clerkship rotation or longitudinal integrated clerkship) that is required of a student in order to complete the medical education program. These educational units are usually associated with a university course code and appear on the student's transcript. Required learning experiences are in contradistinction to electives, which are learning experiences of the student's choosing.*

Requirements

- 6.1 a The medical education program objectives are framed in competency-based terms.
- 6.1 b The medical education program objectives were reviewed and revised at least once since the time of the last full site visit and approved formally by appropriate key committees of the medical school.
- 6.1 c The medical education program objectives are linked to the relevant specific physician competency.
- 6.1 d The medical school has selected appropriate and sufficiently specific assessment methods/instruments to measure medical students' progress in developing the required competencies throughout the medical education program i.e., meeting the medical education program objectives.
- 6.1 e The medical education program objectives are made known to all medical students and faculty members with leadership roles in the medical education program and others with substantial responsibility for medical student education and assessment.

- 6.1 f The learning objectives of each required learning experience are made known to all medical students and those faculty, residents and others with teaching and assessment responsibilities in those required learning experiences.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

- 6.1a The 28 medical education program objectives are framed in competency-based terms
- 6.1b The medical education program objectives were approved in 2016. Revisions were approved in June 2019.
- 6.1c The medical education program objectives are aligned with the relevant individual CanMEDs physician roles.
- 6.1d The data in the DCI and the accompanying narrative demonstrate that the school uses a system to select appropriate and sufficiently specific assessments to ensure that students meet program objectives.
- 6.1e Strategies are described for orientation of medical students, faculty leads and others with substantial responsibility to the medical education program objectives. These strategies hinge on the publication of the Academic Calendar but do include specific orientation sessions and communications to all these groups/group members. For students, the Competency Framework which includes the key competencies /program objectives are entwined in progress monitoring through the MD Program Learner Chart.
- 6.1f The learning objectives for each required learning experience are available to all medical students and those faculty, residents and others with teaching and assessment responsibilities in those required learning experiences. through the course sites on the Elentra platform. An updated report confirmed that learning objectives are made known to lecturers and seminar leaders through a variety of distribution methods.

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.

Requirements

- 6.2 a The faculty has described each patient type, clinical condition, required procedure and skill, and the clinical setting in which they take place for each required clinical learning experience, including for a longitudinal integrated clerkship if offered.
- 6.2 b For each required patient encounter and procedural skill, the faculty has made explicit the required level(s) of student responsibility in each required clinical learning experience, including in a longitudinal integrated clerkship if offered.
- 6.2 c The list of required patient encounters and procedural skills was reviewed and approved by the 'curriculum committee' or other appropriate oversight committee for relevance and comprehensiveness.
- 6.2 d The faculty expect that students have the majority of required patient encounters with real patients keeping in mind patient safety.
- 6.2 e Alternative experiences (e.g., standardized patients, simulations, virtual patients) have been developed for the required patient encounters that are rare, severe or seasonal.
- 6.2 f Medical students, faculty, and residents are informed of the required patient encounters and procedural skills in each required clinical learning experience in which they participate.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

6.2a A chart with clinical condition and required procedure and skill for each of the required clinical rotations has been provided as a supplementary document with multiple rotation-based tables rather than in the DCI table. The tables indicate for the clinical condition/patient encounters, the numbers of such encounters and whether the encounter has to be with a 'real patient'. The majority of these stipulate the requirement for an encounter with a 'real' patient. As stated in the DCI, 'the clinical setting is generally implicit given that the lists are course-based, and courses typically have specific settings.'

6.2b The expectations on the students re: level of responsibility for each of the procedures for each rotation is outlined. Of the 56 separate procedures or skills included, less than half (23 or 41%) require the student to *perform* the skill/procedure rather than *observe* or *participate* (perform with assistance or assist someone). Ten of the 47 procedures/skills are observation only (17%). There is variability among rotations relating to expectations upon students for these procedures/skills. Of the eight psychiatry related skills, none of them are requiring the student to perform independently. Of the six ER skills, all of them require the student to perform independently [Psychiatry 0/8; Emergency Medicine 6/6; Obstetrics/Gynecology 1/9; Family Medicine 3/4; Surgery 1/5; Ophthalmology 3/4; Anesthesia 11/13; Pediatrics 2/2; Med 3/5, ENT 1/2]. For a given skill, the level of responsibility may differ between rotations. An example of this is for suturing, where one rotation specified *participation* whereas another specified *independent performance* of the skill.

6.2c The list of required patient encounters/procedural skills are reviewed within course teams, then go through a review and approval process in Clerkship Committee. There is a policy (reviewed by the team) detailing the rationale, process, and procedures around the logging of these required patient encounters/procedural skills. This policy does not

include the individual patient encounter/procedural skills lists. As the DCI states, changes to the policy are approved annually by Curriculum Committee; it was confirmed during the visit that this also refers to changes in the 6.2 list itself.

6.2d The expectation as outlined in the *Tables of patient encounters* is that the majority of patient encounters are with real patients. In the rotational tables provided in the DCI there is some variability between rotations in requirements for 'real patients' but at least 80% of required encounters and 80% of required procedures overall must be completed with real patients. Some Case Logs in some rotations are flagged as "Must be Real".

6.2e Appropriate alternatives (e.g., simulation, simulated cases, other clinical opportunities) are available when a student is unable to experience a required clinical encounter with a real patient. These alternatives and the monitoring/follow-up process used were described in the DCI.

6.2f Medical students and residents are informed of the required patient encounters and procedures associated with each rotation. For medical students this is within their transition to clerkship course and also within rotational orientations. There is a mid-rotation review of these requirements and achievements. Residents are informed through their program directors with PGME support.

6.3 SELF-DIRECTED AND LIFE-LONG LEARNING

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

Requirements

- 6.3 a There are learning sessions in required learning experiences in the first two years of the curriculum where in the context of a clinical case, students engage in all of the following components of self-directed learning as a unified sequence:
- i. identify, analyze, and synthesize information relevant to their learning needs
 - ii. assess the credibility of information sources
 - iii. share the information with their peers and tutor/facilitator
 - iv. apply their knowledge to the resolution of the clinical case
 - v. receive feedback and are assessed on their skills in self-directed learning
- 6.3 b There is sufficient scheduled time in the first two years of the medical education program for self-directed learning sessions described in **6.3 a**, to allow students to develop the skills for self-directed learning.
- 6.3 c The faculty ensures there is time for independent study in the first two years of the program.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

6.3a The DCI narrative includes a description of CBL sessions which are scheduled for two half days per week, one half day being student led and the other faculty led. Documentation was provided to demonstrate how each of the five sequential steps required for this element are met.

6.3b There is dedicated time of two half days (2x3 hours) per week as indicated in sample schedules for CBL for both Years 1 and 2 (Appendix C-23).

6.3c As represented in the sample schedules (Appendix C-23), there is an additional one day per week which is reserved for "self-learning". (20%).

The ISA reports that 86% of students were *satisfied/very satisfied* with time spent in educational activities pre-clerkship. (See element 8.8.)

6.4 OUTPATIENT / INPATIENT EXPERIENCES

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

Requirements

- 6.4 a Medical students spend time as appropriate in a) outpatient (ambulatory) and b) inpatient settings to meet the learning objectives of each required clinical learning experience.
- 6.4 b Student survey data show that the vast majority of respondents agree/strongly agree (aggregated) that, when presented with a variety of patients, they have the knowledge and skills to a) care for patients in a hospital setting and b) care for patients in an ambulatory setting.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

6.4a Data indicate that students at all sites spend time of varying percentages in outpatient and inpatient settings as appropriate to meet their learning objectives. The students identify greater variability in the outpatient psychiatry opportunities according to site, with Peters-Boyd Academy students spending 3-8% of their time in OPD, compared to Mississauga Academy students spending 50% of their time in Ambulatory experiences. They report that these differences have both advantages and disadvantages, according to their particular interests, but all agreed that they were able to meet their learning objectives regardless of site.

6.4b Student survey data indicated 95-100% of students from all sites agreed/strongly agreed that, when presented with a variety of patients, they have the knowledge and skills to care for patients in both hospital and in ambulatory settings.

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.

Requirements

- 6.4.1 a The curriculum provides each medical student with broad exposure to, and experience in generalist care including comprehensive family medicine.
- 6.4.1 b Student survey data show that the vast majority of respondents in years 3 and 4 agree/strongly agree (aggregated) that they have had broad exposure to and experience in generalist care.
- 6.4.1 c Student survey data show that the vast majority of respondents in years 3 and 4 agree/strongly agree (aggregated) that they have had broad exposure to and experience in comprehensive family medicine.
- 6.4.1 d The medical school ensures that clinical learning experiences occur in more than one setting ranging from small rural or underserved communities to tertiary care health care centres.
- 6.4.1 e Student survey data show that the vast majority of respondents in year 3 and 4 agree/strongly agree (aggregated) that their clinical learning experiences (required and elective combined) occurred in more than one setting ranging from small rural or underserved communities to tertiary care health centres.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

6.4.1a The medical education program does include mandatory curricular components providing opportunity to experience generalist care including family medicine. Clinical experiences in family medicine (6 weeks), general internal medicine during the 8 weeks of IM rotation, general pediatrics during the 6 weeks of pediatric rotation are included within the Clerkship curriculum. In pre-clerkship there is a longitudinal family medicine experience, which provides opportunity for a student to attend six clinics with a family medicine preceptor during Year 2. In the Case Based Learning in pre-clerkship, a review process to enhance representation of generalist principles in curricular materials for this course component had been undertaken. This included the development of the Toronto-Generalism Assessment Tool (T-GAT).

6.4.1b The ISA student survey data indicate general positivity regarding exposure to generalist care, but with some variability between sites in the responses to the question:
The curriculum provided broad exposure to and experience in generalist care: Between 87.8 and 92.2% of Year 4 students at each of the four sites responded with Yes. Amongst the Year 3 students, between 88.6 and 97.3% of students responded with Yes.

6.4.1c The ISA (Appendix C-1) student survey data indicated some variability between sites, but generally positive response for the question: *The curriculum provided broad exposure to and experience in family medicine specifically.* Between 76 and 87.5% of Year 4 students at each of the four sites responded with Yes. Between 82.9 and 98.3% of Year 3's responded with Yes. The ISA does report some student comments expressing frustration that their Family Medicine training was not reflective of community FM practice, or were "placed with preceptors with a 'specialized practice' and thus lacked a general practice experience."

6.4.1d With respect to how the medical school ensures that clinical learning experiences occur in more than one setting ranging from small rural or underserved communities to tertiary care health centers, the DCI narrative describes a number of approaches, summarized below:

- i) CBSL/EEE clinical encounters provide students with an opportunity to shadow a clinician who works with the underserved populations/communities that the students themselves work with for their service-learning placements.
- ii) Clerkship disciplines utilize teaching units within anchor and associated specialty and community hospitals comprising the four academies.
- iii) Transition to Residency course, all students are required to complete at least one of three selective rotations in a community setting.
- iv) Family and Community Medicine course, all students complete a rotation with a preceptor in an academic and/or community site. Most academic teaching units also schedule their students with preceptors outside of the teaching units to round out their clinical experiences. All sites have identified one or more vulnerable populations as priorities for practice. Students at those sites interact with the identified vulnerable populations as part of their required clinical learning activities.
- v) Clinical placements in small rural settings, and suburban centers are available to MD students in both their core Family and Community Medicine rotation as well as in their Electives/Selectives, through an agreement with Rural Ontario Medical Program.

Each of these five examples provide opportunities to students across a variety of settings. There is a process in place whereby the Transition to Residency (TTR) administrator of the medical school monitors to ensure that each student has a community selective prior to their being allowed to match to any other selective.

6.4.1e The ISA student survey data were somewhat less positive for the survey question: *My clinical learning experiences (required and elective combined) took place in more than one setting ranging from small rural or underserved communities to tertiary care health centres.* Between 68.8% and 82.4% of Year 4 students at each of the four sites responded with Yes. For Year 3 students at each of the four sites responding to this question it ranged between 57.5% and 81.7% who responded with Yes. Taking the student body as a whole the overall percentage of Year 4 and Year 3 students responding Yes were 77.48% and 71.01%.

During the site visit, it was confirmed with Year 3 and Year 4 students that their responses had been more *geographical*, in that there may have been fewer small rural clinical experiences than they would have liked, but that overall their clinical experiences were quite diverse including adequate exposure to underserved patient communities.

6.5 ELECTIVE OPPORTUNITIES

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

Definition taken from CACMS lexicon

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

Requirements

- 6.5 a There are opportunities for elective experiences in the medical curriculum that permit medical students to gain exposure to and deepen their understanding of medical specialties reflecting their career interests and to pursue their individual academic interests.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

There are opportunities for elective experiences that support student exploration of their career interests and academic interests. There are 2 weeks of electives in Year 3 and 13 weeks of electives in Year 4. The new Year 3 home elective was not implemented in 2020, due to restrictions as a result of the pandemic.

There are a further 8 weeks of selectives in *Transition to Residency* in Year 4. At least one selective must be undertaken in a community setting, and many TTR selectives are specific to one or more vulnerable populations served by supervisors and their associated sites.

There are no elective opportunities in pre-clerkship.

6.6 SERVICE-LEARNING

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

Definition taken from CACMS lexicon

- *Service-learning: A structured learning experience that combines community service with preparation and reflection.*

Requirements

- 6.6 a There are opportunities for medical students to participate in service-learning activity during their tenure as a student.
- 6.6 b Student survey data show that the vast majority of medical student respondents who wanted to participate in a service learning activity were able to do so.
- 6.6 c The medical school informs medical students about service learning opportunities and encourages medical students to participate in service learning activity.
- 6.6 d The medical school supports student participation in a service learning activity (e.g., coordination of student placements, development of opportunities in conjunction with community partnerships or provision of financial support).

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

6.6a There are opportunities within curriculum for medical students to participate in service-learning activity during their medical education program. These opportunities are encompassed within the Integrated Clinical Experience: Health and Community (ICE:HC) program components. Each student participates in a service learning placement during Year 1 or 2.

6.6b The ISA data indicate 86.8 to 98% of students from Years 2-4 at the various sites report having participated in a service-learning program (including but not limited to CBSL/HC/community home visits etc.). 85.5 to 96% of Year 1 students also report participating in a service-learning program during their time as a medical student. There was a small percentage of students in all academies who reported that they did not participate in service learning due to too few opportunities. These ranged from 1.0-3.7% in Year One, 1.2-6.5% in Year Two, 0-2.1% in Year Three, and 0-5.9% in Year Four.

6.6c Within the ICE: HC curriculum, all students are now required to participate in a service learning activity during Year 1 or 2. Rare exemptions are granted for a variety of reasons.

6.6d The medical school further supports student participation in service learning activity in a variety of ways including the student placements, development of community partners as co-educators, development and maintenance of partnership agreements, leadership and administrative support (2.3 FTE), and faculty support.

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.

Requirements

6.8 a The medical education program includes at least 130 weeks of instruction.

RATING

- Satisfactory
- Unsatisfactory

Evidence to support the above rating

6.8a The DCI indicates $36+36+50+25 = 147$ weeks of instruction

STANDARD 7
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 7: CURRICULAR CONTENT

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

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 scientific knowledge and concepts and the methods fundamental to applying them to the health of individuals and populations.

Requirements

- 7.1 a A process ensures the faculty of a medical school selects the biomedical, behavioral and social sciences content necessary to support medical students' mastery of contemporary scientific knowledge and concepts.
- 7.1 b Medical students are taught the methods fundamental to the application of contemporary scientific knowledge and concepts to the health of individuals and populations.
- 7.1 c The faculty of a medical school integrates relevant national standards into the medical curriculum.
- 7.1 d The medical curriculum takes into account the school's social accountability mandate as it relates to the health of individuals and populations both regionally and nationally.
- 7.1 e The faculty of a medical school ensure the curricular content remains contemporary.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

7.1a The selection of biomedical, behavioral and social sciences content necessary to support medical students' mastery of contemporary scientific knowledge and concepts is described as based on the *MD Program Competency Framework* (CF). The MCC clinical presentations inform the approach to clinical content identified in the CF. The Curriculum Committee governs selection of content for the curriculum. Specific content is selected to reinforce key concepts, relevance to generalist physicians and for competency development.

7.1b The DCI includes descriptions of teaching/curriculum relating to the methods fundamental to the application of contemporary scientific knowledge and concepts to the health of individuals and populations.

Specifically, there is inclusion and description around: Case-based learning to support integrating basic science content with clinical presentation, applying prior/new knowledge, group collaboration, problem solving, critical thinking skills; clinical skills with inclusion of interviewing, communicating, physical examination and clinical reasoning skills development; application of self-directed learning skills including literature/resource consultation in *Family Medicine Longitudinal Experience*; population health related approaches are included in the public health theme within the four year program and the Health in the Community (ICE:HC) component of the

curriculum. The social determinants of health and impact on individual/population health are also explored in ICE:HC. The Health Science Research curriculum supports students in interpretation of research findings and future application of research results to clinical care. Recognition of health care challenges and needs for vulnerable or marginalized populations is included within the Transition to Residency course.

7.1c The medical education curriculum does integrate relevant national standards.

Specifically, the MCC Objectives/clinical presentations are included and are consulted. From the DCI: "...course directors and week managers ensured that the course objectives are in keeping with the relevant objectives of the MCC...The progress test blueprint is based on MCC learning objectives as well as both physician tasks and dimensions of care."

The AFMC *Entrustable Professional Activities* (EPAs) are also integrated. From the DCI: "The MD Program Competency Framework has also been mapped to the AFMC EPAs".

7.1d The social accountability mandate of the medical school is acknowledged within the curriculum.

This is explicit in that there is curriculum related to recognizing health issues for Indigenous peoples of Canada, Canadian Black population, people from the LGBTQ2S community. The MSS indicates that the health of these three populations form three formal program *integrated themes*. The program identifies the *Integrated Clinical Experience in the Health in the Community* (ICE:HC) component of the curriculum in pre-clerkship as a substantial component contributing to social accountability in the curriculum. In this component (also referenced in element 6.6) students engage in a "longitudinal, immersive community-engaged learning experience, with a model of service-learning that aims to change systems and that is community driven... The intention of this experience is for students to participate in a clinical experience (which complements the community-based service learning placement through the *Enriching Educational Experiences* program) that will inform a reflective discussion with their community partners and increase awareness of the roles physicians play in marginalized/specialized populations." The program includes a *Transition to Clerkship* small group onboarding session relating to poverty and health which includes optimization of care for and advocating on behalf of patients living in poverty. The *Transition to Residency* course incorporates "two main themes: understanding health care needs of individual members of diverse groups within the Canadian population and learning to use the health care system to meet those needs."

7.1e The process of ensuring that the curricular content remains contemporary is not described in detail but the DCI does state that "[t]he ultimate authority for determining and updating content rests with the MD Program Curriculum Committee (MDCC)." The DCI described three examples of the addition of content to the curriculum. These include:

1. A resilience curriculum added to the program in 2016-17, through lectures, online modules and small group sessions and "Monologues in Medicine" (student narratives of challenges and triumphs in medical school). In 2017-18 the resilience curriculum was integrated in Year 2 and in 2018-19 into Year 3.
2. Medical cannabinoids content was added to the pain curriculum in 2018-19.
3. The Black Health Theme was introduced in 2017-18. This includes integrated educational elements within sessions and materials, which support inclusion of a black health perspective throughout the medical curriculum.

There was no description of curricular elements that were deleted.

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

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

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

Definition taken from CACMS lexicon

- *End of life care: Care of patients with terminal illness or condition; includes palliative care and medical assistance in dying.*

Requirements

- 7.2 a There is a process by which the faculty of a medical school ensure that the medical curriculum includes appropriate content and clinical experiences that address each organ system, each phase of the human life cycle and across the spectrum of care.
- 7.2 b There is a process by which the faculty of a medical school ensure that the medical curriculum prepares medical students to:
- i. recognize wellness, determinants of health, and opportunities for health promotion and illness prevention.
 - ii. recognize and interpret symptoms and signs of disease.
 - iii. develop differential diagnoses and treatment plans.
 - iv. recognize the potential health-related impact of behavioral and socioeconomic factors on patients.
 - v. assist patients in addressing health-related issues involving all organ systems.
- 7.2 c Student survey data show that the vast majority of respondents agree/strongly agree (aggregated) that, when presented with a variety of patients, they have the knowledge and skills to perform the physician tasks listed in Table 7.2-1 of the Data Collection Instrument.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

7.2a The process whereby the medical program ensures the inclusion of appropriate content and clinical experiences that address each organ system, each phase of the human life cycle and across the spectrum of care (including continuity of care, acute care, chronic care, rehabilitative care, end-of life care, primary care) is clearly described and credible.

7.2b. The process by which the medical program ensure that the medical curriculum prepares medical students to recognize wellness, determinants of health, opportunities for health promotion and illness prevention; recognize and interpret symptoms and signs of disease; develop differential diagnoses and treatment plans' recognize the potential health-related impact of behavioral and socioeconomic factors on patients; assist patients in addressing health-related issues involving all organ systems is clearly described and credible.

7.2c AFMC GQ data: The majority of respondents agree/strongly agree that when presented with a variety of patients, they have the knowledge and skills to perform the physician tasks listed in Table 7.2-1 in the DCI (Appendix C-25). The proportions of respondents who agreed/strongly agreed, across the various tasks on the list, ranged from 79.1 to 98.7% (2017), 87.4 to 100% (2018), and 86.4 to 100% (2019).

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.

Definition taken from CACMS lexicon

- *Translational research: Studies or investigations aimed at finding solutions to clinical problems such as those: applying discoveries generated in the laboratory or through preclinical studies to the development of trials and studies in humans; promoting the adoption of best practices in the community or targeting cost-effectiveness of prevention and treatment strategies.*

Requirements

- 7.3 a The medical curriculum includes in a required learning experience(s), learning objectives that address the scientific method and the basic scientific and ethical principles of clinical and translational research including how this research is conducted, evaluated, explained to patients and applied to patient care.
- 7.3 b Instruction on the scientific method, the basic scientific and ethical principles of clinical and translational research, including how this research is conducted, evaluated, explained to patients and applied to patient care prepares medical students for the subsequent contemporary practice of medicine.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

7.3a The DCI clearly outlines a list of courses/sessions where learning objectives are included which address each of: a) scientific method, b) basic scientific and ethical principles of clinical and translational research, c) conduct and evaluation of clinical research and d) application to patient care. As requested by the team, the updated report from October 28, 2020 described specific curricular components that provide explicit instruction in how research is explained to patients as part of the application of research to patient care.

7.3b The DCI describes how the relevant curricular components relate to how research is conducted, evaluated and applied to patient care, which prepares students to be effective research consumers in their subsequent contemporary practice of medicine.

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.

Definition taken from CACMS lexicon

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

Requirements

- 7.4 a The following are taught and assessed in a required learning experience(s):
- i. clinical decision-making skills including critical appraisal of new evidence related to the care of patients
 - ii. application of the best available information to the care of patients
 - iii. medical problem-solving skills
- 7.4 b Student survey data show that the vast majority of respondents agree/strongly agree (aggregated) that they have the knowledge and skills to perform the following:
- i. reason clinically
 - ii. incorporate evidence-informed decision-making into patient care
 - iii. access evidence-informed treatment guidelines
 - iv. use technology to access information at the time of a patient encounter (just in time/point of care) if needed.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

7.4a. The DCI lists the required learning experience in each of Years 1, 2, 3 and 4 which include teaching and assessment of i) clinical decision-making skills, including critical appraisal of new evidence related to the care of patients, ii) application of the best available information to the care of patients, and iii) medical problem-solving skills.

7.4b. AFMC GQ data indicate the percentage of respondents between 2017 and 2019 who responded *agreed/strongly agreed* that they had the knowledge and skills to:

- reason clinically: 95.4-100%
- incorporate evidence-informed decision making into patient care: 92.2-97.1%
- access evidence-informed treatment guidelines: 94.1-97.7%
- use technology to access information at the time of a patient encounter (just in time/point of care) if needed: 90.8-95.4%

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.

Requirements

- 7.5 a The curriculum includes instruction and has learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting (if relevant), and treatment of the medical consequences of common societal problems.
- 7.5 b The process by which the faculty of a medical school select societal problems to be included in the curriculum ensures content is relevant to the contemporary practice of medicine.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

7.5a The narrative provided describes how “the Public Health theme has objectives focused on the diagnosis, prevention, reporting and treatment of the medical consequences of common societal problems.” In terms of how the faculty may ensure that such curriculum be included, a description of “a Public Health Education Advisory Committee that meets quarterly that considers curricular content that addresses population health” is included in the narrative response. The MSS response indicates that “The (various) theme leads and theme committees are charged with ensuring that content and learning objectives related to common societal problems in their themes are included across the MD Program curriculum”.

7.5b The DCI narrative describes the process undertaken for selection/inclusion of curricular content relevant to specific societal problems/issues. As requested in the DCI, three examples of recent changes are described and include the addition of curriculum relating to: i) Nutrition (malnutrition/obesity) in 2016/17, ii) Family and Domestic Violence in 2016/17, and iii) MAID in 2017/18. Learning objectives for experiences relating to these topics were provided for review by the team.

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.*

Requirements

- 7.6 a The medical curriculum includes opportunities with explicit learning objectives in required learning experiences 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.
- 7.6 b The curriculum prepares medical students to be aware of their own biases (cultural, gender, racial, beliefs) and how these biases influence clinical decision-making and the care provided to patients.
- 7.6 c Educational activities prepare medical students in developing the basic skills needed to provide culturally competent health care.
- 7.6 d The medical curriculum prepares medical students to a) identify health care disparities and b) identify opportunities to participate in developing solutions to address these health care disparities.
- 7.6 e Student survey data show that the vast majority of respondents agree/strongly agree (aggregated) that they have been adequately trained to provide appropriate care, and to advocate for access to health care, for the unique needs of peoples of diverse cultures, genders, races and belief systems, in particular the Indigenous peoples of Canada.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The Supplementary Appendix (S-3) provides a brochure outline for the Indigenous Health Curriculum which contributes to the documentation and description of curricular components addressing the various sections within this element.

7.6a The DCI narrative for this section includes a description of various sessions which address the requirements. The explicit learning objectives themselves are not provided.

The sessions addressing the unique needs of people of diverse cultures, genders, races and belief systems include:

- Culture: Year One: Cultural Safety and Anti-oppression workshop; Year Two within the Intersectionality and Equity Week these concepts are addressed in various forums in relationship to black, indigenous and LGBTQ2S populations. Also, in Year Two there is a week of global health content “with specific objectives relating to cultural sensitivity and safety, and the inclusion of culturally appropriate care providers (e.g., traditional healers) in care”. Year Four during the TTR course “there is a 3 hour large group and panel discussion on Cultural Safety and Indigenous Health. There is also a 1.25

hour Global Health session, a 1.5 hour large-group session on Immigrant and Refugee Health and a 1 hour session on Black Health.

- **Genders:** Year One: a gender and health module is included in the cardiology curriculum block. A Year Two Life Cycle course lecture includes concepts related to gender identity. Cross-sex hormone therapy and transition-related surgical procedures are covered in the Endocrinology and Intersectionality weeks in Year Two. A Clinical Skills sexual health module includes concepts around history-taking for people with diversity in gender expression. Year Four: in TTR, a large group 1.5 hour session and panel discussion on LGBTQ2S Health includes “health care needs and approaches to provision of comfortable and equitable health care to people of diverse gender and sexual identities”.
- **Races:** there is specific in-class time related to care of Indigenous and Black populations in Year Two Intersectionality and Equity week. Otherwise, concepts relating to Black and Indigenous health “are addressed in objectives integrated throughout the Foundations curriculum.” (DCI) In Year Four TTR, there are sessions as described (in 1. Culture above) and a further one hour large group session on Black Health and systemic racism as a social determinant of health.
- **Belief systems:** Year Two: “the role of traditional medicine providers is explored in Intersectionality and Equity week in Foundations”. In the Year Four in the TTR course, in addition to sessions mentioned in the earlier portion of the response to this element, a further session is described for ‘Alternate Health and Integrative Medicine’ which is a two hour “large group session that addresses alternative health practices, outlines some modalities which patients may be using and explores ways in which patients may integrate these into more conventional health care.”

The following are listed as opportunities for students to learn to recognize and appropriately address the unique needs specifically of the Indigenous peoples of Canada:

- Cultural Safety and Anti-Oppression workshop.
- Week 26 CBL case invoking social determinants of health, traditional medicine and Indigenous world view can impact chronic disease management.
- Life cycle: week 54 – self-learning module related to indigenous concepts towards gender; week 56 – cultural concepts and practices around pregnancy and birth; week 58 – impact of generational trauma is taught through a 90 min. experiential workshop; palliative wee – “a self-learning module introduces students to Indigenous views and cultural practices around palliative care and death.”
- Complexity and Chronicity: a two hour lecture on indigenous health; a CBL module based on the Brian Sinclair case; additional modules during the week addressing indigenous cancer care and indigenous traditions as they impact health.
- Year Four: TTR Cultural Safety and Indigenous Health session
- Indigenous Health elective (8 two-hour sessions with healers, knowledge keepers, indigenous practitioners and policy makers) open to all medical students. There are also Clerkship electives in various Northern and Indigenous communities.
- Truth and Reconciliation Commission Reading Group (elective)
- Clerkship elective: Through the Medicine Wheel: An urban Indigenous Health Elective

7.6b Description is provided as to how and where the curriculum prepares medical students to be aware of their own biases (cultural, gender, racial, beliefs) and how these biases influence clinical decision-making and the care provided to patients. The curricular locations highlighted include:

- Cultural Safety and Anti-oppression Workshop.
- Intersectionality and Equity week
- Transition to Residency course: Cultural Safety and Indigenous Health, Global Health, Immigrant and Refugee, LGBTQ Health, Poverty, Ability in Intellectual Disability, Increasing Accessibility.
- Internal Medicine Clerkship: assignment reflection on a patient they have encountered who met with barriers or health inequities based on bias, racism or other structural inequities.

7.6c Educational activities preparing medical students in developing basic skills for delivery of culturally competent health care are described in the DCI and include:

- Pre-clerkship: LGBTQ2S: Clinical skills sexual health session, reinforced by lectures in Year 2 on “LGBTQ2S terminology and inclusive history taking”.
- “Indigenous/black/refugee/new immigrants: See topics described above in Intersectionality and Equity

- and global health weeks.”
- “TTR: See Cultural Safety and Indigenous Health, Global Health, Immigrant and Refugee and Black Health sessions as described above”.

7.6d The medical curriculum prepares students to identify health care disparities and identify opportunities to participate in developing solutions to address these health care disparities. Curricular components addressing this requirement are listed below:

- Year One: Health in the Community—upstream medicine, determinants of health, impact on community care and practice. Field experiences (2, one as a home visit and the other at an assisted living facility or equivalent for people with intellectual and developmental disabilities. These field experiences are followed by tutorials focusing on the field experience through the relationship with social determinants of health and concepts of health promotion and patient education.
- Year Two: “social determinants of health and health disparities for marginalized populations are included in a number of weeks in second-year, particularly Intersectionality and Equity Week and Global Health Week”. A focus on how to address and “move from awareness to action” is included. A focus on impact of poverty on health is also included in the Complexity and Chronicity course.
- Clerkship: TTC a 2.5 hour small group Poverty and Health onboarding session provides students with tools for recognizing poverty and optimizing care/advocating for patients.
- TTR: Various sessions, beyond those mentioned earlier, support development of skills in identification and addressing health care disparities are included in this course: including on poverty, increasing accessibility, ability in intellectual disability, surfing the silver tsunami, addictions and medicine. Two written assignments include one on Health Equity and one on Health Systems analysis.

7.6e AFMC GQ data indicate that the vast majority of respondents agreed/strongly agreed to the following statements. Percentage ranges between 2017-2019 are in brackets following each statement.

- I was appropriately trained to care for individuals from diverse backgrounds (91.5-97.7%)
- Overall my clinical experience highlighted the need to understand and incorporate diversity and culture in delivering patient care (92.2-98.3%)
- I feel prepared to provide culturally competent care (89.5-92.6%)
- I feel appropriately prepared to advocate for my future patients (90.8-97.1%)
- I feel appropriately prepared to advocate for the communities of my future patients to better meet their health needs (83.7-92.0%)

ISA data indicate that the majority of respondents were satisfied/very satisfied with their education in caring for individuals from diverse backgrounds. Percentage ranges from each Academy for each Year of training are listed below. Total for all students is in brackets.

- Year One: 79-83% (80.7%)
- Year Two: 75-85.7% (81.6%)
- Year Three: 87-98.6% (92.3%)
- Year Four: 87.5-98.6% (94.6%)

AFMC GQ data in Table 7.6-3, indicate that the vast majority of respondents agree/strongly agree that “A commitment to advocate for access to health care for members of traditionally underserved populations” was emphasized in the medical education program. Data for each Academy were provided for the years 2017-19.

Ranges for each Academy were:

- FitzGerald Academy: 91.7-93%
- Mississauga Academy: 89.7-100%
- Peters-Boyd Academy: 92.9-97.1%
- Wightman-Berris Academy: 90.6-98.2%

7.7 MEDICAL ETHICS

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

Requirements

- 7.7 a The medical curriculum, in required learning experiences, includes explicit learning objectives in medical ethics and human values both prior to and during their participation in patient care activities.
- 7.7 b Student survey data show that the vast majority of respondents agree/strongly agree (aggregated) that they understand the principles that govern ethical decision-making, and the major ethical dilemmas that arise in medicine.
- 7.7 c The medical school uses appropriate methods to ensure medical students' ethical behaviour in the care of patient.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

7.7a The DCI narrative describes where in each segment of the curriculum (pre-clerkship and clerkship) there are required learning experiences which include explicit objectives relating to medical ethics and human values. A table was provided to the team that articulates the explicit learning objectives for each listed course, including courses that are concurrent with clinical rotations.

7.7b AFMC GQ data show that the vast majority of respondents *agree/strongly agree* that they understand:

- The principles that govern ethical decision-making (between 2017-19, 94.7-98.9%) and
- the major ethical dilemmas that arise in medicine (between 2017-19, 94.7-98.3%).

7.7c A description of the requirement for professionalism throughout the program is included in the narrative response as well as an outline of a “graduated response to students who have received low professionalism scores.” This ranges from initial dialogue with a course director all the way up to a formal presentation to the Board of Examiners. Description is provided of activities for students needing greater guidance and remediation including completion of a focused professionalism learning plan and also of a period of formal professionalism remediation. There are Faculty Development efforts towards reporting by faculty of professionalism lapses.

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.

Requirements

- 7.8 a There are explicit learning objectives and specific educational activities in required learning experiences, including clinical learning experiences, related to:
- i. communicating with patients and patient's families
 - ii. communicating with physicians (e.g., as part of the medical team)
 - iii. communicating with non-physician health professionals (e.g., as part of the health care team)
- 7.8 b Student survey data show that the vast majority of respondents agree/strongly agree (aggregated) that they have the knowledge and skills related to communication skills.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

7.8a The DCI details required learning experiences in Years 1, 2 and 3/4 where there are explicit learning objectives which are taught and assessed related to communication with: i) patients and patient's families, ii) physicians and iii) with non-physician health professionals. These learning objectives were collated into a summary document for review by the team, demonstrating that this requirement is fully addressed. (Supplemental Appendix S-4)

7.8b. AFMC GQ data show positive responses from students overall. The percentages of students between 2017-19 who agreed/strongly agreed that they have the knowledge and skills to perform each of the following tasks are indicated below.

- Communicate effectively with patients and their families: 98-100%
- Communicate with other physicians: 94.8-99.4%
- Communicate with other health professionals: 96.7-100%
- Discuss options with a patient and/or family members who request unnecessary tests or procedures: 90.8-94.8%
- Discuss the health practices of a patient using alternate therapies: 77.1-85.5%; 80.7% in 2019

7.9 INTERPROFESSIONAL COLLABORATIVE SKILLS

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

Requirements

- 7.9 a There is a linkage between the medical education program objectives/competencies and the learning objectives of required learning experiences related to interprofessional collaborative practice skills.
- 7.9 b There are sufficient instances of required learning experiences where medical students are brought together with students or practitioners from other health professions to learn to function collaboratively on health care teams as they provide coordinated services to patients.
- 7.9 c These educational experiences have learning objectives related to the development of interprofessional collaborative practice competencies, and medical students' attainment of the learning objectives is assessed.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

7.9a Documents were provided that illustrate the linkage between medical education program objectives/competencies and the learning experience objectives relating to interprofessional collaborative practice skills.

7.9b Three examples are provided in the DCI of required learning experiences where medical students are brought together with students or practitioners from other health professions to learn to function collaboratively on health care teams as they provide coordinated services to patients. The three examples provided describe two pre-clerkship activities, one in each of Year One and Two, which are large auditorium sessions with team-based small group discussion formats (pre-pandemic) and one in Year 3 *Transition to Clerkship, IPE Component* in a Practice Setting exercise which is a 1:1 clinical-based shadowing of another health care professional. A varied list of other health care team members is provided for each example.

7.9c The learning objectives for the three educational experiences described do relate to the development of interprofessional collaborative practice competencies. An assessment process is described for each of the three experiences:

- Year One: "IPE Interactive Module (MCQs) – credit/no credit"
- Year Two: "MCQs on Mastery Exercise"
- Year Three: "a mandatory small group debrief, and experiential reflection led by a facilitator at academies – credit/no credit"

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.

Requirements

- 7.10 a The medical school has defined the professional attributes (behaviors and attitudes) that medical students are expected to develop.
- 7.10 b These expected professional attributes are effectively communicated to faculty, residents and others in the medical school and clinical learning environments.
- 7.10 c There are learning objectives and medical students are assessed in required learning experience on the following topics:
- i. development of professional identity
 - ii. core professional attributes
 - iii. knowledge of professional responsibilities
 - iv. leadership skills
- 7.10 d Student survey data show that the vast majority of respondents agree (agree + strongly agree aggregated) that the beliefs/values and behaviours in Table 7.10-3 were emphasized in the medical education program.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

7.10a. the medical school has identified four professional attributes that medical students are expected to develop.

They are to “demonstrate a commitment to:

1. patients by applying best practices and adhering to high ethical standards.
2. society by recognizing and responding to societal expectations in health care
3. the profession by adhering to standards and participating in physician-led regulation
4. physician health and well-being to foster optimal patient care.

7.10b Since the professional attributes identified by the medical school are incorporated within the *Competency Framework*, communication is through the academic calendar as described in element 6.1e for medical students and faculty leaders. The professionalism assessment form, which is completed by those assessing students, is organized by domains that address each of the competencies. There is a faculty development online e-module for ‘assessing student professionalism’ and the related objectives are available on Elentra.

7.10c A tabular inventory was provided to the team, demonstrating that each of these four topics are specifically taught and assessed in each of Years One, Two and Three/Four.

7.10d The AFMC GQ response from the student body as a whole between 2017-19 for several physician tasks provides the percentage range of respondents between 2017-19 who *agreed/strongly agreed* that the following beliefs/values and behaviours were emphasized in the medical education program, as listed below:

- A commitment to advocate at all times the interest of one's own patients over one's own interests: 85-96%
- The threats to medical professionalism posed by conflicts of interest: 75.7-91.5% (91.5% in 2019)
- The compassionate treatment of patients: 96.0-98.9%
- Respect for the privacy and dignity of patients: 96.7-98.9%
- The value of honesty and integrity in all professional interactions: 95.4-97.1%
- The recognition and acceptance of limitations in one's own knowledge and skills: 90.1-94.3%

STANDARD 8
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 8: CURRICULAR MANAGEMENT, EVALUATION, AND ENHANCEMENT

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

8.1 CURRICULAR MANAGEMENT

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

Requirements

- 8.1 a There is a duly constituted faculty body (commonly called the curriculum committee) that has authority and responsibility for the medical education program.
- 8.1 b The ‘curriculum committee’ and its subcommittees or other structures that achieve the same functionality, oversee the curriculum as a whole and have responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum as articulated in the terms of reference of these committees.
- 8.1 c The committees or groups that implement and deliver the curriculum (e.g., directors of required learning experiences, chairs of committees for years or segments or themes of the curriculum) operate under the authority of the ‘curriculum committee’ and its subcommittee (i.e., there are reporting lines of these operational committees/groups to the ‘curriculum committee’).
- 8.1 d The minutes of the ‘curriculum committee’ provided in the DCI from the last two years show that the ‘curriculum committee’ has overseen the curriculum as a whole and has demonstrated its responsibility by reviewing and approving any changes to the medical education program objectives and the learning objectives of required learning experiences; changes to the design of the program; ensuring that curriculum content is coordinated and integrated within and across academic years; monitoring the overall quality and effectiveness of all required learning experiences, and the curriculum as a whole; and ensuring that identified deficiencies are addressed (i.e. quality improvement).

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

8.1a The MD Program Curriculum Committee (MDCC) has authority and responsibility for the MD Program curriculum. The committee operates under the authority of the Faculty Council with delegated responsibility from the Dean, Faculty of Medicine to the Vice Dean, MD Program and has primary responsibility for the undergraduate medical education program. (Appendix C-28)

The Vice Dean, MD Program is the ex officio co-Chair of the Curriculum Committee. The other co-Chair is an

MD Program/Wilson Centre Education Scientist, appointed by the Vice Dean.

Ex officio members of the Curriculum Committee:

- Foundations Director
- Clerkship Director
- Director, Program Evaluation
- Director, Student Assessment
- Director, Program Integration
- Academy Directors (4)
- Associate Dean, Medical Education (Regional)
- Associate Dean, Health Professions Student Affairs
- Faculty Lead, Ethics and Professionalism
- Director, Enrolment Services and Faculty Registrar
- Manager, Curriculum
- Manager, Strategic Operations and Policy.

Faculty members-at-large of the Curriculum Committee (2) – the Vice Dean solicits nominations for these positions from department chairs, with the principle of broad faculty input, including from members who do not hold leadership positions in the MD Program. The term of the at-large faculty members is normally three years.

Representative members of the Curriculum Committee:

- Medical student representatives (4: Medical Society Senior and Junior Vice-Presidents Education, Clinical Clerk Delegates)
- MD/PhD student representative
- Postgraduate Medical Education representative
- Clinical Chairs representative
- Basic Science Chairs representative
- Resident representatives (2)

The representative faculty members are appointed by the Vice Dean, in consultation with the leaders of the groups being represented, normally for a term of three years. The student representatives, including the clerkship delegates, are chosen by the students according to Medical Society procedures.

8.1b The following subcommittees report to the MD Program Curriculum Committee (MDCC): Foundations, Clerkship, Student Assessment and Standards (SASC), Program Evaluation (PEC), and Student Progress (SPC).

The terms of reference of the parent committee (Appendix C-29) and its subcommittees (Appendix C-30) clearly articulate their roles and responsibilities in the design, management, and evaluation of the curriculum as a whole. The MDCC holds ultimate responsibility for the review and approval of all curriculum changes across the curriculum as a whole. The Foundations and Clerkship committees are responsible for the approval of minor curriculum changes, and report to the MDCC on the consultations conducted to ensure integration and appropriate alignment and enhancement of the curriculum. The program evaluation committee (PEC) also submits reports to the MDCC for review of program evaluation initiatives, including course reports, and important outcome measures. The SASC and SPC work closely with Foundations, Clerkship, and Program Evaluation to ensure assessment of medical students supports a coherent and coordinated medical education program.

The Clerkship and Foundations Committees include course directors for specific segments of the curriculum as well as directors for themes or longitudinal components (e.g., Portfolio, Clinical Skills, Health Science Research). The SASC and PEC include the Clerkship and Foundation Directors. These four committees report the MDCC through their respective Chairs or co-Chairs, who are members of the MDCC. The Director of Program Evaluation is also the Chair of PEC and is a member of the MDCC.

The MD Curriculum Committee has ultimate responsibility and final authority for ensuring that the overall quality and outcomes of all required learning experiences are monitored. This responsibility is supported through the work of its subcommittees, as follows:

The responsibilities of the Program Evaluation Committee (PEC) include monitoring the overall quality and outcomes of all required learning experiences. Actions taken by the PEC include carrying out regular performance reviews of all MD Program courses and theme content areas to ensure effectiveness and compliance with established standards, with respect to each of the following:

- Course management
- Course objectives, including in relation to program-level objectives
- Course content
- Teaching methods
- Assessment methods
- Course outcomes, including consideration of student performance, teaching evaluations, course evaluations, external data (e.g., CGQ, MCCQE), and internal student surveys
- Areas of strength and areas for improvement
- Changes made or planned

To achieve this, the PEC:

- Utilizes a template to facilitate collection and dissemination of relevant data pertaining to course performance
- Ensures timely collection of data including annual course reports and additional data as needed
- Performs reviews of individual courses
- Provide reports to the Curriculum Committee regarding these performance reviews, including PEC observations, recommendations and actions

The PEC performance reviews are supported by the Student Assessment and Standards Committee (SASC), which is responsible for review of each course's assessment methodology as well as standard setting approaches utilized for each assessment method.

The responsibilities of the Foundations and Clerkship Committees include contributing and responding to the monitoring by the PEC and SASC of overall student achievement of the Foundations and Clerkship curriculum objectives and the objectives of the constituent parts of the Foundations/Clerkship curricula. Any curriculum changes made in response to this monitoring are reviewed and endorsed by the Foundations and Clerkship Committees, respectively, prior to consideration and approval by the Curriculum Committee.

8.1c The Program Governance organizational chart (Appendix C-28) demonstrates that the committees and other groups responsible for the delivery of the curriculum operate under the ultimate authority of the MDCC. All subcommittee chairs are also members of the MDCC, and report to the committee on behalf of their subcommittees. All minutes of the sub-committees are also reviewed by the MDCC. The MDCC is responsible for reviewing and developing medical education program objectives, ensuring horizontal and vertical curriculum integration, quality and outcomes of required learning experiences and effectiveness of segments of the curriculum and the curriculum as a whole and achieves this with MDCC subcommittees through integrated processes.

8.1d The minutes of two meetings of the MDCC for each of the last two academic years (2018-19 and 2017-18) were provided and reviewed by the team. The minutes contain several detailed examples of reviewing and approving changes to learning objectives and program design. There are standing reports from the subcommittees, covering both Foundations and Clerkship years. The minutes also contain examples of quality improvement (e.g., standard-setting or modifying standards for mastery exercises and OSCEs) and identifying and addressing deficiencies (e.g., revision of absence policy).

8.2 USE OF PROGRAM AND LEARNING OBJECTIVES

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

Definitions taken from CACMS lexicon

- *Learning objectives: Statements of what medical students are expected to be able to do at the end of a required learning experience (see lexicon).*
- *Medical education program objectives: Statements of what medical students are expected to be able to do at the end of the educational program i.e., exit or graduate level competencies.*
- *Required learning experience: An educational unit (e.g., course, block, clerkship rotation or longitudinal integrated clerkship) that is required of a student in order to complete the medical education program. These educational units are usually associated with a university course code and appear on the student's transcript. Required learning experiences are in contradistinction to electives, which are learning experiences of the student's choosing.*

Requirements

- 8.2 a The 'curriculum committee' ensures the medical education program objectives are used to select curriculum content and determine its placement in required learning experiences throughout the educational program.
- 8.2 b The 'curriculum committee' ensures that the medical education program objectives are used to evaluate the effectiveness of curriculum.
- 8.2 c Directors of required learning experiences and other educational leaders contribute to the development of the linkage between the learning objectives and the medical education program objectives. The 'curriculum committee' has the overall responsibility to ensure that the medical education program objectives are appropriately linked to the learning objectives of all of the required learning experiences so that the medical education program objectives can be achieved.
- 8.2 d The examples provided in the DCI show there is appropriate linkage between the medical education program objectives and the learning objectives of required learning experiences.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

8.2a Under the authority of the Curriculum Committee, faculty engaged in curricular development must complete a process of reviewing their session and/or course level objectives in reference to the *Competency Framework* (CF). This process is articulated in the *Guidelines for Making Curriculum Changes*. The guidelines and processes ensure that the appropriate stakeholders are engaged and aware of any new curricular developments (minor and major) and able to ensure that changes, deletions or additions of objectives are consistent with curricular support for the CF. The processes also mandate referencing the Curriculum Map which ensures that users are aware of all session and week objectives that support the CF *Key and Enabling Competencies*. The DCI indicates that, depending upon the extent of the curricular change, proposals are mandated to be reviewed and approved at the appropriate committee level, and by the Directors of Foundations, Clerkship, Faculty Development, Student Assessment, and Program Evaluation.

8.2b The Office of Assessment and Evaluation (OAE) has developed a Program Evaluation Framework, which links program evaluation data to MD Program objectives using the Curriculum Map. The OAE collates program evaluations data and presents to the MDCC annually. Furthermore, Course Directors reflect in their annual course reports on how their courses contribute to MD Program objectives. These reports are also provided to the MDCC for review and action where required.

8.2c The *Guidelines for Making Curriculum Changes* require that directors of required learning experiences review the Competency Framework and Curriculum Map when developing, revising, and removing content. Course Directors must reflect on how their courses contribute to MD Program objectives in their annual course report. Other educational leaders (e.g., Directors of Faculty Development, Student Assessment, and Program Evaluation), must also be consulted for major curricular changes, and they are responsible for ensuring that the curriculum and assessments are directly linked to the Competency Framework and that appropriate faculty development resources and support are in place.

The mandated *Curriculum Change Forms* capture a record of this review and consultation and is presented to all committees with responsibility for approval, including the MDCC. All course, component and theme leads are either standing members of the Foundations and Clerkship Committees or make regular reports to these committees. Foundations and Clerkship committee minutes are reported to the MDCC. Beginning in 2019-2020, all faculty theme leads also present on their theme content and curriculum to the MDCC in each academic year.

8.2d The school provided an example from the Life Cycle course where the approach to abdominal pain is linked to the MD Program Enabling Competency Medical Expert 2.2. An example from the Family and Community Medicine Clerkship demonstrates a linkage between the required Motivational Interviewing activity to Enabling Competency Communicator 3.1. There is a similar linkage between individual learning activities in both Foundations and Clerkship and the MD Program's Key and Enabling Competencies (i.e., program-level learning objectives). These linkages can be viewed at various levels by using the Curriculum Map and Curriculum Search features of the MD Program's Elenra platform.

8.3 CURRICULAR DESIGN, REVIEW, REVISION/CONTENT MONITORING

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

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

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

Definitions taken from CACMS lexicon

- *Learning objectives: Statements of what medical students are expected to be able to do at the end of a required learning experience (see lexicon).*
- *Medical education program objectives: Statements of what medical students are expected to be able to do at the end of the educational program i.e., exit or graduate level competencies.*
- *Required learning experience: An educational unit (e.g., course, block, clerkship rotation or longitudinal integrated clerkship) that is required of a student in order to complete the medical education program. These educational units are usually associated with a university course code and appear on the student's transcript. Required learning experiences are in contradistinction to electives, which are learning experiences of the student's choosing.*

Requirements

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

- 8.3 h Curricular content is monitored on a regular basis to identify gaps and unwanted redundancies. The ‘curriculum committee’ ensures that the process occurs and that gaps and unwanted redundancies in content areas are addressed.
- 8.3 i Teaching faculty can directly access information on the content of the curriculum as a whole and for specific required learning experiences, or the information can be provided to them in a timely manner.
- 8.3 j The system used for curricular mapping is effective in identifying where in the curriculum, and to what extent, topics are addressed.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

8.3a The *Guidelines for Making Curriculum Changes* require that directors of required learning experiences review the Competency Framework and Curriculum Map when developing, revising, and removing content. The Guidelines clearly state that “[t]he MD Program Curriculum Committee (MDCC) is responsible for oversight of all changes to the program curriculum.”

8.3b Course committees propose content based on the course’s learning objectives, the integration of curricular theme content, priority topics (e.g., those identified by the MDCC or by a particular clinical department), and relevant national standards.

The mandated *Curriculum Change Forms* require an academic rationale for added, changed, or removed content. These forms are used to report (minor changes) and propose for approval (major changes) to the MDCC. All approved changes are updated in the curriculum map within the Elenra system, which ensures ongoing alignment with the MD Program Competency Framework.

8.3c Course directors, supported by course committees, are responsible for creating outlines for each teaching session that include guidance for the activities of teachers and students. Individual teaching faculty who are responsible for delivering sessions and/or curriculum leads determine the specific content of the session, as well as how it will be delivered and assessed. The course directors and course committees review the teaching and assessment methods and propose changes as needed.

Assessment methods are reviewed by the Student Assessment and Standards Committee (SASC) and Program Evaluation Committee (PEC). The annual course report process ensures that both teaching and assessment methods are reviewed by PEC and MDCC.

8.3d Students evaluate individual teachers after each educational encounter. Aggregated numerical scores are derived from teacher evaluation forms to provide a Teacher Effectiveness Score (TES), which together with any submitted narrative feedback are available to each teacher 30 days after their educational activity, provided at least three evaluations have been submitted to ensure anonymity of students.

The MD Program Office of Assessment and Evaluation (OAE) analyzes each teacher’s score, and those whose performance is significantly lower than the average of the cohort receive follow-up and remediation, as needed, from a designated individual or group. This is also described in Elements 4.4 and 4.5.

8.3e Students are asked to complete course evaluations, which are then analyzed in aggregate by PEC. Course evaluation data are provided to Course Directors who review the evaluations as part of their annual course reports and use the evaluation data to provide commentary and quality improvement plans. The Foundations and Clerkship Directors review individual Course Reports with course directors. An aggregate of themes and trends in

the Course Reports is prepared by PEC and presented to the Foundations, Clerkship and MD Program Curriculum committees. The MDCC may require follow-up activities individual courses or curriculum phases, based on the results of the course reports.

8.3f Course reports are submitted annually for all MD Program courses. The accompanying PEC and MDCC review processes are completed as early as possible to enable action on any identified issues in the course for the following academic year.

8.3g The sample review forms that were provided for review cover 14 distinct topic areas. Report topics include identification of strengths and weaknesses, commentary on the contribution of the course to the MD Program Education Goals and Competency Framework, and suggestions and plans for continuous quality improvement of the course. They are thorough and would be useful in identifying areas of strength and areas in need of improvement.

8.3h The MDCC delegates responsibility for the detailed monitoring of curricular content to its subcommittees: the Foundations Committee (for courses in Years 1 and 2), the Clerkship Committee (for courses in Years 3 and 4), and the Program Evaluation Committee (PEC) (for the curriculum as a whole).

In accordance with the *Guidelines for Making Curriculum Changes*, curricular content is monitored on an ongoing basis at the level of the Foundations and Clerkship. Submission of a standardized curriculum change form is required for the review and approval of curriculum changes. The curriculum change process ensures that new, changed, or removed course content is appropriately mapped in real time within the comprehensive curriculum map in Elentra. Sponsors of curriculum changes must conduct a review of the topic/objective in the curriculum map, and comment on how the change will affect coverage throughout the curriculum as a whole. The MDCC and its subcommittees consider this review when approving curriculum changes.

8.3i All faculty members with teaching responsibilities have access to the comprehensive Curriculum Map and Curriculum Search features in Elentra. Faculty users in Elentra can be added directly to a course website by administrative staff, or they may opt into courses they wish to access. Faculty members can access learning objectives and topics for specific learning experiences using the Curriculum Map and Search. Overview information on the whole curriculum is publicly available through the MD Program Academic Calendar.

8.3j In the Curriculum Map interface within Elentra, users may select specific Key and Enabling Competencies (program-level objectives) and drill down to review all learning activities across the curriculum that support those competencies. Results from a Curriculum Map review can be filtered according to academic year, class cohort, and specific required learning experience.

8.4 PROGRAM EVALUATION

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

Definition taken from CACMS lexicon

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

Requirements

- 8.4 a The medical school 'curriculum committee' uses all of the outcome measures listed in Table 8.4-1 of the DCI to evaluate the extent to which medical students are achieving the medical education program objectives.
- 8.4 b Based on the annual review of the outcomes used to evaluate the program effectiveness, appropriate steps are taken to improve the quality of the medical education program.
- 8.4 c Student survey data show that:
- the vast majority of graduating respondents agree/strongly agree (aggregated) that they have developed the clinical skills required to begin a residency program
 - the vast majority of graduating respondents rate the quality of the medical education program as good/very good/excellent (aggregated), and
 - the vast majority of respondents in third and fourth years of the program are satisfied/very satisfied (aggregated) with the effectiveness of the first and second year as preparation for clinical learning involving patient care.
- 8.4 d Since the time of the last full site visit, the medical school 'curriculum committee' has taken appropriate steps to address gaps between desired and actual outcomes when medical students'/graduates' performance is suboptimal in one or more medical education program objectives.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

8.4a All outcome indicators specified in the DCI (Appendix C-31) were completed and reported to the curriculum committee in accordance with the outlined schedule. Many of these indicators also inform the Program Evaluation Framework utilized by the Office of Assessment and Evaluation.

8.4b Annual course reports include plans for improvement in the following academic year, along with a proposed follow-up process. A summary of all plans is presented to the MD Program Curriculum Committee (MDCC) with common issues and themes that extend throughout curriculum phases (Foundations/Clerkship) or the curriculum as a whole. MDCC also has access to all individual course, component and theme reports.

8.4 c:

- AFMC GQ data in Table 8.4-3 (Appendix C-33) show that, in 2019, between 95-100% of respondents agree that they are well prepared to begin a residency program. These rates have generally increased over 3 years, with the exception of MAM where they have remained stable for 2018 and 2019.

ii. AFMC GQ data in Table 8.4-4 (Appendix C-34) indicate that between 95-100% of respondents rate the quality of the MD Program as Good, Very good, or Excellent.

iii. ISA data (Appendix C-35) indicate that, in aggregate, approximately 78% of third- and fourth-year students are *satisfied/very satisfied* with the effectiveness of the pre-clerkship curriculum “in preparation for clinical learning.” Year 4 respondents were taught in the former pre-clerkship curriculum, while Year 3 students were the first cohort of students in the new Foundations Curriculum. The rates of satisfaction are lower in both years at FitzGerald (69.8% and 76.5%), and in Year 4 at the Mississauga Academy (62.5%). Possible causes for this lower satisfaction in these specific cohorts are being explored through qualitative data analysis of course evaluations and other MD student surveys. No interventions have been initiated at this time, pending the outcome of this analysis.

Follow up internal survey data from January 2020 yielded more positive results to a somewhat modified question: “The Foundations Curriculum prepared me for my Year 3 Clerkship courses.” The respondents agreed/strongly agreed with this statement as follows: FitzGerald 77.8%; Mississauga 93.3%; Peters-Boyd 87.5%; Wightman-Berris 80.5%.

This issue was reviewed with students during the visit. Most considered that the two statements were addressing slightly different issues. They interpreted the ISA statement to reflect their readiness to learn while in clinical environments; some students reported ongoing concern about this. They interpreted the follow up statement to reflect their readiness to perform well on written learning assessments (formal “exams”) in Clerkship courses, and did not think it directly addressed the concern articulated in the ISA.

During the visit, students identified that they are not currently well positioned to assess the impact of changes that have been made to the pre-clerkship curriculum to address this concern, because hands-on clinical education is the very aspect of the Foundations Curriculum that has been most disrupted by the pandemic. (SM)

8.4d The medical school has taken appropriate steps to address gaps between desired and actual outcomes when medical students’/graduates’ performance is suboptimal in one or more medical education program objectives. For example:

i) The proportion of students passing the MCCQE-Part 1 (Appendix C-32) has been lower than the school’s own target of exceeding the national pass rate. Several interventions have been undertaken to address this (fusion week lectures, practice exams, introduction of progress testing).

ii) Student CaRMS match rates and satisfaction with Career Planning have been lower than desired by the school. Several initiatives have been undertaken (e.g., Matchchannel, CAP course, practice interviews, OHPSA scheduled meetings). Satisfaction rates improved with a 9% increase in proportion of students being satisfied, according to the MSS. This is also described in Element 11.2 Career Advising.

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 their required learning experiences, teachers, and other relevant aspects of the medical education program.

Definition taken from CACMS lexicon

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

Requirements

- 8.5 a The medical school has processes in place to collect evaluation data from students about their learning experiences and teaching faculty, including residents where applicable.
- 8.5 b The participation rate of medical students in responding to the evaluation form for required learning experiences is sufficient to provide reliable data for program evaluation purposes.
- 8.5 c The 'curriculum committee' (or its subcommittee) uses evaluation data to identify problem areas related to required learning experiences or to curriculum structure and/or delivery and takes effective steps to address these identified problems.
- 8.5 d The evaluation summary data for required learning experiences show that the majority of medical students provide feedback, and that problems and strengths are identified that can be used for program improvement.
- 8.5 e Medical students' evaluation data on individual faculty, residents, and others who teach and supervise them in required learning experiences, are collected by the medical school.
- 8.5 f The evaluation data mentioned in **8.5 e** provided by medical students are used to improve the teaching of faculty, residents and others who teach and supervise medical students in required learning experiences.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

8.5a Student evaluations of seminars, small group learning sessions, lectures, and courses are expected to be completed at the end of the required courses using the online Medical Student Information System (MedSIS) platform. Input regarding learning activities is also collected through student representatives on course committees, the Foundations and Clerkship Committees, and the MD Program Curriculum Committee. The MedSoc Class Presidents also gather students' input and then share it with program leadership.

Students provide evaluation data on individual teaching faculty and residents using a standardized online form that addresses several teaching criteria. This applies to large group, small group and one-on-one teaching formats. Students are invited to complete these forms at the end of each learning activity or course using MedSIS.

8.5b Many students complete the end of course evaluations. Response rates, however, vary between 20-98% for Foundations courses, and 83-99% in Clerkship.

The low response rate for Foundations has been identified as an issue by the school, and the team concurs, particularly in light of the relatively recent introduction of the Foundations Curriculum. Initiatives in 2019-2020 have been implemented to improve response rates; their effectiveness is not yet known. (SM)

8.5c The MDCC and appropriate subcommittee uses evaluation data to identify problem areas related to required learning experiences or to curriculum structure and/or delivery and takes effective steps to address these identified problems. Persuasive examples were provided for the team's review.

8.5d Students are required to complete evaluations. As indicated in the DCI, students who do not meet this requirement must contact their course director for access to their own electronic assessments. This does not apply to final component grades, which are provided regardless of student compliance with this requirement. The Office of Assessment and Evaluation (OAE) aggregates data from course evaluations, analyzes the data based on average scores, standard deviation and number of responses. The OAE provides the summary course evaluation data to course directors and their course committees, who use the data to highlight areas of strength, and to determine areas of challenge/improvement in annual course reports. Each course director must provide commentary on the results of course evaluations in the annual course report, particularly in areas where results show low performance

8.5e Students provide evaluation data on individual faculty and residents using a standardized online form that includes several teaching criteria. This applies to large group, small group and individual teaching formats. Students are notified to complete these forms at the end of each learning experience using the online platform MedSIS. Students are required to complete evaluations, and as indicated in the DCI, students who do not meet this requirement must contact their course director for access to their own electronic assessments. This does not apply to final component grades which are provided regardless of student compliance with this requirement.

8.5f Teaching evaluation reports (TES scores) are provided directly to teaching faculty, as well as relevant designated individuals/groups, such as Course Directors, department Chairs and Vice-Chairs Education, Academy Directors, etc. (see Element 8.3) All full-time faculty members are required to undergo an annual review at which time their chief and/or chair reviews their undergraduate teaching effectiveness. The Department leaders work with the faculty to develop a personalized development plan as needed.

Annually, the MD program flags for each department the bottom decile of teachers as well as those with rating below 3.0 and requires that each department chair report back to the MD Program on what action has been taken to address and remediate those teachers identified as having potential difficulties in teaching. (See Element 4.4)

The MD Program also reports on the top decile of teachers in each course to highlight effective teachers for awards and other department purposes. Teachers in the top decile in each department receive an individualized letter of thanks for their contribution to the MD Program from the Vice Dean and the Chair of the MD Program Awards Committee.

Resident teaching scores are provided to residents as well as to their program directors. Individual scores are also provided to the department chairs who are responsible for reviewing all scores. While there is some variability among departments, the majority of departments delegate review of these scores to division heads and clinical chiefs.

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.

Requirements

- 8.6 a The vast majority of students completed (either with real or alternative experiences) all of the required patient encounters and procedures by the time of graduation at each campus over the last three academic years.
- 8.6 b The vast majority of the required patient encounters and procedures took place with real patients at each campus over the last three academic years.
- 8.6 c Standardized patients, simulations, or virtual patients are used to remediate identified gaps in medical students' completion of the required patient encounters and procedures.
- 8.6 d The medical school uses an effective system for students to log their required patient encounters and procedures that can be monitored in real time.
- 8.6 e The completion of the required patient encounters and procedures of each medical student is monitored during all required clinical learning experiences. These data are discussed with the student at the mid-point of a required clinical learning experience by the student's preceptor, director of the required clinical learning experience, site director or designated faculty member. The student's clinical experience is appropriately altered if needed to optimize completion of the required patient encounters and procedures.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

8.6a Table 8.6-1 (Appendix C-36) shows that over the previous three academic years, 100% of required patient encounters and procedures (Case Logs) have been completed for each graduating class.

8.6b Required clinical experiences in the core clerkship rotations: The target is to have students complete 80% of all Case Logs in each required Clerkship course with real patients, with 80% of all Case Logs across Clerkship as a whole completed with real patients. See Element 6.2 for further details.

8.6c Various alternative learning experiences are illustrated in table 8.6-2 (Appendix C-37). Also, high fidelity simulations, online cases/videos, completion of theoretical cases with physician supervisors, and additional reading materials are available to students where a Case Log requirement is not mandated to be completed with a real patient.

8.6d All MD students use MedSIS to indicate completion of Case Logs for each course and the Clerkship as a whole. Students use the Case Logs in MedSIS to keep track of their progress online. Course directors, the Clerkship Director, and MD Program staff with a need to verify Case Logs may access a student's progress in the system.

8.6e All physicians who supervise a medical student must discuss the Case Logs with the student at the mid-point of the rotation. If needed, there is review with the student and plans and adjustments are made to ensure completion of required patient encounters and procedures are completed by the end of the rotation.

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.

Definitions taken from CACMS lexicon

- *Comparable: Very similar, like, commensurate, close.*
- *Equivalent: Essentially equal, identical, same.*
- *Learning objectives: Statements of what medical students are expected to be able to do at the end of a required learning experience (see lexicon).*
- *Required learning experience: An educational unit (e.g., course, block, clerkship rotation or longitudinal integrated clerkship) that is required of a student in order to complete the medical education program. These educational units are usually associated with a university course code and appear on the student's transcript. Required learning experiences are in contradistinction to electives, which are learning experiences of the student's choosing.*

Requirements

- 8.7 a The overview data in the DCI show that medical curriculum includes comparable/similar educational experiences and equivalent/same methods of assessment across all locations within a given required learning experience.
- 8.7 b The faculty at each instructional site at each campus are informed of, and oriented to the learning objectives, required patient encounters and procedural skills (when relevant) and assessment methods for the required learning experience in which they participate.
- 8.7 c Faculty members with responsibility for each required learning experience at each instructional sites communicate with each other regarding planning and implementation of the educational experience, student assessment, and evaluation of the required learning experience to ensure that educational experiences are comparable, and methods of assessment are equivalent.
- 8.7 d There are mechanism for the review and dissemination of student evaluations of their educational experience, data regarding students' completion of required patient encounters and procedural skills (when relevant), and student performance data, and any other information reflecting the comparability of learning experiences across instructional sites.
- 8.7 e The 'curriculum committee' (or its subcommittee) reviews the data mentioned in **8.7 d** and takes steps when needed to address lack of comparability in the educational experience identified in the data.
- 8.7 f The strategies used by the medical school to address inconsistencies across instructional sites that were identified in student satisfaction data and/or student performance data are appropriate and likely to address identified problems.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

8.7a The overview data in the DCI show that medical curriculum includes comparable educational experiences and same methods of assessment across all locations within a given required learning experience. At the site visit, both leaders and faculty members confirmed that considerable attention is paid to ensure comparability of learning experiences. Examples are also provided in the documentation to support this.

8.7b Detailed information for each required learning experience (i.e., course) is made known to all faculty members at all instructional sites via the MD Program's web-based learning management system (Elentra). This information includes the course learning objectives as well as details regarding teaching methods, required experiences, assessment methods, and evaluation criteria. Course administrators inform faculty members participating in the teaching of a course of the location/availability of this detailed course information in Elentra.

8.7c The Foundations clinical skills director meets with site leads and administrators regularly to ensure consistent content delivery.

In Clerkship, communication occurs between course directors and site leads. All Clerkship site leads are members of their respective Clerkship course committees.

The Academy Directors Committee meets monthly, and includes the Vice Dean, MD Program, Foundations Director, Clerkship Director, and Associate Dean, Health Professions Student Affairs. Part of the mandate of the committee is to review curriculum delivery across sites for consistency and equity.

8.7d Throughout the year, all students are assessed by their clinical preceptors. The assessment tools are standardized for all students. This process – including the management of forms and data collection – is supported through the program's student information system (MedSIS). Comparability of student assessments and student experiences, as reflected in student evaluations of those experiences, is reviewed and compared across sites by all course directors.

8.7e The course committees of all courses in both Foundations and Clerkship review the comparability across sites for their course. The results of the course committee's interpretation of and response to these data are included in the annual course report, and these elements are reviewed in conjunction with the annual course report/review process by the Program Evaluation Committee, and subsequently by the MD Curriculum Committee. Discrepancies in performance or experience would then be explored and addressed as appropriate.

8.7f Two specific examples were provided:

- “The first example is student driven. Rotation evaluations reviewed from an affiliated site demonstrated a poor student experience. The course director working with both the academy director and the clerkship director removed students from this site and placed them at another site with capacity and with excellent rotation evaluations. Ongoing discussions regarding capacity and student experience between the site leads involved and directors ensures both that we are responsive to both student learning experience and learning environment and that we provide the required clinical activities.”
- A second example was identified by a site lead at one of the hospitals with regards to the challenges of recruiting patients with psychiatric illnesses. This issue was brought to the academy directors' table where discussions ensued on how different hospitals/academies were addressing this patient recruitment problem. By having a central table, it was determined that this was a challenge at all sites, so solutions were implemented uniformly.”

The strategies used by the medical school to address inconsistencies across instructional sites are appropriate and likely to address identified problems.

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.

Definition taken from CACMS lexicon

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

Requirements

- 8.8 a There is a policy or equivalent document(s) related to the amount of time per week that students spend in required learning activities including required activities assigned to be completed outside of scheduled class time during the first two years of the curriculum.
- 8.8 b This policy was approved by the 'curriculum committee' and is disseminated to students, faculty, residents and others involved in required learning experiences in the first two years of the curriculum.
- 8.8 c The 'curriculum committee' (or its subcommittee) monitors the spent in educational activities of medical students in the first two years of the program on a regular basis.
- 8.8 d There are mechanisms for students to report violations of the policy mentioned in **8.8 a** and steps are taken to rectify identified problems.
- 8.8 e Student survey data show that the vast majority of respondents in all years of the program are satisfied/very satisfied (aggregated) with the time spent in educational activities in the pre-clerkship years of the program.
- 8.8 f There is a policy or equivalent document related to the time students spend in educational and clinical activities during required clinical learning experiences, including on-call requirements.
- 8.8 g The policy mentioned in **8.8 f** was developed by appropriate faculty members, approved by the 'curriculum committee' and disseminated to students, faculty, residents and others involved in required clinical learning experiences.
- 8.8 h The 'curriculum committee' (or its subcommittee) monitors the effective application of the policies for required clinical learning experiences on a regular basis.
- 8.8 i There are mechanisms for students to report violations of the policy mentioned in **8.8 f**, and steps are taken to rectify identified problems.
- 8.8 j Student survey data show that the vast majority of respondents in year 3 and year 4 of the program are satisfied/very satisfied (aggregated) with the time spent in educational activities and patient care activities in the clerkship years of the program.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

8.8a The *Standards for time spent in required learning activities in the Foundations Curriculum* clearly stipulate the amount of time per week that students spend in required learning activities including required activities assigned to be completed outside of scheduled class time during the first two years of the curriculum.

8.8b The Standards were developed by the Foundations Committee (members include the Foundations Director, Course directors, and medical students) and subsequently approved by the MD Curriculum Committee. The Standards are referenced in the MD Program Academic Calendar, which is published annually. An email announcing the publication of the calendar is sent to students and teachers in mid-August. The MSS and the DCI indicate that medical students are required to submit an acknowledgement form saying they have reviewed the Academic Calendar.

8.8c At the end of each Foundations course, an estimate of the amount of time spent on self-learning activities and scheduled learning events is generated from data captured in Elentra. Students are asked to complete weekly evaluation forms which specifically ask about the appropriateness of the duration of self-learning activities. Course directors review all these data at the end of each Foundations Course and include commentary in their course reports. In the DCI and MSS it is indicated that course reports, including commentary on time spent in educational activities are reported to the MD Curriculum Committee.

8.8d Course directors hold primary responsibility for ensuring compliance with Standards. Concerns from students, teachers or administrative staff regarding breaches can and are brought to the attention of the Course Director. Course evaluation forms completed by students at the end of each course include questions related to whether the course complies with Standards. As per the DCI and the MSS, if any breaches are reported, this information is sent to the Foundations Director to be reviewed and addressed.

8.8e In the DCI, ISA data confirm that that the vast majority of respondents in all years of the program (aggregate) are satisfied/very satisfied with time spent in pre-clerkship educational activities: Year 1 – 84.8%; Year 2 – 88.5%; Year 3 – 86.5%; Year 4 – 84.2%

The vast majority of students from all years in all academies located at the St. George Campus (FitzGerald, Peters-Boyd and Wightman-Berris) were satisfied/very satisfied with time spent in pre-clerkship educational activities, with values ranging from 80.7-92.8%. Only Year 1, Year 2 and Year 4 students from the MAM Academy expressed slightly lower degrees of satisfaction with values of 75.9%, 79.2%, and 79.2% respectively.

Based on feedback from student members of the MSS subcommittees, it was noted in the MSS that the lower satisfaction rates among MAM students may indicate dissatisfaction with commute times to various required educational activities, rather than time spent in the activities themselves.

8.8f The Standards for call duty and student workload in the Clerkship (Appendix 8.8.b) include daily work hour limits (including clinical and educational activities) as well as on-call requirements.

8.8g The Standards are aligned with existing Professional Association of Residents of Ontario (PARO) guidelines, and were developed and approved by the Clerkship Committee, and subsequently approved by the MD Curriculum Committee.

The Standards are referenced in the MD Program Academic Calendar and are available on the MD Program webpage. Students are also made aware of the Standards through e-mails, orientation activities (Clerkship Information Night, Transition to Clerkship, course orientations), and on course websites in Elentra. In the DCI it is documented that faculty members and residents are notified of these Standards via communication from course directors, and through their inclusion in teaching materials and course websites.

8.8h The MD Curriculum Committee has delegated responsibility for monitoring compliance with the Standards to the Clerkship Committee, and receives reports twice annually from the Clerkship Committee during the academic year, and from the Program Evaluation Committee as part of annual course reports

8.8i A Duty Hours Working Group was struck to address the concerns noted at the time of the 2012 visit. It is

confirmed in the DCI and MSS that as a result of the work of that group, policy infractions have come down dramatically over time. Improved data collection and review efforts have enabled the Clerkship Committee to focus on sites where problems emerge and to involve course directors early in the resolution of issues.

8.8j ISA data in the DCI show that satisfaction (satisfied/very satisfied) with time spent in clinical and educational learning activities across clerkship is very high, ranging from 91.7-97.9% among all academies

STANDARD 9
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

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

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

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.

Definitions taken from CACMS lexicon

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

Requirements

- 9.1 a The learning objectives and the methods of assessment of the required learning experience are explained to residents, graduate students, postdoctoral fellows and other non-faculty instructors who supervise, teach or assess medical students before engaging in teaching and assessment activities at all instructional sites.
- 9.1 b Residents at all instructional sites participate in centrally or departmentally delivered faculty development activities to enhance their skills in teaching and assessing medical students.
- 9.1 c The faculty development activities noted in **9.1 b** are mandatory for residents who supervise, teach or assess medical students and attendance is centrally monitored.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.1a In the DCI it is shown that there are various means through which residents and non-faculty instructors are oriented to the learning objectives and assessment methods for required learning experiences (i.e., MD Program courses), which include Elentra (the program's learning management system), targeted emails, in-person orientation, and course-specific faculty development activities.

9.1b The DCI shows that all residents must complete an online module (“Teaching in Residency”) that is part of a suite of online learning modules (PGCorEd) required for all PGY1 resident learners at the University of Toronto. There are also program- and department-specific program(s) available to residents to enhance their skills in teaching and assessing medical students. University of Toronto residents are also invited to attend faculty development activities through the Centre for Faculty Development and MD Office of Faculty Development.

9.1c The “Teaching in Residency” module is mandatory for all PGY1 resident learners at the University of Toronto, who must successfully complete the module by September 30th of their PGY1 training year. The DCI indicates that residents must achieve a passing score to receive credit for the module. Completion is monitored and tracked by the PGME office.

9.2 FACULTY APPOINTMENTS

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

Definition taken from CACMS lexicon

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

Requirements

- 9.2 a The medical school has a policy requiring physicians who supervise, teach and assess medical students in required clinical learning experiences to have a faculty appointment in the medical school.
- 9.2 b All physicians who supervise, teach and assess medical students in a required clinical learning experience at all instructional sites have a faculty appointment in the medical school.
- 9.2 c Where direct teaching or assessment of students in a required clinical learning experience is carried out by individuals who do not hold a faculty appointment, the teaching activities provided by these individuals are overseen by physicians who hold a faculty appointment. The faculty member ensures that the teaching is aligned with the learning objectives, is of good quality, and the learning environment is appropriate.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.2a The MD Program Academic Calendar states that any physician who supervises, teaches, and assesses and MD student must have a faculty appointment. The MSS reports that all university-hospital affiliation agreements contain a requirement that any staff physician who supervises a student must apply for and obtain a University faculty appointment.

9.2b The DCI shows that in each required MD course, the number of individuals supervising and assessing without a faculty appointment is very low (106/2846*; 3.7%). In cases where physicians do not have a faculty appointment, the teacher's educational activities are overseen by a site coordinator, who is in all cases a member of the faculty. (*Denominator: All supervisors who assessed a student and/or for whom a teaching evaluation was triggered.)

9.2c The DCI indicates that all Clerkship site leads/coordinators hold faculty appointments and are responsible for ensuring the quality of teaching, assessment, and learning environment, including supervising any teachers without University faculty appointments. Site leads are accountable to Clerkship course directors for all educational activities, and all course directors have an active faculty appointment.

9.3 CLINICAL SUPERVISION OF MEDICAL STUDENTS

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

Requirements

- 9.3 a The medical school central administration and the departments ensure that medical students in clinical learning situations involving patient care are appropriately supervised at all times to ensure patient and student safety.
- 9.3 b The medical school has policies or guidelines related to medical student supervision during clinical learning experiences involving patient care that ensure student and patient safety.
- 9.3 c There are mechanisms by which medical students can express concern about the adequacy and availability of supervision. The concerns raised by medical students are acted upon.
- 9.3 d The medical school ensures that the level of responsibility delegated to a medical student is appropriate to the student's level of training and experience.
- 9.3 e The activities delegated to a student and supervised by a health professional, who is not a physician, are within the scope of practice of that health care professional.
- 9.3 f Student survey data show that the vast majority of respondents at each campus agree/strongly agree (aggregated) that 1) the level of supervision a) ensured their safety, and b) ensured the safety of the patients for whom they provided care and 2) that they were given appropriate responsibility for patient care.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.3a Medical students are carefully supervised on every clerkship rotation. The DCI indicates that during required clerkship rotations, there are in general two kinds of supervisory situations that may be used: students are either assigned directly to a single faculty supervisor, or they are assigned to a multi-level team that includes a staff physician and one or more resident physicians plus one or more students. Ultimately, the faculty physician is responsible for both the patient care and teaching activities of any such team. Students are never on-call by themselves. While students are permitted to write orders (or enter orders into an electronic order-entry system), these orders are not carried out until they have been verified by either the supervising resident or attending physician. Students are carefully observed at the start of each rotation by their supervising resident and/or attending physician to ensure they are demonstrating a suitable level of clinical skill to permit them to assess patients on their own.

9.3b The Faculty of Medicine/Affiliated Institutions *Guidelines for Ethics & Professionalism in Healthcare Professional Clinical Training and Teaching* describes the expectations of clinical faculty members who supervise medical trainees, with specific consideration of both student and patient safety. The MSS indicates that the College of Physicians and Surgeons of Ontario (CPSO) policies on learner supervision also address the need for student and patient safety and are provided to all faculty members in all departments by the Office of the Dean each year.

9.3c Students are asked to complete online evaluations for all supervisors/teachers they encounter (including

faculty members and residents). Each end-of-course evaluation contains questions that enable students to evaluate adequacy of supervision by residents and attending physicians. The DCI documents that when serious concerns are identified, the following individuals are empowered to respond: site directors, course directors, Academy Directors, Clerkship Director, and Vice Dean, MD Program. The level to which the concern is escalated depends on the site and seriousness of the concern.

9.3d As outlined in the DCI, all students who enter clerkship must have completed the Foundations curriculum (Years 1 and 2) and Transition to Clerkship (TTC) course satisfactorily. In the early portion of each clerkship course, students are carefully observed to ensure they can appropriately carry out key tasks such as taking a history, performing a physical examination, documenting clinical findings, and interacting appropriately with patients, families and other health professionals. Also, students are able to provide feedback about the level of responsibility they had on each rotation, via the end-of-rotation evaluation forms. The responses to these questions, and any associated comments, are scrutinized by Site Directors and Clerkship Course Directors, and if any concerns are identified (i.e., students having either not enough responsibility or being given too much responsibility), then appropriate corrective action is taken by either the Site Director or Course Director as required.

9.3e The DCI indicates that medical students in the clinical environment are under the primary supervision of the “Most Responsible Physician”, in accordance with CPSO policy. Since patient care is often provided in teams with non-physician professionals, students may work alongside these professionals in a clinical environment, but in all cases the students are supervised and assessed by a physician supervisor who is a member of the faculty.

9.3f Student survey data show that the vast majority of respondents at each campus agree/strongly agree (aggregated) that 1) the level of supervision a) ensured their safety, and b) ensured the safety of the patients for whom they provided care and 2) that they were given appropriate responsibility for patient care.

The DCI shows that the following percentage of respondents agreed/strongly agreed that the level of supervision:

- ensured their safety: 92.3-100% in 2018-2019
- ensured safety of patients for whom they provided care: 92.3-100% in 2018 (except 88.1% in Surgery at one academy) and 94.6-100% in 2019.

The percentage who agreed/strongly agreed they had appropriate responsibility for patient care:

- 80.6-100% in 2018 & 2019, except in Surgery at FitzGerald Academy in 2018 (66.7% – up to 82.9% in 2019) and Surgery at MAM in 2019 (76.5%), During the visit, students were split on whether they would want more or less responsibility in Surgery. They postulated that these numbers reflect the career interests of the students themselves: would-be surgeons would seek more responsibilities, while non-surgeons would seek less.
- 50% in Longitudinal Integrated Clerkship (LInC) in 2019

LInC had a low number of participants and was discontinued in January 2018 (i.e., not available for the 2018-19 academic year and beyond).

9.4 ASSESSMENT SYSTEM

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

Definition taken from CACMS lexicon

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

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

This element was cited (as Standard ED-27) in 2012.

9.4a The DCI documents that the medical school has a centralized system in place that monitors student achievement of the medical education program objectives including core clinical skills throughout the duration of the MD program at all instructional sites.

9.4b Student achievement of the learning objectives of each required learning experience and of the medical education program as a whole is systematically assessed using a variety of measures. In the DCI it is described how assessment tools, methods and processes are planned, arranged and coordinated to give the school a comprehensive and holistic picture of learner progress.

9.4c The various methods of assessment are determined by the knowledge, core clinical skills, behaviours and attitudes being acquired and are appropriate for the respective learning experiences.

9.4d The program requires a Year 1 mid-term formative Clinical Skills assessment and OSCEs in Years 1 and 2. The Clerkship integrated OSCE (iOSCE) occurs in two phases, one at the mid-point of Year 3, and the final iOSCE at the end of the Year 3 Clerkship (after 48 weeks of instruction and completion of all required core clinical courses).

9.4e The MD Program Curriculum Committee makes all final decisions related to standards of achievement and grading policies. The Student Assessment and Standards Committee (SASC), reporting directly to the MD Curriculum Committee, has delegated responsibility for the review of methods of assessment and standards of achievement set by each course committee.

9.4f The Board of Examiners (BOE) has responsibility for approval of grades and decisions about promotion and remediation. The Foundations Student Progress Committee reviews individual student progress and makes recommendations to the BOE. Similarly, the Clerkship director and Clerkship Course Directors make decisions about student progress and remediation within Clerkship, which are submitted as recommendations to the BOE. Students identified as being in difficulty are required to attend student check-ins and successfully complete focused learning plans or formal remediation, depending on the severity of the difficulty being experienced.

9.4g There is centralized organization of progress tests for all four years. The Office of Assessment and Evaluation and the Curriculum Office plan and schedule written assessments in Years 1 and 2 (weekly feedback quizzes, mastery exercises).

9.4h Data in the DCI show high agreement that respondents were observed taking a history, ranging in all disciplines from 84.6% to 100%, except in Obstetrics & Gynecology at FitzGerald (77.8%) and in Surgery at Mississauga (76.5%), Peters-Boyd (70.3%) and Wightman-Berris (78%). Agreement in Surgery was 85.7% at FitzGerald. The Surgery numbers fluctuated at all academies over the last three years but are generally stable or increasing slightly.

ISA data show similarly high levels of agreement in observed history taking across academies, with some notable exceptions. Year 3 ranges from 100% to a low outlier at 68.2% in OBGYN at Mississauga. Year 4 shows a range of agreement, with the lowest agreement in Surgery at all four academies (69.9% to 77.1%) and OBGYN at FitzGerald, Mississauga and Wightman-Berris. (U)

9.4i AFMC GQ data show that 2019 respondents agree in large numbers for all disciplines, except Surgery, that they were observed conducting a physical exam, ranging from 90.5 to 100%. The agreement in Surgery at Mississauga and Peters-Boyd was 79.4% and 70.3%, respectively. These numbers are increasing over time at Mississauga.

ISA data also demonstrate generally high agreement with regards to direct observation of a student undertaking a physical examination. Significant outliers are Year 4 Surgery at FitzGerald (70.6%), Years 3 & 4 Surgery at Peters-Boyd (74.1 and 78.0%), and Years 3 & 4 Surgery at Wightman-Berris (73.3 and 79.5%). (U)

9.5 NARRATIVE ASSESSMENT

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

Definitions taken from CACMS lexicon

- *Narrative assessment: A written description of a student's performance that is provided in addition to a grade (e.g., pass/fail, letter or number) to help guide learning.*
- *Non-cognitive: Refers to the physician's intrinsic CanMEDs roles.*
- *Required learning experience: An educational unit (e.g., course, block, clerkship rotation or longitudinal integrated clerkship) that is required of a student in order to complete the medical education program. These educational units are usually associated with a university course code and appear on the student's transcript. Required learning experiences are in contradistinction to electives, which are learning experiences of the student's choosing.*

Requirements

- 9.5 a A narrative/written description of a medical student's performance, including his or her non-cognitive achievement is included as a component of the assessment in all required learning experiences whenever teacher-student interaction permits this form of assessment.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.5a The MD Program's Standards for formative and narrative assessment and feedback stipulates that "For all required learning experiences, a narrative description of a medical student's performance, including his or her non-cognitive achievement, should be included as an assessment component whenever teacher-student interaction permits this form of assessment." Narrative feedback is also provided at midpoint for programs 4 weeks duration or longer.

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.

Definition taken from CACMS lexicon

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

Requirements

- 9.6 a The medical school ensures that faculty members with appropriate knowledge and expertise set the standards of achievement for required learning experiences and for the curriculum as a whole.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.6a The MD Program Student Assessment and Standards Committee (SASC) is a subcommittee of the MD Program Curriculum Committee with delegated responsibility for reviewing the assessment methods and standards of achievement of every required learning experience to verify the appropriateness, reliability and validity of the methods and standards based on best available evidence. All recommendations from SASC are presented to the MD Program Curriculum Committee for final approval. SASC membership is comprised of MD Program faculty leadership (assessment and curriculum), clinical department appointed faculty, students, residents, MD Program Office of Assessment and Evaluation education scientists, analysts, and a psychometrician. Membership expertise is in the areas of assessment, curriculum and standard setting. Each required learning experience has a course committee that is comprised of faculty members, including the course director, as well as medical student representatives. See also Element 8.1 for constitution of the MDCC and the various subcommittees.

9.7 TIMELY FORMATIVE ASSESSMENT AND FEEDBACK

A medical school ensures that the medical education program provides timely formative assessment consisting of appropriate measures by which a medical student can measure his or her progress in learning. Each medical student is assessed and provided with formal formative feedback early enough during each required learning experience four or more weeks in length to allow sufficient time for remediation. Formal feedback 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 required learning experiences) formal feedback occurs approximately every six weeks. For required learning experiences less than four weeks in length alternate means are provided by which a medical student can measure his or her progress in learning.

Definition taken from CACMS lexicon

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

Requirements

- 9.7 a Formative assessment consisting of appropriate measures by which a medical student can measure his or her progress in learning is provided in all required learning experiences.
- 9.7 b Provision of formative assessment in required learning experiences is monitored.
- 9.7 c Each medical student is assessed and provided with formal formative feedback early enough during each required learning experience four or more weeks in length to allow sufficient time for remediation.
 - i. Formal feedback occurs at least at the mid-point of the learning experience or
 - ii. Formal feedback occurs approximately every six weeks for required learning experiences that are semester or year-long (e.g., longitudinal integrated clerkship).
- 9.7 d Provision of formal feedback described in **9.7 c** is monitored to ensure it occurs at all instructional sites.
- 9.7 e Alternate means are provided by which a medical student can measure his or her progress in learning in required learning experiences less than four weeks in length.
- 9.7f Student survey data or medical school administrative data show that the vast majority of medical students received mid-point feedback (early enough to allow them to improve their performance) in each required clinical learning experience. Student survey data show that the vast majority of respondents in all levels of the program are satisfied/very satisfied (aggregated) with the amount and quality of formative feedback they received.
- 9.7 g Medical school administrative data or other data source for the last three academic years show that students in longer educational experiences (half-year, year-long required experiences, (e.g., longitudinal integrated clerkship)) receive formal feedback approximately every six weeks.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.7a The MD Program's Standards for formative and narrative assessment and feedback describes the requirements for all required courses to provide formative and/or narrative feedback.

Data show that all Foundations courses provide ongoing formative assessment in a wide variety of formats, including written assessments, assessment forms (e.g., Professionalism), presentations, formative OSCEs, and progress tests.

Clerkship courses of four weeks or longer require the provision of formative feedback by at least at the mid-point of the rotation. The Standards describe requirements for rotations that are less than four weeks as well as for sub-rotations. Other formative feedback mechanisms in Clerkship include “frequent encounter cards” (in Anesthesia, OB/GYN, Emergency), observed clinical encounters (Family Medicine, Psychiatry), and feedback on written reflections for Portfolio.

9.7b The MD Program follows a programmatic assessment model, which informs the design of each course to ensure ongoing, formative assessments. Foundations course directors monitor the provision of formative feedback to all students based on data provided by the MD Office of Assessment and Evaluation.

All Clerkship students must receive mid-point feedback from site directors or their delegates during required rotations of four weeks or longer. Students must have a completed standardized Interim Feedback Form to receive credit for the course. MedSIS-generated reminders are sent to preceptors and students to ensure completion of the Interim Feedback Form, and course directors and course administrative staff monitor and ensure completion of Interim Feedback Forms for each Clerkship course.

9.7c Students in Foundations courses receive ongoing feedback throughout each course, at a minimum on a weekly basis.

For Clerkship courses that are four weeks or longer, the Interim Feedback Form is triggered at the mid-point of the rotation (2, 3, or 4 weeks, depending on the length of the rotation). A completed Interim Feedback Form is required for Clerkship courses that are four weeks or longer, and course directors and administrative staff follow up with faculty members and students regarding delinquent submission of forms to ensure compliance.

9.7d Provision of feedback in all years of the MD Program is monitored centrally by course directors and administrative staff. The MD Program utilizes centralized technology (e.g., ExamSoft, Learner Chart, and MedSIS) to monitor formative feedback to students. Course directors and course staff are responsible for ensuring that students at all four academies and across all distributed sites complete the same requirements.

9.7e In programs less than 4 weeks in length, students interact one-on-one with supervising physicians and residents. Students also receive physical exam skills encounter cards that must be completed and observed by faculty members during clinics. Another program provides mid-point feedback to all students. Students also work one-on-one with a staff and complete an entry and exit simulation day, which includes observed clinical skills with immediate feedback.

9.7f The ISA survey data show that a large number of students in Years 3 and 4 acknowledge receiving mid-point feedback during required Clerkship courses. There is some variability across the four academies, across courses, and between years, but in general rates are high. Areas of concern in these data are: Mississauga – Ob/Gyn, Year 4 (77.1%); Peters-Boyd – Surgery (66.7% and 74.0%).

The AFMC GQ shows generally stable or increasing acknowledgement by respondents over the last three years that they received mid-point feedback. There is some spread across academies and courses, but with rates generally ranging from the high 79% to 100%. The main exceptions to this are in Surgery at all academies (except Wightman-Berris 90% in 2018-2019) - Mississauga 75.9% - 80.8% - 67.6%, FitzGerald 75% - 65.9% - 77.1%, Peters-Boyd 71.4% - 85.1% - 75.7% and Ob/Gyn at FitzGerald (decreasing from 83.3% to 76.2% to 75.0%).

Despite the retrospective survey data from the ISA and the GQ, the administrative report from MedSIS of data gathered immediately following Clerkship rotations on the completion of the Interim Feedback Form for all Clerkship courses demonstrates that nearly 100% of all students had an Interim Feedback Form submitted for them. The team accepted this record as more accurately reflecting the school’s adherence to this requirement.

ISA data show that students in all four years of the program are satisfied/very satisfied with the amount and quality of formative feedback received. Satisfaction is particularly high across all four years for feedback received during pre-clerkship, ranging from a low of 87.3% in Year 2 to above 90% in all other years. Satisfaction for feedback received during Clerkship is lower than pre-clerkship, but still very high – 86.0% in Year 3 and 80.2% in Year 4.

9.7g Not applicable to this MD program

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.

Definition taken from CACMS lexicon

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

Requirements

- 9.8 a All students receive their final grades no more than six weeks after the end of a required learning experience at each campus.
- 9.8 b Provision of final grades is monitored, and steps are taken to meet the expected timeline.
- 9.8 c The medical school has a policy or guidelines specifying the timeline for provision of final grades for all required learning experiences.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.8a DCI data (Appendix C-49) show that all Foundations courses provide final grades to students within six weeks of the end of the course. Those students who received grades after the six week mark were identified as being in academic difficulty and were notified of the need for remedial work before a final grade could be issued. That notification was made within the six week period.

On average, most Clerkship courses provided final grades to students at both campuses within the six week maximum. There are still rare outliers for the maximum time to receive grades, but numbers of students who fall into this category are quite low. Data for Otolaryngology (a one-week rotation) still shows that > 16% of students do NOT receive grades within 6 weeks (maximum time 7.9 weeks), but most Clerkships are at 0-3% for this measure.

The school pays close attention to these data, and escalating steps are taken to address issues of compliance with this requirement. These measures have been successful for most Clerkships; Otolaryngology has been more refractory to intervention. (SM)

9.8b In Foundations, the Foundations Student Progress Committee (SPC) meetings are scheduled near the end of each course and prior to the Board of Examiners (BOE) meeting to ensure that final grades can be released to students in a timely manner.

The Clerkship Committee reviews grade availability data for all courses on a twice annual basis. If course-specific issues arise, data are distilled down by site so those issues can be identified and addressed. Course directors may be asked to develop action plans at the course committee level and report back to the Clerkship Committee. The Clerkship Course Administrators group meets monthly and discusses and monitors compliance with the Standards for timely completion of student assessment and release of marks

9.8c The MD Program abides by the Standards for timely completion of student assessment and release of marks,

approved and reviewed on an ongoing basis by the MD Curriculum Committee.

9.9 STUDENT ADVANCEMENT AND APPEAL PROCESS

A medical school ensures that the medical education program has a single standard for the advancement and graduation of medical students across all locations. The medical school has 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.*

Requirements

- 9.9 a The requirements for advancement and graduation are the same at all locations.
- 9.9 b A mechanism exists that ensures that the same principles are consistently applied in analyzing student performance data and making pass/fail and advancement decisions at all instructional sites.
- 9.9 c The medical school's requirements for advancement and graduation are made known to students and teaching faculty.
- 9.9 d There is a fair and formal (documented) process for taking any action that may adversely affect the status of a medical student that includes timely notice of impending action, disclosure of the evidence on which the action would be based, an opportunity for the medical student to respond, and an opportunity to appeal any adverse decision related to advancement, graduation, or dismissal in a fair and impartial hearing.
- 9.9 e A description of the process for taking any action that may adversely affect the status of a medical student, and a description of the appeals process are made known to all medical students.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.9a The MD Program's Standards for grading and promotion of MD students – Foundations (Years 1 and 2), Standards for grading and promotion of MD students – Clerkship (Years 3 and 4), and Guidelines for the Assessment of Student Professionalism (which applies to students across all four years of the program) articulate standards for advancement and graduation that apply across all locations. There are processes and practices that ensure that these standards for advancement and graduation are applied across all locations.

9.9b There are processes and practices that ensure that these standards for advancement and graduation are applied across all locations. Under the leadership of the course directors, it is the responsibility of each Foundations and Clerkship course committee, in consultation with relevant curriculum leaders and the Student Assessment and Standards Committee (SASC), to define satisfactory completion of each type of assessment required for their respective course. The program's Guidelines for the assessment of student professionalism articulate professionalism standards of achievement that apply across all courses and locations. The assessment of student professionalism is supported through the use of a standardized competency-based student professionalism assessment form. A description of course-specific assessments, as well as the standards of achievement for the course as a whole, are made known to students and teaching faculty at all locations. Marking rubrics are provided to standardize assessment where judgement is required.

9.9c Requirements for advancement and graduation are explicitly referenced in the MD Program Academic Calendar, which students are required to review on an annual basis. Those requirements are also publicly

available at all times on the MD Program's Policies webpage and are made available on individual course websites in Elentra, the program's learning management system.

9.9d The Foundations and Clerkship *Guidelines for the Assessment of MD Students in Academic Difficulty* and *Guidelines for the Assessment of Student Professionalism*, and *Faculty of Medicine Appeals Guidelines*, describe processes for timely notification of students of any impending action, actions taken, adverse decisions, and opportunities to respond or appeal. Templated letters and oral communication from the Foundations or Clerkship director outline the evidence as well as opportunities to respond or appeal.

9.9e Information regarding the process is made know via the MD Program Academic Calendar, which students are required to review on an annual basis and is also publicly available at all times on the MD Program's Policies webpage. A description of the process and information on how to appeal adverse decisions is also made available to students in templated letters if they are found to be in academic or professionalism difficulty.

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*

Requirements

- 9.10 a 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.
- 9.10 b Medical students are informed of these policies before they are placed in situations involving patient care.
- 9.10 c Student survey data show that the vast majority of respondents who are placed in situations involving patient care answered they know that their medical school requires them to report situations in which their personal health poses a risk of harm to patients.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

9.10a The following policies and procedures enable the MD Program to address situations, once identified, in which a student's personal health reasonably poses a risk of harm to patients:

- COFM Immunization Policy
- COFM Blood Borne Viruses Policy
- Guidelines Regarding Infectious Diseases and Occupational Health for Applicants to and Learners of the Faculty of Medicine Academic Programs
- Regulations for Student Attendance and Guidelines for Absences from Mandatory Activities
- Regulations and Guidelines for Leaves of Absence from the MD Program
- Faculty of Medicine Expert Panel on Infection Control Terms of Reference
- MD Program Protocol for Incidents of Medical Student Workplace Injury and Exposure to Infectious Disease in Clinical Settings
- University of Toronto University-Mandated Leave of Absence Policy

Depending upon the nature of the situation, the applicable policy or policies describe or address timely response by the medical school, provision of accommodation to the extent possible, leaves of absence, and withdrawal processes

9.10b Medical students are informed of the policies in multiple ways before they are placed in situations involving patient care, including via:

- MD Program Academic Calendar (annual email announcement in mid-August and statement of acknowledgement registration requirement)
- Immunization registration requirement by mid-August prior to each year of study (see Element 12.7)
- As part of orientation to/education about infectious and environmental hazards (see Element 12.8)

9.10c The majority of respondents across all years and academies know that the University of Toronto Faculty of Medicine requires them to report situations in which their personal health poses a risk of harm to patients. The lowest proportion of students responding "Yes," is 83.3% in Year 2 at Mississauga Academy, ranging to a high of 98.6% in Year 3 at Wightman-Berris.

STANDARD 10
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 10: MEDICAL STUDENT SELECTION, ASSIGNMENT, AND PROGRESS

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

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.

Requirements

- 10.1 a The medical school's requirements for admission encourage potential applicants to the medical education program to acquire a broad undergraduate education that includes the study of the humanities, natural sciences, and social sciences.
- 10.1 b The education requirements for admission to the MD program are restricted to those deemed essential preparation for the successful completion of the medical education program.
- 10.1 c The education requirements for admission to the medical education program were reviewed and revised, as needed, since the time of the last full site visit.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

10.1a The prerequisites for application include two full course equivalents in life science and one full-course equivalent in humanities, social sciences or languages and completion of at least three years of undergraduate study. This provides significant latitude for course selection/degree type (BA, BSc, BFA e.g.)

10.1b The prerequisites are minimal-two full course equivalents in life science and one full course in humanities, social sciences or languages.

10.1c The requirements are reviewed annually. Last approved April 24, 2019 by the Admissions Committee.

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.

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

10.2a The MD Admissions Committee Terms of Reference stipulate that the MD Admissions Committee is accountable to and derives its authority from the Faculty of Medicine Faculty Council. The composition of the committee and its subcommittees, as well as the rules of operation and voting privileges are specified in the MD Admissions Committee Terms of Reference.

10.2 b) The description of the composition of the committee (Appendix C-50) demonstrates that all committee members have documented experience in undergraduate educational activities and have been selected by their peers to represent diverse constituencies within the Faculty and, more broadly, the University of Toronto. Membership includes faculty members, program administrators, representation from among both Post-graduate and MD students, and associated members with particular expertise in the support and facilitation of the admissions process.

10.2 c) The MD Admissions Committee Terms of Reference stipulate that faculty members constitute a majority of voting members at all meetings. Quorum for the Admissions Committee consists of a simple majority of faculty members and at least one student member.

10.2d All new members of the Admissions Committee meet with the Director, Admissions and Student Finances, to review the overall function of the Committee. Extensive online resources and training material are available to all members of the Admissions Committee.

10.2e The MD Admissions Committee Terms of Reference clearly states that the Admissions Committee makes the final and sole decision regarding all offers of admission to the MD Program.

10.2f There is a policy on conflict of interest relevant to the Admissions committee that ensures that conflicts of interests of committee members are identified and dealt with appropriately.

10.2g Admissions decisions are made by committee members, who are free of conflict of interest. Every Admissions Committee member signs a confidentiality and non-disclosure agreement at the beginning of each admissions cycle.

10.3 POLICIES REGARDING STUDENT SELECTION / ADVANCEMENT AND THEIR DISSEMINATION

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

Requirements

- 10.3 a The faculty of the medical school developed and approved the policies, procedures, and criteria for medical student selection.
- 10.3 b The policies, procedures, and criteria for medical student selection are disseminated to potential and actual applicants and other interested parties.
- 10.3 c In each of the steps in the admission process to the MD program listed below, the established procedures and criteria are followed to make the relevant decision by the appropriate individuals or groups.
 - i. Selection for the interview
 - ii. The interview
 - iii. The acceptance decision
 - iv. The offer of admission
- 10.3 d The authority and composition of the advancement committee (or advancement committees, if there is more than one) and its rules of operation, including voting privileges and definition of a quorum are specified in bylaws or other medical school policies.
- 10.3 e The composition of the medical student advancement committee (or advancement committees if there are more than one) is appropriate to enable the committee to make objective and informed decisions on student advancement.
- 10.3 f The policies for the assessment, advancement and graduation of medical students and policies for disciplinary action are available to medical students and teaching faculty.
- 10.3 g Decisions on the advancement of a medical student to the next academic year, phase or segment of the curriculum, and on the graduation of a medical student is made by the committee with the authority to make those decisions.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

10.3a Supporting documentation clearly describes that all admissions policies, procedures and criteria for student selection are developed, approved and reviewed regularly by the Admissions Committee. Major changes of any component are reviewed and approved by a separate, independent committee-Faculty of Medicine's Education Committee.

10.3b Information on the policies, procedures and criteria are communicated in multiple ways, including publicly accessible website (reviewed by the team), blog and social media accounts, through videos, townhalls, information fairs and publication on the Ontario Medical School Application Service (OMSAS). Changes are announced at least one cycle in advance. The steps for interview selection, the interview, acceptance decisions and offer of admission are all clearly described.

10.3d The authority and composition of the advancement committee and its rules of operation, including voting

privileges and definition of a quorum are specified in the terms of reference.

10.3.e Each advancement committee is comprised of appropriate voting and non-voting members to maintain objectivity and arrive to informed decisions. Student Progress Committee voting members are appointed by the Chair, in consultation with the relevant stakeholder groups. Non-voting advisory members are invited to contribute to the committee as required at the discretion of the Chair and are normally not present during the voting process.

Board of Examiners members include both the appointed and elected faculty members and two medical students. A Board member must declare a potential conflict of interest with any case presented to the Board of Examiners to ensure an appropriate action is taken.

10.3f The policies for the assessment, advancement and graduation of medical students and policies for disciplinary action are available to medical students and teaching faculty. They clearly specify the composition of the Progress Committee and the Board of Examiners and that each committee is comprised of appropriate voting and non-voting members. Conflict of interests are determined prior to any discussion. The school publishes annually in the Academic Calendar the policies of student assessment, advancement and graduation and policies for disciplinary action. Students in academic or professionalism jeopardy are provided with written.

10.3g The Board of Examiners is responsible and has authority for final decisions regarding the advancement of a medical student to the next academic period as well as final graduation decisions, informed by recommendations from the Student Progress Committee (for Foundations students) or Clerkship Director or designate (for Clerkship students) and/or Faculty Lead, Ethics & Professionalism (for students in all years).

10.4 CHARACTERISTICS OF ACCEPTED APPLICANTS

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

Requirements

- 10.4 a The characteristics (including intelligence integrity, and others) of applicants considered during the admission process are necessary for them to become competent physicians.
- 10.4 b The characteristics (including intelligence integrity, and others) of applicants considered during the admission process were developed, reviewed, and approved by appropriate individuals or groups.
- 10.4 c Members of the admission committee and the individuals who interview applicants (if different than members of the admission committee) are prepared and trained to evaluate applicants for the required characteristics.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

10.4a The characteristics and values for a medical school student that the working group members identified as important included: Academic excellence, altruism, being caring, collaboration, commitment, communication, compassion, courage, empathy, ethical behaviour, fairness, grit, honesty, humanity, humility, integrity, intelligence, leadership, maturity, morality, perseverance, professionalism, reflection, research potential, resilience, and responsibility. These were further distilled down to four themes of personal attributes:

- Intelligence
- Ethics
- Resilience
- Leadership

The team concurred that these characteristics are reasonably considered necessary for competent physicians.

10.4b The list of characteristics was developed by the MD Admissions Requirements Working Group between January 2017 and November 2018, and subsequently approved by the MD Admissions Committee. The membership of this working group was comprised of an appropriately diverse group of faculty members, students, education scientists, and admissions officers.

10.4c Interviewers must attend a training preparation on the day of the interview. All interviewers are “given access to online training modules” and “can attend on-site training workshops” but have not always done so. This year the office was able to track the number of interviewers who did the online modules. It was reported during the visit that participation in the online training modules is now required for all new interviewers.

10.5 TECHNICAL STANDARDS

A medical school develops and publishes technical standards for the admission of applicants and the retention and graduation of medical students.

Definition taken from CACMS lexicon

- *Technical standards: The underlying cognitive, communication, sensory, motor and social skills necessary to interview; examine; diagnose and provide comprehensive compassionate care; and competently complete certain technical procedures in a reasonable time while ensuring patient safety.*

Requirements

- 10.5 a The medical school has technical standards for the admission, retention, and graduation of applicants and students.
- 10.5 b The medical school's technical standards noted in **10.5 a** were developed and approved by the faculty. These technical standards are reviewed and revised when needed on a regular basis.
- 10.5 c The medical school's technical standards noted in **10.5 a** are disseminated to potential and actual applicants, enrolled students and teaching faculty.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

10.5a There are published technical standards ("Essential Skills") for admissions and retention of applicants. It is the standard adopted by the Council of Ontario Faculties of Medicine (COFM) of which U o T is an active participant.

10.5b The Essential Skills were revised and approved by the Undergraduate Education Committee of COFM on October 11, 2016 and approved by the COFM Deans on October 26, 2016. They are reviewed by COFM on an as-needed basis in order to remain compliant with new legislation and medical school requirements.

10.5c Applicants are made aware of the standards when they begin their application to any Ontario Medical school. Annually the school publishes the requirements on a public policies webpage (verified by the team).

10.6 CONTENT OF INFORMATIONAL MATERIALS

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

Definitions taken from CACMS lexicon

- *Academic schedule: The academic schedule indicates dates when classes start and end, and timing of breaks and vacations.*
- *Calendar: The calendar is the university's official listing of admission procedures and deadlines, academic regulations, programs of study, academic standards, degree requirements and general university policies and codes.*
- *Medical education program objectives: Statements of what medical students are expected to be able to do at the end of the educational program i.e., exit or graduate level competencies.*
- *Required learning experience: An educational unit (e.g., course, block, clerkship rotation or longitudinal integrated clerkship) that is required of a student in order to complete the medical education program. These educational units are usually associated with a university course code and appear on the student's transcript. Required learning experiences are in contradistinction to electives, which are learning experiences of the student's choosing.*

Requirements

- 10.6 a 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 degree of Doctor of Medicine and all associated joint degree programs,
 - iii. provide the most recent academic schedule for each curricular option, and
 - iv. describe all required learning experiences in the medical education program.
- 10.6 b Recruitment materials about the medical education program are made available to potential and actual applicants, career advisors, and the public.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

10.6 a The MD Program's mission, goals, and Competency Framework (program objectives) are presented in the *MD Program Academic Calendar*, and are reiterated across the MD Program's websites and associated webpage (which was reviewed by the team).
10.6 b <http://applymd.utoronto.ca> webpage was reviewed and all admission and recruitment information is clearly outlined.

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 medical students in the class that he or she would join. 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.

Definitions taken from CACMS lexicon

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

Requirements

- 10.7 a The medical school has policies and/or procedures related to transfer/admission with advanced standing.
- 10.7 b There are procedures in place for the selection of applicants for transfer or admission with advanced standing whereby the medical school determines the comparability of the applicant's educational program and prior academic achievement to those of medical students in the class they would join.
- 10.7 c In making decisions of accepting transfer students or admitting students with advanced standing, the admission committee or other governance body with the appropriate authority and members of the medical school administrative leadership determine if space and resources are adequate.
- 10.7 d The transfer students and students admitted with advanced standing listed in the DCI demonstrated academic achievements, completion of relevant prior required learning experiences, and had other characteristics comparable to the medical students in the class that they joined.
- 10.7 e Only rare and extraordinary personal or educational circumstances accounted for the decisions to accept any transfer students into the final year of the curriculum during any year since the last full site visit.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

10.7a The school does not accept transfer students or admit students with advanced standing, and this is clearly articulated on the MD Admissions website.

10.7b Students who are currently attending another MD program at another institution must apply for admission with the other first-time applicants and must complete the entire 4-year MD Program at the University of Toronto.

10.7c The MD Program does not accept transfer students; no resource implications need to be considered.

10.7d No transfer or advanced-standing students have been admitted to any year of the MD Program in the previous two academic years. Assessment of credentials is therefore not applicable.

10.7e No transfer students have been admitted to the final year of the MD Program since the last site visit in 2012.

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 medical students he or she would join in educational experiences*
- 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*

Definition taken from CACMS lexicon

- *Comparable: Very similar, like, commensurate, close.*

Requirements

- 10.9 a The medical school verifies the academic credentials and immunization status of each visiting student.
- 10.9 b There are procedures and criteria used by the medical school to determine if the qualifications of potential visiting medical students are comparable to those of the medical students they would join in a clinical experience.
- 10.9 c The process of evaluating whether potential visiting students have comparable qualifications to those of the school's own students is centrally overseen and managed within the medical school.
- 10.9 d The medical school approves the assignment of a visiting student after ensuring there are adequate resources (including clinical resources) and appropriate supervision at the site for both the visiting student and any of the medical school's own students.
- 10.9 e The medical school ensures that a performance assessment is provided for each visiting student.
- 10.9 f An accurate and up-to-date roster of visiting medical students is maintained by medical school or university administrative personnel who ensure that the medical school's requirements for visiting medical students are met.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

10.9a The standardized AFMC Immunization form is a requirement, and it is reviewed by the Visiting Electives Administrator.

10.9b The school's Visiting Electives Administrator or Electives Director reviews Home School Verification form, which requires verification that the student is in good standing, is in the clerkship phase of their education, and that the elective is being completed for credit. The University of Toronto also requires English language proficiency (standardized testing results), that the visiting student's home school is on the world directory of medical schools and is listed as acceptable to the medical regulatory authorities in Canada.

10.9c The school has a Visiting Electives Administrator who evaluates all applicants for visiting electives. Oversight of visiting electives processes is provided by the Electives Director, who is an appointed faculty member with an education leadership role in the MD Program.

10.9d Clinical sites are consulted prior to approving a visiting elective placement. The needs of current core (i.e.,

University of Toronto) learners, historic numbers, and anticipated changes in resources are taken into consideration. Visiting elective requests at sites where capacity is of concern are declined.

10.9e Visiting students are assessed using forms provided by their home schools. The Visiting Electives Administrator is available to facilitate the completion of an assessment directly with the supervisor and/or the supervisor's staff at the clinical site.

10.9f All visiting electives applicants must use the AFMC Electives Portal. All of these data are captured in the Electives Portal.

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.

Requirements

- 10.11 a There is a centralized process for the initial assignment of students to each location and/or parallel curriculum (as relevant).
- 10.11 b The medical school considers the preferences of students in determining the initial placement.
- 10.11 c A process exists whereby a medical student with an appropriate rationale can request an alternative assignment when circumstances allow for it.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

10.11a The school has 2 campuses (Mississauga and St. George). The offers of Admission are tied to the specific campus and this is a centralized process.

10.11b Student preference is taken into account in their initial placement.

10.11c Transfers are considered for three reasons: Educational-MD/PhD students whose research would benefit from or requires transfer, academic transfer for students to insure optimal educational experience, and personal transfers when supported by Student Affairs. The processes for these are clearly articulated.

STANDARD 11
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

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

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

11.1 ACADEMIC ADVISING

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

Definition taken from CACMS lexicon

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

Requirements

- 11.1 a The medical school has a 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.
- 11.1 b The medical school has a process to identify students experiencing academic difficulty early in the medical program.
- 11.1 c Medical students at each campus are informed about the availability of academic advising and how they may be identified as needing these services, or how they can access these services if they perceive the need for academic advising.
- 11.1 d Academic advising/counseling is available to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkship).
- 11.1 e 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.
- 11.1 f The data in the DCI show that only a small percentage of first year medical students and of all medical students at each campus withdrew or were dismissed from the medical school in the last three academic years.
- 11.1 g The data provided in the DCI show that only a small number of medical students at each campus in years 1-4 over the past two academic years experienced academic difficulty.
- 11.1 h The overall graduation rate, and the percentage of medical students that graduated at the expected time at each campus are very high.
- 11.1 i Student survey data show that the vast majority of respondents at each campus in all years of the MD

program were satisfied/very satisfied (aggregated) with academic advising/counseling.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

11.1a The medical school has both formal and informal academic advising. All course and component directors, theme leads, the Foundations and Clerkship Directors, other MD Program curriculum leaders, and student affairs staff provide individual academic support to students for identified concerns related to the material being studied.

11.1b In Years 1 & 2, there are formal multipoint assessments and informal observations by tutors that identify students who are struggling. The details are provided in the *Guidelines for the assessment of MD students in academic difficulty*.

11.1c On an academy cohort basis, information about academic coaching is readily available on the publicly accessible OHPSA website. This information is also available on the Academic Calendar as well as the student-created Clerkship “survival” manual, both of which are updated annually. Cohorts are also introduced to/reminded about academic coaching at the various orientation and transition junctures (i.e., “orientation week”, Transition to Clerkship). Students can then self-refer, and/or education leaders can connect students with OHPSA via email or via a “Recommendation for OHPSA Services” form.

11.1d The Office of Health Professions Student Affairs (OHPSA) offers several elements of advising and support and are well described in the DCI. The St. George campus has academic counseling service on site; the Mississauga campus does not but an academic coach visits from the other campus.

11.1e The Associate Dean, Health Professions Student Affairs (HPSA), the Office of Health Professions Student Affairs (OHPSA), counsellors and academic advisors do not have any role in the assessment or advancement of medical students.

11.1f In 2017-18, 0.6% students at the Mississauga campus and 0.32% students in the St. George campus withdrew or were dismissed. In 2016-17 and 2018-19, no students at either campus were dismissed or withdrew. No first year students withdrew or were dismissed. (Appendix C-54)

11.1g In 2018-19, a total of 19 students across all four years experienced some form of academic difficulty. This amounts to 1.9% of the total student population. In 2017-18, there were 15 students identified as having academic difficulty, or approximately 1.5% of the total student population.

Numbers of students in difficulty within each year of the program are small at both campuses and across all academies, with the numbers increasing slightly in Year 3. (Appendix C-55)

11.1h The average graduation rates over five years are 98.51% and 97.76% Mississauga and St. George campuses, respectively. (Appendix C-56)

11.1i According to the AFMC GQ, student satisfaction with academic advising in 2019 ranged between academies from 64.9%-94%. The FitzGerald Academy consistently has lower satisfaction rates (*satisfied/very satisfied*) compared with the other academies through 2017-19: 60.6% in 2017, 66.7% in 2018 and 64.9% in 2019. The MAM satisfaction rate was also low in 2019, at 68.6%. See Appendix C-51.

ISA data (Appendix C-52) show that FitzGerald Academy has high rates of *satisfied/very satisfied* in Year 1 (95%) Year 2 (90.9%) and Year 3 (83.3%) but falls to 69.1% in Year 4. This is in contrast to the other academies which have higher rates of satisfaction in all years and 80% or higher in Year 4.

The ISA data show generally higher levels of satisfaction among students in all four years and does not reflect the

general decline in the GQ results. Aggregated results from the ISA survey show that 86.1% of Year 1, 85.7% of Year 2, 84.7% of Year 3, and 80.0% of Year 4 students are satisfied/very satisfied with academic advising/counselling. The only major outlier in the ISA data is again the satisfaction reported by Year 4 students in the FitzGerald academy (69.1%).

A new, more robust system of designated faculty advisors at each Academy has recently been established. Although framed as Career advisors (see more detail in 11.2), both faculty and students reported that these academy-specific advisors also engage in ensuring that students get academic assistance as needed.

During the site visit, students with early experience of the new system, even during the challenges of the COVID-19 pandemic, spoke of it favourably. (SM)

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.

Definition taken from CACMS lexicon

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

Requirements

- 11.2 a Faculty members, directors of required clinical learning experiences, and student affairs staff provide career advising to medical students at all campuses.
- 11.2 b The career advising system provides appropriate mandatory and optional, and where appropriate confidential career advising activities to students in each year of the program to assist them in evaluating career options, choosing electives and applying to residency programs.
- 11.2 c The medical school provides career advising to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).
- 11.2 d There is an individual(s) who is primarily responsible for providing guidance to medical students on their choice of intramural and extramural electives during each year of the curriculum at each campus and to students who are away from the medical school for a six-month or more consecutive period.
- 11.2 e The percentage of participating medical students who remained unmatched at the end of the second iteration of the Canadian Residency Match Service (CaRMS) match has been low for the last three academic years.
- 11.2 f Student survey data show that the vast majority of respondents at each campus in all years of the MD program were satisfied/very satisfied (aggregated) with career advising (career planning) services and information about specialties.
- 11.2 g Student survey data show that the vast majority of respondents at each campus in all years of the MD program were satisfied/very satisfied (aggregated) with guidance when choosing electives.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

This element was cited (as Standard MS-19) in 2012.

11.2a In person meetings and consultations by phone and/or video are provided to all students at both campuses. A career counselor is onsite one day/week at the Mississauga campus which accounts for 20% of the student population.

11.2b An overview was provided for review by the team (see Supplemental Appendix S-5) of all mandatory and optional career information and advising sessions at all both campuses. There are more optional offerings in Year 1 for St. George campus students (orientation booth fair and Dean's Breakfast). There are 9 required sessions spread across the 4 years and available for both campuses.

11.2.c Career advising is available to students on both the St. George and Mississauga campuses from multiple faculty and staff members, including the Associate Dean, HPSA; Director, Career Advising System; Academic Coach; OHPSA career counsellors; and Academy Directors.

No students are "away" from either campus for longer than 6 weeks. Core clerkship rotations are distributed across anchor and community hospitals, but students maintain access to career advising at their Academy sites and associated campus.

11.2d There are orientation and large group information sessions, overseen by the Director of Electives, provided to medical students in preparation for selecting electives. Electives Office staff provide logistical support for medical students in securing and registering for home and extramural electives.

In 2019-2020, the Director of Electives established a schedule of drop-in, one-on-one sessions to provide individual guidance on electives selection. These sessions are provided via teleconference technology to students in the Mississauga Academy, or to those students who are at distributed sites that make on-campus meetings difficult.

11.2.e The percentage of unmatched medical students was 5.06 %, 7.25% and 2.75% in the years 2017, 2018 and 2019, respectively.

11.2f The AFMC GQ data (Appendix C-51) show low levels of overall satisfaction with career planning services, There are significant differences among academies: FitzGerald Academy for last 3 consecutive years has overall satisfaction percentages in the mid 50s, whereas the Mississauga Academy had overall satisfaction of 57.1% in 2017, which improved to 72.5% in 2019. Wightman-Berris is a recent, positive outlier with a satisfaction rate in 2019 of 85.7%.

There is some discrepancy with the ISA data (Appendix C-58) where somewhat higher rates are reported. Satisfaction rates in Years 1-4 are as follows:

- FitzGerald: 88.7%, 66.1%, 72.1%, 64.7%
- Mississauga: 87.9%, 75.0%, 69.6%, 60.4%
- Peters-Boyd: 87%, 77.2%, 87.2%, 84.0%
- Wightman-Berris: 84.0%, 94.6%, 97.5%, 93.8%

11.2g AFMC GQ data show student satisfaction with guidance when choosing electives has fluctuated over the last three years, but has remained low, between 35.3% (Wightman-Berris, 2017) to 69.2% (Mississauga, 2018). The only academy to show progressively increasing satisfaction with guidance when choosing electives is the Wightman-Berris Academy (35.3%, 44.1%, and 69.14%).

The ISA survey asked Year 3 and 4 students about their satisfaction with guidance when choosing electives, and still shows low satisfaction rates. The aggregated satisfaction for Year 3 is 57.8% and for Year 4 is 49.5%.

In response to these data, a robust system of advising has been developed with designated faculty advisors at each academy. These *Academy Career and Transition Leads* were appointed in the Spring of 2020. They report to the Director of Career Advising. Their roles and responsibilities are described in detail in Supplemental Appendix S-6.

During the site visit, students who had accessed the new system, even during the challenges of the COVID-19 pandemic, spoke of it positively. (SM)

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.*

Requirements

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

11.3a All extramural elective placements within Canada occur at institutions that are affiliated with and approved by an accredited Canadian medical school. Although the numbers are small, the MD Program does allow electives outside of Canada, and there is a similar approval process. Students apply for elective placements to Canadian medical schools through the AFMC national electives portal. Electives undertaken by University of Toronto students at other Canadian Medical Schools are vetted by the Electives Offices at the hosting school. These opportunities include placements at other Canadian medical schools, within Ontario through the Rural Ontario Medical Program (ROMP), and international electives.

11.3b: There is a well described process in the DCI of vetting such electives taking into account items i.-vi above.

The Director of Electives oversees and must approve all such elective requests and there is mandatory 1) signed student placement agreements for international placements, and 2) pre-departure training at the medical school, participation in safety abroad curricula, and 3) debriefing upon return. There is an Agreement between the University and the Placement Site that addresses all of these requirements.

11.3c As reported for 11.3b, there is pre-departure training, mandatory participation in safety abroad curricula, and debriefing on return. Further, all students must have a U of T supervisor in place for all electives outside Canada. This supervisor is in touch with the students while away for follow up and acts as faculty support before, during and after the placement.

11.3d Electronic evaluations are sent directly to supervisors for completion. The MD Program's Electives and Transition to Residency Course (TTR) administrators ensure these assessments are completed in a timely fashion through reminders. Students completing electives at other Canadian institutions complete evaluations of their electives/supervisors administered directly by the affiliated medical school. A course evaluation is administered to students at the end of the electives course which also evaluates extramural elective experiences. Students completing international electives are asked to complete a Post-Return Questionnaire that asks about their international experience and if they encountered any challenges while abroad.

11.3e Evaluation data completed by students about all electives, including extramural electives, are reviewed every year by the Electives Course Director. Areas of concern are shared and discussed at course committee meetings. They are also reviewed as part of the annual course report/review process, which is managed by the Program Evaluation Committee and involves active participation by the course director and Clerkship Director. Placements that are poorly evaluated are reviewed. Placement sites or electives offices are contacted for further understanding of issues and exploration of possible areas for modification. Thereafter it is determined whether an opportunity should not be offered or is modified to address issues identified.

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.

Requirements

11.4 a The medical school provides the Medical Student Performance Record only on or after October 1st of the student's final year of the medical education program.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

UME-Enrolment Services generates the MSPR each academic year by the end of October. In 2019, the release date was October 30.

11.5 CONFIDENTIALITY OF STUDENT EDUCATIONAL RECORDS

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

Requirements

- 11.5 a The medical school has and follows policy(ies) for the collection, storage, disclosure and retrieval of student educational records that is in compliance with relevant privacy legislation.
- 11.5 b A medical student's educational record/file is kept in a separate location from his or her health record/file.
- 11.5 c There is a policy and procedure that specifies which individuals have the right to review a medical student's educational file. The individual(s) who is/are responsible for providing access to a student's educational file ensures that only those authorized individuals are given access.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

11.5a. The Medical School has and follows policies supporting this element. The policy references the University of Toronto *Undergraduate Student Records Retention Guideline* and University of Toronto *Guidelines Concerning Access to Official Student Academic Records*. The MD Program policy and University of Toronto guidelines are in compliance with provincial Freedom of Information and Protection of Privacy Act (FIPPA) regulations.

11.5b Records pertaining to student health and special personal circumstances are stored in the Office of Health Profession Student Affairs (OHPSA) student files. OHPSA personal counsellors are employees of the university hired by the MD Program. They function however as independent regulated health clinicians and must comply with the provincial Personal Health Information Protection Act (PHIPA). Academic records are held separately in the UME Enrolment Services Office.

11.5c There is an MD Program policy that references the University of Toronto's guidelines concerning access to official student academic records, dated May 2008. To ensure that access to a student's educational file is granted on a need-to-know basis, the MD Program determines individual faculty/staff/learners' access to specific records based on their roles. The MD Program has mechanisms in place to provide role-appropriate permissions for access to student academic records. These permissions are controlled by senior leadership in UME Enrolment Services, the Office of the Vice Dean, MD Program, and OHPSA. The policy for the collection, storage, disclosure, and retrieval of student records is in compliance with relevant privacy legislation.

11.6 STUDENT ACCESS TO EDUCATIONAL RECORDS

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

Requirements

- 11.6 a The medical school has policies and procedures in place that permit a medical student to review all components of their educational records including the Medical Student Performance Record.
- 11.6 b Medical students are given timely access to review their educational records.
- 11.6 c A medical student can challenge the following if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.
- i. content of the Medical Student Performance Record
 - ii. examination performance, tutor/preceptor assessment in a required learning experience
 - iii. final grade for a required learning experience
- 11.6 d Medical school policies and procedures related to medical students' ability to review and challenge their records are made known to students and teaching faculty at each campus.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

11.6a There is an Access to Student Academic Records policy and procedure document. Students are allowed to see their educational records, with the exception of their Admissions file.

11.6b Assessment information and clinical evaluations are made available as soon as possible following the assessment throughout the year. Students are able to review their MSPR prior to its submission to CaRMS. Students have access to all course specific information reported in the MSPR within 30 days of completing the course.

11.6c Students may view their clinical evaluations throughout the year, which makes up the contents of the MSPR. They have access to course specific information used in the MSPR within 30 days of completing each course. Students are able to review their MSPR prior to and after its submission to CaRMS.

Students can review assessment information for all required learning experience using the Learner Chart (a guide to students' progress throughout the MD Program), which is populated with assessment information from their various electronic systems. Students can review the final grades for any required learning experiences. Students may challenge the mark on an individual assessment or a final grade in a course in accordance with the MD Program's *Assessment Rules and Regulations*.

11.6d The MD Program's *Access to Student Academic Records* and *Assessment Rules and Regulations* are made know to all students and teachers via Academic Calendar, which is published annually. Medical students and teaching faculty are informed in mid-August regarding the release of the Academic Calendar for the academic year. Medical students are required annually complete and submit a statement of acknowledgement they have reviewed the Academic Calendar.

STANDARD 12
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

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

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

12.1 FINANCIAL AID / DEBT MANAGEMENT COUNSELING/ STUDENT EDUCATIONAL DEBT

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

Requirements

- 12.1 a The medical school ensures that required and optional financial aid and debt management counseling/advising activities are available to medical students in each year of the curriculum.
- 12.1 b The medical school ensures that financial aid management services are available to students who are away from the medical school for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).
- 12.1 c The medical school ensures that conflicts of interests for those providing debt management counselling and information on student loans are identified and appropriately managed.
- 12.1 d The medical school has awarded bursaries, grants and scholarships and extended loans to students over the past three academic years.
- 12.1 e The medical school or university has engaged in activities to increase the amount and availability of scholarship, bursary, grant and loan support for medical students.
- 12.1 f The medical school and the university have worked to limit tuition increases or limit student debt since the time of the last full site visit.
- 12.1 g Student survey data show that the average medical education debt of all graduating students over the last three years is comparable to that of other Canadian medical schools.
- 12.1 h Student survey data show that the vast majority respondents at each campus are satisfied/very satisfied (aggregated) with financial aid administrative services, and overall educational debt management counselling.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

12.1a One-to-one financial counselling and debt management sessions are available in person, by phone, or by Skype for all Years of the program. Otherwise, financial aid sessions are only required for those who are flagged
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as accruing large amounts of educational debt (e.g., greater than \$100,000 debt in Year 1). A mandatory financial literacy session was implemented for the 2020-2021 academic year in the Year 2 curriculum.

12.1b Financial aid counseling is available from Student Financial Services staff by teleconference. For those who are on a leave of absence, they are still eligible to access Student Financial Services.

12.1c Debt management counselling sessions are offered internally by the Student Financial Services staff. The MD program does not invite “for-profit” organizations to speak to students, however, students may self-arrange speaking arrangements by “for-profit” organizations for other students.

12.1d The school has awarded \$18,085,572 in bursaries, \$647,224 in grants, and \$1,073,310 in scholarships over the past three years. The school has also given \$6,804,000 in provincial stipends for Year 4 students over the past three years. The school does not extend financial aid in the form of loans.

12.1e Since the time of the last full site visit, the Faculty of Medicine Office of Advancement appointed a Senior Development Officer to facilitate fundraising activities to support the MD program, including monies for student financial support. The school has engaged in activities to support further availability of scholarship, bursary, and grant support for medical students, including through the “University of Toronto Boundless Campaign.” As a result of the campaign, \$16.4 million in additional funding was secured for medical students, which resulted in 91 additional scholarships, awards, and bursaries.

12.1f Tuition increases and decreases are controlled by mandated envelopes from the Government of Ontario. Tuition for the MD program increased to a cap of 5% annually from 2014-2015 to 2018-2019 (\$27,769.28 for the Mississauga campus and \$27,309.48 for the St. George campus). For the 2019-2020 academic year, tuition decreased by 10% to \$23,090. In-province and out-of-province tuition costs have remained the same for the past three years.

12.1g There is some variability between the academies and the debt accrued by students (e.g., \$130,000 at the Mississauga academy and \$100,000 at the FitzGerald and Peters-Boyd academies) based on the data from the AFMC GQ. For graduates with debt greater than or equal to \$200,000, the percentages have improved or remain relatively similar to national averages for the past three years. The school has ensured that student debt has not increased dramatically over the past three years. This is evident by the increasing number of awards and scholarships available for students and the sizeable decrease in tuition for the past academic year.

12.1h The data from the AFMC GQ (Appendix C-62) show overall improvement in satisfaction with financial aid administrative services across the academies, with some variability between academies (e.g., Mississauga: 83.3% in 2019; Peters-Boyd: 100% in 2019). Good strides have been made in terms of overall educational debt management counselling (e.g., FitzGerald: 53.5% in 2017 to 89.2% in 2018, down to 75.0% in 2019).

The data from the ISA (Appendix C-63) show that, across all academies, satisfaction with financial aid services is strong and relatively stable across all four years of the program. Satisfaction rates (*satisfied/very satisfied*) in Years 1-4 are as follows:

- FitzGerald: 90.0%, 82.8%, 80.0%, 78.1%
- Mississauga: 89.7%, 75.0%, 85.0%, 82.8%
- Peters-Boyd: 79.3%, 87.1%, 77.4%, 92.9%
- Wightman-Berris: 77.4%, 77.8%, 84.4%, 94.7%

In terms of debt management counselling, there is more variability in satisfaction rates across the years of the program and between academies:

- FitzGerald: 79.0%, 75.0%, 62.5%, 62.1%
- Mississauga: 84.6%, 58.8%, 88.2%, 63.6%
- Peters-Boyd: 73.9%, 71.4%, 69.6%, 80.0%
- Wightman-Berris: 77.8%, 70.0%, 86.2%, 79.4%

12.2 TUITION REFUND POLICY

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

Requirements

- 12.2 a The medical school has clear, reasonable, and fair policies for the refund of a medical student's tuition, fees and other allowable payments (e.g., payments made for health or disability insurance, parking, housing, and other similar services for which a student may no longer be eligible following withdrawal).
- 12.2 b These policies are disseminated to and are accessible by medical students.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

12.2a The University of Toronto Governing Council's Tuition Refund Policy applies to the MD program. The tuition policy requires that the refund schedule allows for a period of time early in the term where the student will not be penalized for add/drop activities and limit the financial penalty for courses dropped later in the term.

The MD program 2019-2020 refund schedule clearly identifies deadlines for reversing registration and the refund of tuition that is applicable based on the date the student withdraws from the term. The refund schedule applies to tuition, campus fees, student services fees, and program-specific fees.

12.2b The MD program e-mails students prior to the start of the school year and specifies registration requirements, payment due dates, and the tuition refund schedule. Refund schedules are also available in the MD Program Academic Calendar, which is available to students on the MD program website. The program also reminds students who miss fee deadlines. The University communicates directly with students regarding tuition payments and refund schedules.

12.3 PERSONAL COUNSELING / WELL-BEING PROGRAMS

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

Requirements

- 12.3 a The medical school provides personal counseling and well-being programs to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).
- 12.3 b Medical students are informed about the availability of personal counseling and well-being programs provided by the medical school at each campus.
- 12.3 c Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with personal counseling provided by the medical school and its availability and confidentiality.
- 12.3 d Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with programs that promote effective stress management, a balanced lifestyle and overall well-being.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

12.3a Personal counselling and well-being programs are under the umbrella of the Office of Health Professions Student Affairs (OHPSA). The office employs counsellors who are registered social workers with further training in psychotherapy.

Support is available for students at the Health and Wellness Centre at the St. George and Mississauga campuses. Personal counselling is available face-to-face, telephone, or Zoom. Appointments are offered both in the daytime and evening. At the St. George campus, in-person personal counselling services are located separately from the Medical Sciences Building to increase privacy. At the Mississauga campus, in-person personal counselling is located within administrative offices. To ensure privacy at this office, staff are trained on managing student confidentiality. Students also sign a confidentiality agreement prior to accessing personal counselling. Further, an annual survey is conducted that monitors student concerns about accessing personal counselling due to confidentiality concerns, which has indicated that confidentiality is not a significant barrier to students accessing personal counselling.

If further support is needed, the OHPSA can connect students with psychologists and psychiatrists.

The OHPSA created a Resilience Curriculum that was integrated into the core medical school curriculum in 2016. Currently, the Resilience Curriculum spans across all four years of the program. The curriculum focuses on themes most relevant to students in each Year:

- Year 1: topics include resilience in medical school, stigma, imposter syndrome, hidden curriculum, upward and downward spirals
- Year 2: topics include transition to clerkship, uncertainty, navigating transitions, expectations and medical error, burnout, compassion fatigue
- Year 3: topics include recognizing and managing demands of personal and professional identity, learning to set emotional boundaries to maintain good mental health, discussing techniques to manage

- feedback, identifying maltreatment, understanding avenues to address it
- Year 4: topics include model for cultural and systemic change in medicine at all levels of the medical hierarchy, dealing with uncertainty of CaRMS

The curriculum is delivered through online modules and mandatory workshops.

The University of Toronto has a program, called “My Student Support Program” which can provide students with immediate and ongoing confidential support for school, health, or other concerns at no additional costs.

12.3b Medical students are informed about counselling services in a number of ways, including presentations during all years of the program, information on Elentra, brochures, and *Student Health Initiatives and Education* (SHINE), a student-run group that promotes personal counselling services through presentations and social media campaigns.

12.3c Data from the AFMC GQ (Appendix C-65) suggest that, across most academies (i.e., FitzGerald, Peters-Boyd, and Wightman-Berris), satisfaction with personal counselling has either remained stable (e.g., FitzGerald: 71.9% in 2017 to 73.1% in 2019) or improved (Wightman-Berris: 86.4% in 2017 to 100% in 2019). At MAM, over the past three years, satisfaction with personal counselling reached a high of 93.3% in 2018, and then fell to 78.3% in 2019.

Data from the ISA (Appendix C-67) suggest that, overall, students are *satisfied/very satisfied* with availability of personal counselling across all Years of the program: 87.7% in Year 1, 87.8% in Year 2, 89.9% in Year 3, and 84.5% in Year 4. There is considerable variability between the Mississauga academy and the remaining academies, with only 66.7% in Year 1, 68.8% in Year 2, 91.2% in Year 3, and 66.7% in Year 4 being *satisfied/very satisfied* with the availability of personal counselling.

12.3d The AFMC GQ data (Appendix C-66) suggest fairly low rates of satisfaction with programs that promote effective stress management, balanced lifestyle, and overall well-being across all academies. For example, in 2019, the *satisfied/very satisfied* rates among academies were as follows: FitzGerald: 48.6%, Mississauga 28.6%, Peters-Boyd 58.5%, Wightman-Berris 71.7%. All academies have seen an overall decline in satisfaction rates compared to 2017 results.

In distinct contrast from the GQ data, data from the ISA (Appendix C-67) demonstrate that, overall, students were highly satisfied with the availability of programs to support student well-being across all Years (Year 1: 88.6%, Year 2: 89.4%, Year 3: 94.4%, Year 4: 82.5%). Rates of satisfaction appear to be somewhat lower among the Mississauga Academy students in Years 1 (76.3%), 2 (70.0%), and 4 (74.4%) compared to other academies. However, satisfaction at Mississauga in Year 3 was 100%.

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.

Definition taken from CACMS lexicon

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

Requirements

- 12.4 a The medical school at each campus facilitates medical students' timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of required learning experiences.
- 12.4 b Medical students at all instructional sites and campuses are informed about availability and access to health services.
- 12.4 c The medical school at each campus has policies and procedures in place that permit students to be excused from required learning experiences including required clinical learning experiences to seek needed care.
- 12.4 d The policies and procedures mentioned in **12.4 c** are disseminated to medical students, faculty, and residents.
- 12.4 e Student survey data show that the vast majority of respondents at each campus are satisfied/very satisfied (aggregated) with student health services and mental health services and their availability.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

12.4a Students from Ontario are registered under the provincial health insurance plan (OHIP). For students from other provinces, they are covered by their provincial health plan. Out-of-country students are required to purchase the University Health Insurance Plan.

Medical students have access to medical care through the following means:

- (1) University Health and Wellness Services, where students can book appointments/drop in for medical and psychiatric services.
- (2) Office of Health Professional Student Affairs (OHPSA) Personal Counselling, where students can access urgent and non-urgent personal counselling. Personal counselling services are available at both the Mississauga and St. George campuses.
- (3) Accessibility Services, where students who identify with a disability can access resources including psychologists, social workers, and occupational therapists.

12.4b The program has a statement of access to preventative, diagnostic, and therapeutic health services for medical students available on the policy section of the program website. The policy identifies ways for students to access healthcare, including university services and publicly funded healthcare options. Additionally, a "Student

Assistance” button is visible on the MD program website that can provide students with information for healthcare options. Finally, students are informed about the availability of healthcare services in Year 1 during the orientation portion of the curriculum.

In 2018, five focus groups were held to understand student awareness of services provided by OHPSA. They found that, overall

- (1) there was a lack of awareness of the full scope of services offered by OHPSA,
- (2) MD/PhD students felt that their needs were unique and not adequately addressed by OHPSA, and
- (3) there were concerns about the availability of appointments and the location of services on campus.

The focus group resulted in a number of actions taken, including some of the following appropriate to health services:

- (1) secure new space and increase physical presence of a personal counsellor at the Mississauga campus,
- (2) expand the “Check Your Pulse” program to students in all Years of the program.

12.4c The program has a policy, *Regulations for Student Attendance and Guidelines for Absences from Mandatory Activities* that outlines permissible absences from mandatory learning activities for students to seek healthcare services.

Students are required to submit a “University of Toronto Verification of Illness Form” for health-related absences from assessments or for health-related absences of more than 2 consecutive days of mandatory learning sessions. According to the policy, the form must be submitted within five business days after the last day of the unplanned absence. Additional supporting documentation may be required from students to support the verification form.

The program has identified two types of absences that would permit students to be excused from required learning experiences to seek healthcare.

- (1) Unplanned absences, which arise due to unforeseen/emergent circumstances. Students must fill out the program’s “Unplanned Absence Notification Form” as soon as possible. If an absence of three or more days is required, additional documentation may be needed. Students are able to consult the Associate Dean, Health Professions Student Affairs, or a counsellor in OHPSA if the nature of the absence is confidential.
- (2) Planned absences, which arise due to known or anticipated circumstances and require prior approval. Students must fill out the program’s “Planned Absence Request Form” to request an absence. For clerkship students, they are required to submit the planned absence at least 30 days prior to the start date of the rotation in which the absence will occur. For pre-clerkship students, they are required to submit the planned absence at least 30 days in advance of the absence.

The University’s leave of absence policy affords students the ability to request defined, long-term periods of time away from the MD program for personal reasons. These LOA requests are considered by the Associate Dean, Health Professions Student Affairs. Personal LOAs will normally be granted for a maximum of one full academic year at a time. For academic enrichment, the LOA request is considered by the Vice Dean, MD Program. Academic LOAs will normally be granted for a maximum of two full academic years.

Students who are granted a LOA are not registered as medical students for the duration of the leave. In anticipation of re-entry to the MD program, students are expected to contact the Associate Dean, HPSA and Registrar at least 2 months before their intended return to the program.

12.4d Medical students, faculty and residents are informed of the policy via the MD Program Academic Calendar. Medical students and faculty are made aware of the published calendar via email at the beginning of the academic year. Additionally, the policies are made available on the Elentra course pages.

Students are also informed of these policies in person at the start of Year 1 during orientation and at the start of Year 3 during the transition to clerkship.

12.4e Data from the AFMC GQ indicate that, overall, students are satisfied with student health services, with *satisfied/very satisfied* scores of 88.0%-100% across academies in 2019. Students at the FitzGerald academy in

2017 were generally less satisfied (64.5%) compared to students at other academies, but satisfaction at the FitzGerald Academy rose to 88.9% in 2019.

Overall, the ISA data demonstrate high satisfaction with the availability of student health services across all years (aggregate for Years 1-4: 82.2%, 82.6%, 87.9%, and 84.9%). The percentages of respondents reporting *satisfied/very satisfied* follows:

- FitzGerald: 96.3%, 83.3%, 85.2%, 81.8%
- Mississauga: 69.2%, 81.3%, 84.9%, 78.1%
- Peters-Boyd: 83.9%, 86.7%, 93.1%, 91.9%
- Wightman-Berris: 80.0%, 80.4%, 88.7%, 86.0%

Data from the AFMC GQ indicate that students are somewhat less satisfied with mental health services compared to student health services, but there is variability among the academies and across years. The AFMC GQ data are reproduced below for 2017-19:

- FitzGerald: 65.4%, 81.5%, 68.0%
- Mississauga: 63.2%, 86.7%, 70.6%
- Peters-Boyd: 80.0%, %, 83.3%, 81.5%
- Wightman-Berris: 75.8%, 75.7%, 91.9%

Again, the ISA data demonstrate high overall satisfaction with the availability of mental health services across all years (aggregate for Years 1-4: 85.7%, 82.6%, 88.9%, and 83.8%). The percentages of respondents reporting *satisfied/very satisfied* follows:

- FitzGerald: 87.0%, 86.4%, 80.8%, 87.0%
- Mississauga: 61.1%, 61.5%, 85.2%, 73.7%
- Peters-Boyd: 96.0%, 86.7%, 93.1%, 91.9%
- Wightman-Berris: 90.6%, 95.1%, 91.9%, 76.9%

In discussion with students on site, the Mississauga students expressed satisfaction with the current availability and responsiveness of mental health services, which have been augmented (increased on-site staff presence pre-COVID; enhanced “virtual” accessibility during the pandemic) since the ISA was submitted.

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

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

Requirements

- 12.5 a The medical school has and follows a policy that no provider of health and/or psychiatric/psychological services to a medical student has no current or future involvement in the academic assessment of, or in decisions about, the promotion of that student.
- 12.5 b The medical school informs students, residents and faculty of this policy mentioned in **12.5 a**.
- 12.5 c The medical school has processes in place to mitigate against bias in assessment and ensures the safety of the medical student in the rare circumstance in which a health care professional providing health services (excluding mental health services) has been involved in the supervision and assessment of a medical student.
- 12.5 d The medical school maintains medical student health records in accordance with legal requirements for security, privacy, confidentiality, and accessibility.
- 12.5 e There is a documentation that describes the security, privacy, confidentiality and accessibility of a medical student 's health record/file.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

12.5a The MD program, through the *Procedure for Conflicts of Clinical and Education Roles*, identifies the potential for conflict of roles for teachers who are also clinicians. The policy identifies two conflicts that may arise:

- (1) A teacher may be assigned to supervise a medical student previously cared for or currently being seen as a patient.
- (2) A teacher may be asked to provide care to a current or former student.

If a conflict is identified as in (1), the teacher is instructed not to participate in the assessment of the student in question. If possible, students can be scheduled for alternative supervision. If the conflict arises during an assessment (e.g., OSCE), the student/examiner may stop the station and notify staff immediately. If the conflict involves a faculty member in a leadership position (e.g., course directors, clerkship director), the faculty is responsible for notifying the MD program so that alternates can be involved if the student requires “extra attention.”

If a conflict is identified as in (2), the teacher must inform the appropriate MD program leader prior to commencing care. Otherwise, students are encouraged to seek care from their family physician or other healthcare provider if possible.

12.5b Medical students, faculty, and residents are informed of the procedure via the MD Program Academic Calendar. An email is sent to all medical students and faculty to notify them of the Academic Calendar prior to

the commencement of the academic year. The program additionally has this policy available for view on their *Policies* webpage.

12.5c The *Procedure for Conflicts of Clinical and Educational Roles* outlines procedures to mitigate biases in assessments in the following ways:

- (1) By stating that if there is an identified role conflict, the teacher must not participate in the assessment of the student in question, either directly or indirectly.
- (2) Allowing both students and teachers to report potential role conflict to MD program leadership, which then places responsibility on the faculty leadership to make arrangements to remove the student from the teacher's supervisor or ensure that the assessment is conducted exclusively by other faculty members with no input from that teacher in the role conflict.
- (3) Students are not required to disclose the nature of the healthcare they received, and teachers will not be informed of the reason for the change unless necessary, and only after consent is provided by the student. Teachers who report do not need to enclose the nature of their conflict of interest, only that one has arisen.
- (4) Requiring MD program leadership to report role conflict to the Vice Dean, MD Program as soon as they are aware of a conflict.
- (5) Requiring teachers asked to provide care to a current or former student to inform the appropriate MD program leader prior to commencing care.

If a breach of the policy has occurred, students are encouraged to submit a "Disclosure Form" which will prompt a review of the potential breach by the appropriate program leader. A reminder will be sent to the teacher of the role conflict policy in the MD program.

12.5d Student mental health services on University campuses are provided by the Office of Health Professions Student Affairs (OHPSA). If a student accesses the University's health services, their health records are secured on an EMR at OHPSA that is not tied to any other EMR system.

Student health service providers are required to comply with provincial legislation with regards to the privacy of health care information (e.g., *Ontario Personal Health Information Protection Act*). This includes all OHPSA staff signing a confidentiality agreement prior to employment. Health records are maintained for 10 years, in compliance with the College of Physician and Surgeons of Ontario recommendations.

Student academic records may include medical information "relative to a student's academic performance which has been furnished at the request of or with the consent of the student concerned" as outlined in the *Access to Student Academic Records* policy. The policy identifies who has access to student academic records and for what purposes.

12.5 e The program has a number of policies related to security, privacy, confidentiality, and accessibility of a medical student's health record/file:

Provincial legislation (Ontario Personal Health Information Protection Act) governs security, privacy, confidentiality, and accessibility of the medical student's health record.

University of Toronto *Health and Wellness, Student Life Programs and Services* has a statement on privacy and confidentiality which states that Health and Wellness will hold information about student's health confidentially and will not be released without the student's consent. The statement identifies the situations in which a student's health record may be disclosed (e.g., concern that a student may harm themselves or be unable to care for themselves).

The MD Program's *Access to Student Academic Records* outlines who has access to student academic records (which may have medical information relative to a student's academic performance, with the student's permission as described above) and for what purpose.

12.6 STUDENT HEALTH AND DISABILITY INSURANCE

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

Requirements

- 12.6 a Supplemental health insurance is available to each medical student and his or her dependents at each campus.
- 12.6 b Medical students at each campus are informed of the availability of supplemental health insurance on entry into the medical education program.
- 12.6 c Disability insurance is available to each medical student at each campus.
- 12.6 d Medical students are informed about the availability of disability insurance on entry into the medical education program.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

12.6a University of Toronto's students have basic health insurance coverage through the provincial government's Ontario Health Insurance Plan (OHIP). These plans cover doctor and hospital visits, but exclude prescription medications, physiotherapy, dental care, vision care, and psychological services.

A supplemental health insurance plan is available from the University of Toronto Students' Union and UTM Students Union, which provides extended health, dental, vision, and travel insurance coverage.

12.6 b Incoming and returning students are informed about the supplemental health insurance plan during individual financial counselling appointments and through the University's website on the "fees" webpage.

12.6c Disability insurance is not provided directly by the University of Toronto or by the University of Toronto Students' Union. Disability insurance coverage is available to students from the Ontario Medical Association or through any number of private insurance providers.

12.6 d During orientation to medical school, insurance providers are present to provide information to students about disability insurance. Disability insurance is also addressed during the one-on-one financial counselling appointment with incoming students. For fourth year students, a session is held that discusses disability insurance with the focus on the transition to residency.

All incoming students are required to review their Workplace Safety and Insurance board coverage and the University's private insurance coverage as part of the first-year registration requirements.

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.

Requirements

- 12.7 a The immunization requirements for students in the medical education program follow national and provincial recommendations.
- 12.7 b Immunizations are provided at locations close to where students participate in required learning experiences including required clinical learning experiences.
- 12.7 c There is an effective system at each campus to monitor students' immunization status to ensure compliance with immunization requirements prior to involvement in patient care activities.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

12.7a The immunization requirements for University of Toronto medical students align with the national (AFMC) and provincial (COFM) recommendations. The immunization requirements are posted for students on the MD program website.

Year 1 students have an immunization form that they can take to their healthcare professional to complete requirements. Returning students have a separate immunization form that they can take to their healthcare professional to document their tuberculin test and seasonal influenza vaccination.

12.7b Immunizations are provided for students at the University of Toronto's Health and Wellness Centres on all campuses and are free or low-cost (e.g., Hepatitis B: \$30/dose).

12.7c Immunization records are tracked and reviewed by staff at the Undergraduate Medical Education Enrolment Services office. Records are recorded in the program's student information system and monitored for compliance.

For students with complex health histories, they are referred to infectious disease/public health specialists that are members of the University of Toronto Faculty of Medicine Expert Panel on Infection Control.

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.

Requirements

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

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

12.8a
i. The Faculty of Medicine educates students about exposure to infectious and environmental hazards and prevention according to the policy *Guidelines Regarding Infectious Diseases and Occupational Health for Applicants to and Learners of the Faculty of Medicine Academic Programs*. The policy indicates that the Faculty of Medicine and clinical teaching sites are both responsible for ensuring that learners are adequately instructed in infection control procedures.

Additionally, the Faculty of Medicine and clinical teaching sites, as part of the affiliation agreement, jointly educate medical learners about infection control procedures, including in the preclinical curriculum, and on-site safety instructions in hospital settings (Section III.4.6, *Specification of the Responsibility for Safety Instruction, Treatment, and Follow-Up in the Event of Student Injury or Exposure to an Infectious or Environmental Hazard*).

ii. The MD program policy *Protocol for incidents of medical student workplace injury and Exposure to Infectious Disease in Clinical Settings* outlines the procedures for care and treatment for students who are injured or exposed to infectious diseases in clinical settings. The policy identifies the roles and responsibilities of all parties involved in the incident. In terms of financial responsibility, medical students are eligible for provincial Workplace Safety and Insurance Board (WSIB) coverage claims when engaging in a placement required by the program and private insurance if the placement is within a site not covered by WSIB. The Ministry of Advanced Education and Skills Development ensures students receive coverage should a claim occur.

iii. The Faculty of Medicine *Guidelines Regarding Infectious Diseases and Occupational Health for Applicants to and Learners of the Faculty of Medicine Academic Programs* includes guidelines regarding the implications of infectious and/or environment disease or disability on medical student learning experiences, including guidelines for learners with an infectious disease and guidelines regarding learners' participation in care of patients with infectious diseases. The guidelines are consistent with the Council of Ontario Faculties of Medicine (COFM) Blood Borne Viruses Policy.

12.8b Year 1 and Year 3 students complete a "Worker Health and Safety Awareness" module that outlines the rights and responsibilities of a medical student under the Ontario Occupational health and Safety Act. Students also complete e-learning modules that teach hand hygiene, sharps safety, and WHMIS. As part of these modules, students are informed of the relevant medical school policies and procedures related to exposure to infectious and environmental hazards. Visiting medical students are also required to complete these modules and receive a protocol to follow in case of exposure to infectious disease or other injury.

Year 3 students complete clinical skills-based educational session on the following: (1) applying the principles of infection control, and (2) describing the occupational health and safety services available in the hospital. As part of these sessions students are informed of the related medical school policies.

The medical school policies are also available on the academic calendar, and students are required to sign a statement indicating they have reviewed the academic calendar.

12.8c Year 1 and 3 students are required to complete e-learning modules that highlight the relevant medical school policies and procedures related to exposure to infectious and environmental hazards. Visiting medical students are also required to complete these modules and receive a protocol to follow in case of exposure to infectious disease or other injury.

The medical school policies are also available on the academic calendar, and students are required to sign a statement indicating they have reviewed the academic calendar.

12.8d Year 1 and 3 students are informed of exposure to blood-borne and air-borne pathogens as part of the e-learning modules and transition to clerkship clinical skills-based educational sessions. Visiting medical students are also required to complete the e-learning modules referenced above, and thus are also informed of the relevant medical school policies and procedures related to exposure to infectious and environmental hazards. Visiting students are provided with links to the e-learning modules as well as a brief protocol to follow in case of potential exposure to infectious disease or other injury, on the [University of Toronto AFMC portal website](#).

12.8e The AFMC GQ data (Appendix C-68) demonstrate that, overall, students are *satisfied/very satisfied* with the education about exposure to and prevention of infectious diseases. Satisfaction rates have increased from 84.9% in 2017 to 96.6% in 2019.

ISA data (Appendix C-70) also show that a very high percentage of respondents across years and academies are *satisfied/very satisfied* with the education about exposure to and prevention of infectious diseases, with a response range of 80.4% - 100%.

The AFMC GQ data (Appendix C-69) demonstrate that most students indicated Yes to the statement “I know what to do if I am exposed to an infectious or environmental hazard like a needle-stick injury” (range: 94.3% - 100%).

ISA data (Appendix C-71) also show that a very high percentage of respondents at each campus indicate that: “I know what to do if I am exposed to an infectious or environmental hazard like a needle-stick injury” (range: 73.2% - 96.0%). All Year 2 responses were considerably lower than responses in Years 1, 3 and 4, supporting the wisdom of repeating the relevant education from Year 1 prior to the start of Year 3. For example, the 73.2% positive response rate in Year 2 at FitzGerald improved to 93.0% and 94.1% in Years 3 and 4.

APPENDIX