MD Program
UNIVERSITY OF TORONTO

Medical School Self-study Summary Report

Prepared for the *ad* hoc visiting team of the
Committee on Accreditation of Canadian Medical Schools (CACMS)

Site Visit: May 3 – 7, 2020

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Introduction

Prior Accreditation History

University of Toronto, Faculty of Medicine				Last full survey (2012)
Standard/ Element	Old Standard	Full survey Oct 2012	Status Report Oct 2013	Status Report Oct 2015
Standard 3				
3.3	IS-16	NC	CM	C
3.3	MS-8	CM	CM	C
3.5	MS-31-A	CM	CM	C
Standard 8				
8.3	ED-35	CM	CM	C
8.8	ED-38	NC	CM	C
Standard 9				
9.4	ED-27	NC	CM	C
9.7	ED-30	CM	C	
Standard 11				
11.2	MS-19	CM	CM	C
Standard 12				
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	Continued accreditation
Next Full Survey		8 year term (2019-2020)	2019-2020	2019-2020

Follow-up to the 2012 Accreditation Survey

IS-16 – Diversity of Faculty, Students and Staff (3.3)
Finding: The school created a new definition of diversity and developed interventions to achieve appropriate diversity for medical students. The school is developing a strategy for other learners and faculty. Monitoring of program effectiveness is ongoing.

Response:
Two new administrative staff positions created: Indigenous Peoples' Undergraduate Medical Education Program Coordinator and Senior Officer, Service Learning & Diversity Outreach.

Update submitted on four initiatives: Diversity Mentorship Program; diversity hiring expectations document; clinical faculty equity survey; and, resident diversity survey. Provided an update regarding the percentage of students, faculty and staff in each of our priority diversity categories.

MS-8 Diversity/Pipeline Programs/Partnerships (3.3)
Finding: Partnerships to enhance the diversity of applicants to the medical school are in place. Evaluation of these programs is underway.

Response: Based on responses from 52% of SMP graduates from 1994–2011 (n=302), 97% of SMP alumni have completed or are currently pursuing post-secondary education; of those 20% are in a health sciences field and 4% are in medicine. The diversity focus of the SMP is larger than that of our single program, and it is against that larger goal of exposing high school students from under-represented populations to the university environment and professional careers in the health sciences that the impact of the SMP is considered.

MS-31-A – Professionalism/Learning Environment/Hidden Curriculum (3.5)
Finding: Regarding the learning environment, the recent introduction of the 'Red Button' web-based initiative seems positive and appears to be widely known among those who were interviewed in student focus groups. Continued observation will determine its effectiveness.

Response:
The focus of the report was on the "Red Button," now known as the "Student Assistance Button." Two important themes emerged from student focus groups: students are aware of the web resource, and students know about the various avenues to report problems in the learning environment. CGQ and course evaluation data show that, overall, the learning environment at the U of T and its clinical affiliates is viewed by students to be positive.

ED-35 – Systematic Review and Revision of the Curriculum (8.3)
Finding: There is low student satisfaction and identified deficiencies in the DOCH courses and in the Surgery, Family Medicine, Ophthalmology, ENT clerkships. Efforts are underway to correct these issues but there is no evidence yet of the effectiveness of change.

Response: Steps were taken to review, renew and revise the DOCH courses, and the Surgery, Family Medicine, Ophthalmology, and ENT clerkships since the May 2012 site visit. Provided student satisfaction data for those courses/rotations, including our Community, Population and Public Health-1 course, which replaced DOCH-1. For all those courses/rotations, the data revealed a pattern of improvement.

ED-38 – Monitoring Student Duty Hours (8.8)
Finding: A policy limiting daytime duty hours for clerks was recently implemented. Some students are not following this policy. Furthermore, some students, supervising residents and junior faculty are unaware of this new policy.

Response:
Ongoing communication efforts since the May 2012 site visit to ensure that students, residents

and faculty are aware of our duty hours policy, including the introduction of a duty hours orientation session in our Transition to Clerkship course and presentation of our duty hours policy at rotation-specific orientation sessions. A duty hours working group was struck to investigate and address the issue, which led to the introduction of a new duty hours "compliance benchmark" that triggers a review and reporting process overseen by the Clerkship Director/Committee.

ED-27 – Direct observation of student performance (9.4)
Finding: A system for ensuring direct observation of history and physical examinations was not consistent across all core clerkship rotations. The CGQ, independent student analysis, institutional self-study and comments from residents identified some continuing issues, especially in Surgery. Processes to correct these deficiencies were initiated but are not yet fully effective.

Response:
Program-level and rotation-specific processes put into place that ensure direct observation across all clerkship rotations, including particular steps taken in Surgery, such as the completion of a mandatory observed session in the general surgery sub-rotation that all clinical clerks are required to complete. Updated survey and administrative data demonstrate that students' clinical skills are being directly observed at a satisfactory rate in each required clerkship rotation, and that underperforming rotations are showing patterns of improvement.

ED-30 – Formative and Summative Assessment (9.8)
Finding: The school recently enhanced its system for the timely reporting of clerkship grades. The school and faculty report 100% success in timely grade reporting over the past three clerkship rotations.

Response: Provided data that demonstrate compliance with our policy that overall course grades be released to students within six weeks of the conclusion of a clerkship rotation.

MS-19 – Career Counseling (11.2)
Finding: An inclusive system to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs was enhanced to encourage the participation of all medical students. Preliminary feedback and high participation rates from 4th year clerks are positive, but results are not yet available for more junior students.

Response: Reported increases from 2013 to 2014 in the U of T CGQ scores, and the U of T scores in 2014 were substantially higher than the All Schools average for career preference assessment activities, information about residency programs, and alternative medical careers, and equivalent for faculty mentoring and resident mentoring. The agreement rates in our internal surveys are consistent with those reported in the CGQ.

MS-23 – Financial Aid/Debt Counseling (12.1)
Finding: Financial aid and debt management counseling were enhanced with new programs and more staffing. Data regarding program effectiveness are currently being collected.

Response: Reported increases from 2013 to 2014 in the U of T CGQ scores, including significant increases in the percent of 'satisfied' or 'very satisfied' students (a 15.6% increase with respect to financial aid services and a 17.9% increase with respect to debt management counselling). The U of T scores for 2014 are noticeably higher than the All Schools scores. The satisfaction scores on our internal surveys are positive, meeting our standard of a mean score of 3.5 or higher.

Description of the Medical School Self-study

The Vice Dean, MD Program, in her role as Faculty Undergraduate Accreditation Lead (FUAL), served as Co-chair of the MSS Steering Committee with the Director, MD Program Operations. Administrative support for the MSS process was provided by the Project Manager, Accreditation; Manager, Strategic Operations & Policy; and Executive Assistant to the Vice Dean.

CACMS standards were reviewed in clusters by five subcommittees:
- University/Affiliate Administration & Learning Environments (Standards 1, 2, and 3)
- Human, Financial, and Physical Resources (Standards 4 & 5)
- Curriculum Design, Development, and Content (Standards 6 & 7)
- Program Evaluation and Student Assessment (Standards 8 & 9)
- Medical Student Selection and Services (Standards 10, 11, and 12)

Each subcommittee had two co-chairs, who in turn served on the MSS Steering Committee. Each subcommittee was broadly representative of the diversity in the MD Program, the Faculty of Medicine, and the University of Toronto communities. In addition to the MSS Subcommittee co-chairs, the Steering Committee members included a dean's designate, the immediate past president of the Medical Student Society (MedSoc), and the accreditation administrative team. The MSS Steering Committee was in place beginning January 2019 and began its work with an orientation in May 2019.

The MD Program Executive Committee approved a two-pronged approach to the MSS. The MSS Steering Committee was responsible for the conduct of the self-study itself and was tasked with discussing and approving high-level CQI recommendations proposed by the MSS subcommittees. The MD Program Executive Committee, which was responsible for managing completion of the DCI, would receive the CQI recommendations from the MSS and determine the best way to operationalize those recommendations. Elements in need of urgent follow-up were assigned to the relevant education leader on the MD Program Executive Committee, based on portfolio.

Members of each MSS subcommittee were chosen to reflect the diversity of the MD Program's educational partners and clinical affiliates. Wherever possible, the subcommittees had representation from each of the four MD Program Academies, from Post-MD Education, from basic science and clinical departments, from full and community affiliated hospitals, from among program and curriculum staff, and curriculum leaders and teaching faculty from all disciplines. Subcommittee meetings were well-attended throughout the MSS process. Members were asked to review and present one or more elements to the full membership of the subcommittee to encourage engagement with the available data, and to provide reasonable CQI recommendations.

Student involvement in the self-study began in the spring of 2018, when the MedSoc Executive and Class Presidents group were asked to recruit a representative group of current students to

develop, deploy, and analyze the Independent Student Analysis survey. Following the publication of the ISA in Summer 2019, student leaders presented their findings to several MD Program committees and leadership groups. Each of the five MSS Subcommittees had student representatives from both pre-clinical (Foundations) and clinical (Clerkship) segments of the program.

The Data Collection Instrument was compiled between January and August 2019, using the 2018-2019 academic year as its data snapshot. The MSS Subcommittees met once monthly between September and December 2019 to review the program's performance on the requirements for each CACMS element. At the end of each month, the MSS Steering Committee held a review meeting where subcommittee co-chairs presented their findings, and discussed the CQI recommendations for all elements, prioritizing any elements that had been rated "Unsatisfactory" or "with a need for ongoing monitoring." Results of these reviews were then reported to the MD Program Executive Committee for follow-up and action planning, with the MSS Steering Committee receiving status reports regarding those action plans.

Evaluation of Elements

**STANDARD 1
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.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

1.1 a
The guiding *vision* articulated in the Faculty of Medicine Academic Strategic Plan 2018-2023 (Appendix 1.1.1.a) represents the medical school's mission for the MD Program. This vision was reaffirmed as part of the Faculty's most recent strategic planning exercise.

The MD Program has *education goals* that were refreshed at the same time the Faculty of Medicine academic strategic plan was being renewed. These refreshed education goals were approved by Faculty of Medicine Faculty Council in February 2019.

1.1 b
The MD Program Strategic Plan (Appendix 1.1.a) articulates the short- and long-term strategic initiatives for the MD Program. These strategic initiatives are grounded in four high-level priority areas (Diversity, Curriculum Innovation, Learner Experience, Teaching & Partnerships) and corresponding strategic objectives. The priority areas and strategic objectives provide the roadmap for MD Program strategic planning, including the identification, prioritization, development and implementation of specific strategic initiatives. These strategic initiatives (or short- and long-term strategic goals) are developed, reviewed, monitored and, if necessary, revised to support achievement of the strategic objectives, which are articulated in a manner that enables a continuous quality improvement approach to strategic planning.

1.1 c
The identification and monitoring of short- and long-term strategic initiatives takes place on iterative basis by the MD Program Executive Committee. This includes reviews in the spring and fall of the strategic initiatives identified by academic and administrative leaders.

1.1 d
To ensure that the MD Program Strategic Plan is effective, the short- and long-term strategic initiatives are monitored according to the corresponding strategic objective(s) and priority area.

1.1 e
At a minimum, the medical school monitors compliance with all CACMS accreditation Standards and Elements approximately every four years, as part of its interim and full accreditation reviews. The MD Program has a commitment to continuous quality improvement beyond interim and full accreditation reviews that is demonstrated through:
- annual course reports/reviews
- MD Program Evaluation Committee reviews of external data sources
- CaRMS reviews
- curriculum change protocol
- scheduled policy reviews

Many of these processes are described in more detail in Elements 8.1 through 8.4 (Curriculum Management; Use of Program and Learning Objectives; Curricular Design, Review, Revision/Content Monitoring; Program Evaluation).

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

1.1.1 a
The populations indicated in the DCI as those that the medical school has a responsibility to serve are:
- o Indigenous peoples
- o Black
- o LGBTQ2S+

The medical has identified the priority health concerns of these populations as demonstrated by curricular content relevant to Indigenous, Black and LGBTQ2S populations/health. Although many of these teaching events were initially developed to focus on a particular population, they have since been revised to be relevant to multiple equity seeking and underrepresented groups, including Indigenous, Black and LBGTQ2S people. The social accountability commitment of the medical school curriculum is informed in general by the following two principles:
- i. provide medical students with intersectional cultural safety and anti-racist teaching that is relevant to all equity seeking and underrepresented groups, and
- ii. provide population-based content and case-based teaching that is integrated into the curriculum (including case-based learning) rather than taught as a 'special topic'.

Curriculum development and teaching about Indigenous, Black and LGBTQ2S health in the MD Program is overseen by theme leads for each of these populations. Identification of population-specific priority health concerns includes consideration of evidence in the medical literature, recognizing at times the limitations or absence of specific evidence related to a population. The theme leads are supported by advisory committees to ensure input from students, faculty and community members. Each of these advisory committees support collaborative governance practices that include participation by Indigenous, Black and LGBTQ2S community advisors and health experts.

1.1.1 b
i.   The medical school's social accountability is articulated in its mission statement via the Faculty of Medicine's

guiding vision:

> *Our learners, graduates, faculty, staff and partners will be an unparalleled force for new knowledge, <u>better health and equity</u>.*

> *We will cultivate and bring to life ideas that <u>impact scholarship and society through unprecedented collaboration drawing in the diverse voices of our research, learning and clinical network</u>.*

This guiding vision was reaffirmed as part of the Faculty's most recent strategic planning exercise (Appendix 1.1.1.a).

ii.   The medical school's social accountability is fulfilled though two alternative admission pathways (Indigenous Student Application Program and Black Student Application Program) and curricular content (teaching events) relevant to Indigenous, Black and LGBTQ2S populations/health.

iii.   The medical school's social accountability is evidenced by the specific outcome measures summarized in DCI Table 1.1.1-2, with steps for monitoring provided in narrative c.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

1.2 a
The conflict of interest policies included in Appendix 1.2.a apply to board members (Governing Council), faculty members, and MD Program leadership and teachers.

1.2 b
Faculty members appointed to the Faculty of Medicine are informed of conflict of interest policies as part of their standardized letters of offer upon appointment and re-appointment.

MD Program teachers are informed of relevant conflict of interest policies by course administrators and are provided with a standardized conflict of interest slide template for use in lectures (Supplemental Appendix 1.2.b). The conflict of interest policies are also made know to MD Program teachers via the *MD Program Academic Calendar*, which is published annually, and are publicly available on the MD Program policies webpage.

Elected and appointed members of the Governing Council are informed by the Governing Council Secretariat of conflict of interest policies (By-law No. 2) when they commence their terms on the Council or its boards.

1.2 c
The conflict of interest policies included in Appendix 1.2.a address conflict of interest in each of research, faculty with academic and teaching responsibilities, and commercial support for continuing professional development. These policies include:
- o U of T *Statement on Conflict of Interest and Conflict of Commitment*
- o U of T *Policy on Conflict of Interest - Academic Staff*
- o U of T *Framework to Address Allegations of Research Misconduct*
- o Faculty of Medicine *Relationships with Industry and the Educational Environment in Undergraduate and*

Postgraduate Medical Education
o   Faculty of Medicine *Standards of Professional Behaviour for Medical Clinical Faculty*
o   MD Program *Procedure for disclosure of potential commercial or professional conflicts of interest by MD Program teachers*
o   Faculty of Medicine *Policy on Sponsorship from Commercial Sources of University of Toronto Accredited Continuing Professional Development Activities*

1.2 d
Strategies for managing potential or actual conflicts of interest include:
o   the submission by faculty members of an annual conflict of interest disclosure form to their department chairs
o   the use of a standardized conflict of interest disclosure slide for all lectures
o   the required declaration of potential conflicts of interest when participating in MD Program or Faculty of Medicine committees or panels

B)   Continuous Quality Improvement Recommendations for this Element

Emphasize for students the ability to report perceived COI and to whom reports should go.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

1.3 a
DCI Table 1.3-1 shows that faculty are voting members on the majority of standing committees in the medical school.

1.3 b
Broad faculty input on Faculty Council that is independent of departmental leadership or central administration is ensured through the election of departmental faculty representatives and at large faculty representatives.

On the standing committees of Faculty Council, broad faculty input independent of departmental leadership or central administration is ensured through elected at-large faculty representatives on each of the standing committees, based on a slate of nominations prepared by the Striking Committee ("nominations committee").

The Striking Committee is responsible for preparing a slate of candidates for each of the standing committees, in accordance with their respective membership categories, following receipt of nominations and constituency-based recommendations.

1.3 c
Changes in policy and other major Faculty-level changes are communicated to members of the faculty through the MedEmail newsletter. All such changes are publicly available on the Faculty of Medicine website.

Input into major changes is handled at the departmental level, and is coordinated by department chairs, in cooperation with committees of the Faculty, and affiliated clinical institutions (e.g., through the Hospital University

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Education Committee).

1.3 d
The Faculty of Medicine Faculty Council meets at least three times per academic year, normally in October, February and April, with dates published in advance. Faculty Council meetings are conducted in person, are open to all faculty, and all agendas and materials are available online in advance.

1.3 e
The MedEmail newsletter is the most wide-reaching communication tool used by the Faculty of Medicine, and reaches faculty, administrators, staff, students, and community members. The websites of both the Faculty of Medicine and the MD Program contain detailed information about the Faculty's and Program's activities and initiatives. The Dean's Annual report, also available online, summarizes past achievements and future plans.

B) **Continuous Quality Improvement Recommendations for this Element**

Ensure that information about Faculty Council meetings, including links to meeting agendas and minutes, are clearly presented in MedEmail to more effectively inform faculty of meeting agendas and outcomes.

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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.

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School must complete sections A and B:

A) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

1.4 a
Appendix 1.4.a contains 19 signed, executed, and currently valid affiliation agreements with clinical learning sites where students complete inpatient portions of required Clerkship courses.

1.4 b
Highlighted sections of Appendices 1.4_a_01 through 1.4_a_19, corresponding to the page numbers included in Table 1.4-1, contain explicit language on access to resources, primacy of program, faculty appointments, environmental hazard, and the learning environment.

B) **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

1.5 a
The By-Laws of the Faculty of Medicine Faculty Council were most recently revised in April 2018. The By-Laws are publicly available at all times on the Faculty of Medicine Faculty Council website.

Appendix 1.5 a indicates that the Faculty Council Constitution and By-Laws describe the "powers, duties and responsibilities" of the Dean of Medicine.

B)   Continuous Quality Improvement Recommendations for this Element

Include Faculty By-laws in faculty on-boarding documentation.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

1.6 a
Both the St. George (downtown Toronto) and Mississauga campuses of the University of Toronto are located in Canada.

1.6 b
All required courses in the MD Program must be completed at the University of Toronto.

1.6 c
The University of Toronto has legal authority to grant the Doctor of Medicine degree.

B)   Continuous Quality Improvement Recommendations for this Element

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STANDARD 2
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.

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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.

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School must complete sections A and B:

C)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

2.1 a

The U of T Governing Council *Policy on Appointment of Academic Administrators* governs the appointment of Department/Division Chairs, Directors of Academic Centres or Institutes, Deans, Vice-Deans, Associate Deans, Principals, and Vice-Principals. For the appointment of such academic administrators, the President of the University receives recommendations from an advisory committee or (for Vice Deans) the Dean. Informed by those recommendations, the President provides his/her own recommendation to the Governing Council for approval.

The *Policy on Academic Appointments* and the *Policy for Clinical Faculty* governs the appointment of faculty. The appointment of tenure-stream faculty is made upon recommendation of a Departmental Committee to the Chair, who in turn submits a recommendation to the Dean. The Dean makes a recommendation to the Provost, who is empowered to grant final approval and to report the appointments to the Academic Board of the Governing Council for information. Non-tenure-stream, non-clinical appointments are approved by the Provost (unless the appointment is part-time and for a short-term contract, status-only, or adjunct) and need not be reported to the Academic Board. Appointments of clinical faculty are approved within the Faculty of Medicine, except full-time appointments at the rank of Full Professor, which require the approval of the Provost.

The Dean appoints senior administrative staff, in accordance with the U of T *Policies for Professional and Managerial Staff*.

D)   **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

2.2 a
Dean Trevor Young holds the rank of Professor and is the former chair of the Department of Psychiatry in the Faculty of Medicine at the University of Toronto; he is also cross-appointed to the Department of Pharmacology and Toxicology.

Dean Young graduated from the Universities of Manitoba (MD) and Toronto (PhD) and completed residency at McGill University and the University of Toronto and a research fellowship at Johns Hopkins University.

He has held appointments as Physician-in-chief and Executive Vice President, Programs at CAMH in Toronto; Head, Department of Psychiatry, UBC; Vice President (Medicine) for BC Mental Health and Addiction Services; and has served on hospital and university boards throughout his career.

As Dean, Professor Young is responsible for all missions of the medical school, as specified by the *Policy on the Appointment of Academic Administrators*. He is "the chief executive officer of the Faculty" and retains ultimate responsibility for budget, appointments/promotions, and all administrative decisions made within his jurisdiction and authority.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

2.3 a
The Organizational chart of the Division of the Vice President and Provost (Appendix 2.3 a_1) demonstrates the reporting relationship of the Dean as Vice-Provost, Relations with Health Care Institutions to the Vice-President and Provost, as well as parallel relationships with other Vice-Provosts and University leaders.

The Dean meets regularly with the President and the Vice President and Provost in order to bring matters of pertaining to the University's relationship with affiliated hospitals to their attention.

2.3 b
The University of Toronto Organization of the Senior Administration (Appendix 2.3 a_2) demonstrates the Dean's relationships with other University officials, in his capacity as Vice-Provost.

The Dean is a member of two Provostial standing committees, and the Provost's Advisory Group. The Dean represents the Faculty of Medicine at the University's Council of Health Sciences, which reports directly to the Provost.

2.3 c
The Dean represents the University at the Toronto Academic Health Science Network (TAHSN) committee of hospital Presidents/CEOs, and on the standing sub-committee of TAHSN that addresses research. Effective October 1, 2019, the administration of TAHSN was relocated to the University of Toronto. The Dean is a member of four

fully-affiliated hospital boards and one community-affiliated hospital board.

2.3 d
The "Role and Mandate" section of the Dean's position description (Appendix 2.3.b) clearly outlines the Dean's responsibilities for the missions of the Faculty of Medicine, including the MD Program (Undergraduate Medical Professions Education), in accordance with the *Policy on the Appointment of Academic Administrators*.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

<p align="center">* * * * * * * * * *</p>

School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

2.4 a
As noted in Table 2.4-1, there are five Vice Deans, five Associate Deans, several portfolio Directors, and sufficient senior administrative staff to cover the portfolios that correspond to the missions of the Faculty of Medicine. Appointed faculty administrators have between 50% and 80% protected time to devote to their administrative work.

2.4 b
Table 2.4-6 shows that all departments and extra-departmental units (e.g., research institutes) have chairs, interim chairs or directors in place. For departments with an interim chair, searches are currently underway or will be during the course of the 2019-20 academic year.

2.4 c
The AFMC GQ data in Table 2.4-2 show generally high levels of satisfaction with the Office of the Vice Dean, MD Program, both in Accessibility (83.5% to 90.9% over three years) and Inclusion of Students on committees and working groups (85.2% to 95.7% over 3 years). Students show somewhat lower levels of satisfaction with the Office of the Vice Dean's Responsiveness to student problems (78.3%, 73.9%, and 75.0% over three years).

ISA data in Table 2.4-3 show overall very high satisfaction in all three domains (aggregated: Accessibility – 83.1%,

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Consultation/Inclusion – 86.3%, and Responsiveness – 82.4%). Year 2 shows the lowest satisfaction with Accessibility (75.0%) and Responsiveness to student concerns (74.5%).

Commentary from the ISA indicates that these lower satisfaction ratings may be due to a lack of awareness of the overall role of the Vice Dean, or a lower level of contact with the Vice Dean in day-to-day activities. It is also the case that many issues that arise in Clerkship (years 3 & 4) are often addressed locally at affiliated sites, rather than being referred to the Vice Dean immediately. It is notable that of the 972 total survey participants, only approximately 390 responded to the questions regarding the Office of the Vice Dean, MD Program, which would support a lack of awareness of the role of the Vice Dean among students.

In response to the ISA data and narrative regarding student perception of the Vice Dean's accessibility and understanding of the Vice Dean role, the Vice Dean implemented an engagement plan that included the following activities during the 2019-20 academic year:
- Year 1: Town Halls/Forums (x3), drop-in visit to Year 1 mandatory lectures (x2)
- Year 2: drop-in visit to mandatory lectures (x2), Town Halls (x2)
- Year 3: drop-in visit to core clinical rotation lectures (x6), attendance at Year 3 Transition Education Days (x3), Year 3 breakfast touch base (x2)
- Year 4: Town Halls (x1)

2.4 d

AFMC GQ data in Table 2.4-4 show very high student satisfaction over the last three years with the Associate Dean, Health Professions Student Affairs (HPSA) in the areas of Accessibility (88.3%, 94.5%, 90.9%) and inclusion of students on key committees and working groups (85.8%, 93.8%, 96.8%). Satisfaction with responsiveness to student problems is very high but decreasing slightly from 84.2% in 2017 to 81.0% in 2019, with a dip to 77.9% in 2018.

ISA data in Table 2.4-5 show very high satisfaction in all three domains for the Associate Dean, HPSA, across each of the four program years. Accessibility ranges from 91.1% in Year 1 to 93.3% in Year 2. Responsiveness ranges from 86.5% in Year 4 to 96.0% in Year 3. Consultation and inclusion of students ranges from 86.4% in Year 4 to 93.2% in Year 3.

B) **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

2.5 a
The Dean has delegated administrative responsibility for the MD Program to the Vice Dean, MD Program, who also serves as the Chief Academic Officer for the University of Toronto St. George Campus. The Vice Dean, MD Program holds ultimate responsibility for (i) the conduct and quality of the medical education program at both campuses, and (ii) the adequacy of faculty at both campuses.

At the University of Toronto Mississauga campus, the CAO is the Associate Dean, Medical Education (ADME) (Regional). The Vice Dean, MD Program works alongside the ADME (Regional) to ensure the delivery of a quality medical education program in Mississauga. The ADME (Regional) is responsible for the management and oversight of medical education in Mississauga and reports directly to the Dean in matters of faculty performance and adequacy. The ADME (Regional) is also the Vice President, Education at the Mississauga Academy's anchor hospital network, Trillium Health Partners.

nd delivery of the MD curriculum and services at both campuses.

B) **Continuous Quality Improvement Recommendations for this Element**

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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 of required learning experiences
     iv. faculty performance related to their educational responsibilities

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

2.6 a
The terms of reference for major MD Program committees, including the MD Curriculum Committee (MDCC) and MD Executive Committee, specify participation by curriculum leaders from both the St. George and Mississauga campuses. The Associate Dean, Medical Education (Regional) and Mississauga Academy of Medicine (MAM) Academy director serve on these committees *ex officio*, while other committees such as Foundations, Clerkship, and Admissions have required faculty and administrative representatives from the Mississauga campus.

Additionally, 43 Mississauga-based faculty are integrated into MDCC subcommittees as campus leads in Foundations courses and components and as faculty site coordinators for Clerkship courses.

2.6 b

The Vice Dean, MD Program is co-chair of the MDCC, and chair of the MD Executive Committee. As in requirement 2.6a, the Associate Dean, Medical Education (Regional) is *ex officio* a member of both the MDCC and the MD Executive Committee.

2.6 c
The MAM Academy director brings Mississauga-based faculty concerns to the attention of the MD Program by means of the Academy Directors Committee.

Each MAM-affiliated clinical site has a faculty site lead for each required Clerkship course, all of whom contribute to the work of the course committees and Foundations/Clerkship committees. The annual course review process captures Mississauga-specific evaluation data and feedback, which is used by course directors for quality improvement initiatives at all sites, including those affiliated with MAM.

2.6 d
The MD Program curriculum is designed and governed centrally and delivered in a distributed manner across the sites affiliated with the St. George and Mississauga campuses. Each course has a single course director, who is responsible for delivery and evaluation of the course for both campuses, with input from the course committees.

2.6 e
The student data collected and reviewed includes:

i.   student required patient encounters and procedural skills
   o   Case Logs (described in detail 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.   student performance data
iii. student evaluation data of required learning experiences
   o   Annual course reports, compiled by Course Directors and reviewed by the MD Program Evaluation Committee (MDPEC) 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 MDCC with action plans to address cases where such differences exist.

iv. faculty performance related to their educational responsibilities
   o   As in items ii. and iii. above, annual course reports also include faculty performance data. Evaluations of individual faculty members are aggregated and reported to Course Directors, Academy Directors, Department Chairs and Vice Chairs Education, and Clinical Department Chiefs, as applicable.

B)   Continuous Quality Improvement Recommendations for this Element

Recommend increased recruitment of Mississauga-based faculty for leadership positions.

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STANDARD 3
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.

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3.1 RESIDENT PARTICIPATION IN MEDICAL STUDENT EDUCATION

Each medical student in a medical education program participates in at least one required 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.

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School must complete sections A and B:

E)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

3.1 a
Table 3.1-1 shows that all students in each of the previous three academic years worked with a resident during required Clerkship courses longer than four weeks' duration.

3.1 b
All Post-graduate Medical Education programs at the University of Toronto are currently accredited. No residents from other programs are involved in MD Student education at affiliated sites.

F)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

3.2 a

During the welcoming activities in August, arriving Year 1 MD students are informed about, encouraged to participate in, and directed to opportunities for research and other scholarly activities. Information is shared with various medical student interest groups. This information is provided in the annual *Academic Calendar* and posted in the research opportunities section of the Faculty of Medicine website. This site includes links to research opportunities through departments, centres and institutes, hospital-based affiliates and research institutes, external awards and studentships, as well as student-run summer opportunities.

At appropriate times during each year, information sessions are organized by the leadership of the Physician-Scientist Training Program and announcements of research opportunities are emailed to eligible medical students about the MD/PhD, Graduate Diploma in Health Research (GDipHR) and Comprehensive Research Experience for Medical Students (CREMS) Programs.

The Research Institutes of the fully affiliated University teaching hospitals advertise their long-running summer student research training programs on their respective websites and information regarding these is also forwarded to students through emails from the Registrar's office.

3.2 b

Coordination of student placements is supported by the various above-mentioned research training programs. There are faculty leads and support staff located at both the St. George Campus and the Mississauga Academy of Medicine who are charged with helping to match students with research and scholarly projects led by faculty at teaching hospitals.

In 2019, the Faculty of Medicine developed and inaugurated a new medical student research opportunity, the Graduate Diploma in Health Research (GDipHR), a credentialed, graduate-level longitudinal 20 month research training program for a limited number of medical students.

On an annual basis, the GDipHR and CREMS programs freshly solicit new opportunities for mentored medical student research from prospective faculty supervisors willing to pay half of the student stipend and all of the expenses of the student's project. Each year there are more such supervisors and projects available than students who are interested in those specific projects.

The very large number of research opportunities at the University of Toronto means that virtually every student's interest can be accommodated. Many interested faculty members regularly welcome students into their laboratories and other research and scholarly settings. Competitions for research student stipend support are held annually by the Departments, Institutes, Research Centres and MD Program. The strength and number of opportunities for medical students to engage in research and scholarly activities in the Faculty of Medicine is reflected in the financial supports provided to qualified MD students in the form of student stipends, bursaries, awards, scholarships, and grant programs, that are in addition to provincial government loan and grant programs. For example, MD/PhD students receive a guaranteed annual stipend valued at over $35,000, and CREMS Scholar and GDipHR students receive a $15,000 stipend for the duration of studies.

3.2 c

Data from the AFMC GQ demonstrate that from 2017–2019 over 85% of students report having participated in research within each academy and less than 4 % of students report no opportunity to engage in research. Similarly, the ISA reports that the majority of students feel there are sufficient opportunities to engage in research at each of the academies. Less than 15% of students in the first year of the MD program report too few opportunities for research. By the Year 4 of the MD Program this value drops to 3.9, 6.3, 0, and 1.4 % at Fitzgerald, Mississauga, Peters-Boyd and Wightman-Berris Academies, respectively.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

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The MD Program was initially rated as 'Not in Compliance' for standard IS-16. The initial finding was: "The school created a new definition of diversity and developed interventions to achieve appropriate diversity for medical students. The school is developing a strategy for other learners and faculty. Monitoring of program effectiveness is ongoing." After submission of follow-up reports, this was changed to 'Compliance with Monitoring' in October 2013 and then to 'In Compliance' in October 2015.

The MD Program was initially rated as 'Compliance with Monitoring' for standard MS-8. The initial finding was: "Partnerships to enhance the diversity of applicants to the medical school are in place. Evaluation of these programs is underway." After submission of follow-up reports, this remained 'Compliance with Monitoring' in October 2013 and then changed to 'In Compliance' in October 2015.

3.3 a
The Faculty of Medicine's *Diversity Statement* – first issued in 2011 and updated in 2018 – is clear in specifying priority groups (included in Table 3.3-1), while identifying an inclusive lens beyond priority groups. The *Diversity Statement* applies to students, faculty and leadership, and is aligned with wider University of Toronto priorities and policies on human rights, diversity, and excellence.

3.3 b
i.   Students: The Summer Mentorship Program (SMP), Community of Support (CoS), Black Student Application Pathway (BSAP), Indigenous Student Application Pathway (ISAP), and financial assistance programs demonstrate ongoing and systematic activities to recruit new students in the identified priority groups.

There is a Black Health Lead and Indigenous Health Lead for the MD Program. These individuals support and participate in both the admissions pathways and support for the students in the program. As well, they contribute to important curricular development, implementation and evaluation in these areas. There is also an office of Indigenous Medical Education (OIME) with a 0.6 FTE administrative support person to support activities and programs for indigenous students. Recent increased bursary funding has also been implemented for the Indigenous students in the program.

ii. Faculty: The Office of Inclusion and Diversity is available for consultation and advice, and has web-based resources for departments in the Faculty of Medicine who are hiring new faculty to assist in searches, including unconscious bias training, etc. The Faculty's new Strategic Plan includes a specific Equity, Diversity, and Inclusion (EDI) plan to increase faculty diversity, including enhanced recruitment and retention activities.

iii. Leadership: U of T diversity policies and protocols are followed for decanal, chair, and director-level administrator positions. EDI considerations are embedded in all searches run by the Office of the Dean, including the writing of job descriptions, postings, search committee membership, EDI and unconscious bias training, and an opening presentation on equity and excellence. For MD Program academic and educational leadership positions, recruitment practices have recently been updated to mirror those summarized above.

3.3 c
i.   Students: The MD Program has in place financial supports, diversity mentorship programs, equity-oriented curriculum theme leads (e.g. Indigenous Health, Black Health, LGBTQ2S Health), community advisory groups, and student groups. There is a staffed Office of Indigenous Medical Education (OIME). The Faculty's Diversity Advisory Council and the Office of Inclusion and Diversity provide activities geared toward student retention. Recent examples are the Black Faculty and Learner event, the Diversity in Medicine Advisory group, an Islamophobia townhall, allyship events, and the Faculty of Medicine's *We All Belong* initiative.

The MD Program provides support to student groups that are doing work of their own initiative (e.g., Jewish Medical Student Association, Social Justice in Medical Education, Black Medical Students Association, Out in Medicine (for LGBTQ2S students and allies), Invisible Challenges in Medicine group)

ii. Faculty: The Office of Inclusion and Diversity has co-sponsored mentorship, career advancement, and

promotions events for Black, Indigenous, and female faculty members. The Faculty's Diversity Advisory Council (DAC) provides a community of practice and source of support for members of the faculty from underrepresented groups, in particular the Faculty's identified priority populations.

iii.   Leadership: The Associate Dean, Inclusion and Diversity is available for consultation with all appointed faculty leaders, and the DAC engages with diverse faculty on Faculty-wide diversity issues.

3.3 d
The Indigenous Student Application Pathway (ISAP), Black Student Application Pathway (BSAP), Summer Mentorship Program (SMP), and Community of Support (CoS) record and report annually on their efforts to achieve the desired student diversity outcomes. The SMP and CoS the SMP were designed as 'early exposure' and support programs for minority students who express an interest in health sciences, regardless of the health sciences program and/or post-secondary institution they eventually attend.

The Faculty of Medicine's, "Voice of …" surveys are administered annually to obtain outcomes data for all learners in the Faculty of Medicine, including medical students. Similar data collection for faculty and senior leadership has been initiated as of 2018. This provides a baseline and ongoing data collection will help determine the effectiveness of the recruitment and retention programs currently in place and those planned for the future

3.3. e
The ISAP, BSAP, SMP, CoS, and holistic admissions processes employed by the MD Program provide significant evidence of partnerships established and maintained to achieve desired outcomes.

The Faculty of Medicine also collaborates with the University of Toronto's equity partners to work toward greater diversity among students, faculty, and staff.

3.3 f
The ISAP, BSAP, SMP, CoS complete annual reports on activities and outcomes to demonstrate effectiveness. Financial support data is also compiled to determine the effect that financial supports have on diversity outcomes.

3.3 g
Student- and admissions-based initiatives are a particular strength of the MD Program, resulting in higher numbers of admissions from priority underrepresented groups and retention through the four years of the program.

Baseline data for faculty and senior leadership has only been collected for 2018, and so progress toward diversity goals cannot be measured at this time.

B)   Continuous Quality Improvement Recommendations for this Element

More systematic efforts in recruiting diverse faculty are needed, particularly for department-level searches.

Data collection on faculty and education leadership diversity should continue as part of the "Voice of..." surveys, and be used to inform and monitor implementation of the Faculty's EDI plan.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

3.4 a
The U of T *Statement on Prohibited Discrimination and Discriminatory Harassment* (Appendix 3.4.a) is referenced in the MD Program Academic Calendar, which students are required to review prior to registration. The *Statement* is reiterated on the landing page for the 'Student Assistance' button and is referenced in the MD Program's *Protocol for addressing incidents of discrimination, harassment, mistreatment and other unprofessional behaviour* (Appendix 3.6.a_2). The *Statement* is also available at all times on the MD Program Policies webpage and the UofT Governing Council's policy page.

3.4 b
The AFMC GQ and ISA show that mistreatment was commonly experienced in the form of sexist remarks (52/140), and racially or ethnically offensive remarks (28/140). There are long-established protocols in place for addressing these incidents in a safe and confidential manner. The MD program has taken recent steps, with further enhancements under development, to reduce barriers to reporting mistreatment, harassment, and discrimination (see Element 3.6).

Other work currently underway to foster an environment in which all individuals are treated with respect includes the development of an e-module for medical clinical faculty on professional values. The e-module is currently in development with a completion date of April 2020. It will be shared with academic departments and the affiliated hospitals and introduced to faculty at the time of initial academic appointment and for inclusion in Faculty of Medicine and hospital-based reappointment processes. In addition, a Faculty Development Advisory Group for Professional Values has been established and planning is underway for education programming for both departmental leadership, and clinical and non-clinical faculty within the Faculty of Medicine. The plan is to offer

departments a suite of offerings including e-learning modules, orientation programs, interactive workshops, and train the trainer opportunities. Among options considered by the advisory group as part of its initial planning sessions are the development of an Equity 101 series as well as an equity, diversity and inclusion (EDI) certificate program designed to "train the trainer" to facilitate and deliver workshops/modules to others in specific contexts.

3.4 c

The MD Program's *Protocol for addressing incidents of discrimination, harassment, mistreatment & other unprofessional behaviour* (Appendix 3.6.a_2) articulates procedures for medical students to disclose incidents of student discrimination experienced or witnessed. The *Protocol* includes measures to enable and support safe reporting, including the option for anonymous reporting via an online Event Disclosure Form (EDF), respect for student confidentiality, the option for students to withdraw from the process, and the option to delay taking action/escalation to preserve anonymity and minimize risk of retaliatory behavior by the individual responsible for the concerning behaviour. Further, operationalization of the *Protocol* is supported by designated MD Program leaders who are not in an evaluative role.

3.4 d

The MD Program's *Protocol for addressing incidents of discrimination, harassment, mistreatment & other unprofessional behaviour* provides approximate timelines for the review of disclosures/reports of experienced or witnessed discrimination. Designated MD Program Leaders are expected to review event disclosures as soon as possible, and always within 24 hours of receipt. If the Designated MD Program Leader is away for longer than 5 days, the person responsible for assuming her or his duties will review the submission (ensuring timely review).

3.4 e

The *Protocol* provides assurances that reports are reviewed within 24 hours, but cannot specify how long it will take to address and resolve the issue. The MD Program understands that some incidents will be more complicated and will take longer to resolve so an upper limit on resolution of an incident may not be possible in all cases. Supplemental Appendix 3.6.f provides a de-identified report that summarizes all mistreatment reports received by the Associate Dean, Health Professions Student Affairs in 2016 and 2017, including actions taken.

B)   Continuous Quality Improvement Recommendations for this Element

Faculty development, including both preventive and remedial training in anti-discrimination policies and practices, should be developed for MD Program teachers. (see also Elements 3.5 and 3.6).

More systematic accountability reporting should be undertaken to provide all Faculty of Medicine stakeholders, including students and clinical faculty, with de-identified information regarding the number and types of mistreatment disclosures/reports submitted by MD students and Post-MD learners over the past two years, including a summary of responsive actions. (See also Elements 3.5 and 3.6.)

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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.

*   *   *   *   *   *   *   *   *   *   *

School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into
         Consideration)

Previous accreditation findings (2012):
The MD Program was initially rated as 'Compliance with Monitoring' for standard MS-31-A. The initial finding
was: "Regarding the learning environment, the recent introduction of the 'Red Button' web-based initiative seems
positive and appears to be widely known among those who were interviewed. Continued observation will determine
its effectiveness." After submission of follow-up reports, this remained 'Compliance with Monitoring' in October
2013 and then changed to 'In Compliance' in October 2015.

3.5 a

Data on the learning environment is collected by both the MD Program and clinical affiliates each academic year. The MD Program includes in its course evaluation forms questions pertaining to professionalism and the learning environment for all required MD courses. Members of the Toronto Academic Health Sciences Network (TAHSN), which includes the Faculty of Medicine and the TAHSN member hospitals, participate in the TAHSN Education Committee's (TAHSNe) learner engagement survey. The results of each year's TAHSNe learner engagement survey are presented to and reviewed by the MD Program Curriculum Committee.

Evaluations and surveys all include the identification of positive and negative influences on the clinical learning environment and are reviewed by both MD Program leadership and the leadership of the affiliated clinical sites.

3.5 b
a) enhance positive influences
MD students report that having supervisors who respect and abide by the time limits on duty hours established by the MD Program's *Standards for call duty and workload in the clerkship* is key to a positive impression of the learning environment. As a result of the work of the Duty Hours Working Group, a compliance benchmark was applied to all Clerkship rotations to ensure compliance with the standards, for rotations that took longer to adapt to the *Standards*, best practices from other rotations were used to increase compliance.

b) mitigate negative influences
The MD Program utilizes all data collected on the learning environment through its evaluation mechanisms and learner surveys. Using qualitative data on the learning environment, the MD Program has identified some very specific barriers to reporting mistreatment, which in itself is a significant negative influence in the learning environment on the maintenance of professional standards. A summary of strategies intended to address barriers to reporting student mistreatment have already been implemented, with further strategies underway.

3.5 c
The MD Program's *Protocol for addressing incidents of discrimination, harassment, mistreatment & other unprofessional behaviour* provides assurances that reports are reviewed within 24 hours but cannot specify how long it will take to address and resolve the issue. The MD Program understands that some incidents will be more complicated and will take longer to resolve so an upper limit on resolution of an incident may not be possible in all cases. Supplemental Appendix 3.6.f provides a de-identified report that summarizes all mistreatment reports received by the Associate Dean, Health Professions Student Affairs in 2016 and 2017, including actions taken.

3.5 d & e
The ISA data in Table 3.5-1 shows that agreement among students that the MD Program and its affiliated sites foster appropriate learning environments.

In response to the question on whether learning environments are "conducive to learning and to the professional development of medical students," the lowest level of agreement with this statement was at the FitzGerald Academy in Year 3 at 88.4%. Several groups reported 100% agreement with this statement: FitzGerald Year 1, Peters-Boyd Year 1, and Wightman-Berris Year 2. Other academies and years ranged from upper 80% to upper 90% agreement.

In response to the question about whether the MD Program and affiliated sites "foster learning environments in which all individuals are treated with respect," there was a similar trend. The lowest agreement with this statement was 81.6% at Mississauga Year 4, with the highest being Peters-Boyd Year 1 at 100%. All other academies and years range from mid-80% to upper-90%.

It should be noted that the ISA survey did not divide the question into four parts. Each question asked about "The University of Toronto MD Program **and** affiliated academy training sites/hospitals." Though this phrasing of the question is "double-barreled," the high levels of agreement across all academies and years indicate that students have a favourable view of the efforts that both the MD Program and its affiliates make toward creating a safe and effective learning environment.

B)   Continuous Quality Improvement Recommendations for this Element

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Continue to coordinate efforts to improve the learning environment with Post-MD education offices and programs.

Implement faculty development to provide both preventive and remedial training on violations of professional standards that may affect the learning environment (see also Elements 3.4 and 3.6).

More systematic accountability reporting should be undertaken to provide all Faculty of Medicine stakeholders, including students and clinical faculty, with de-identified information regarding the number and types of mistreatment disclosures/reports submitted by MD students and Post-MD learners over the past two years, including a summary of responsive actions. (See also Elements 3.4 and 3.6.)

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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.

<p style="text-align:center">* * * * * * * * * * *</p>

School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

3.6 a
The Faculty of Medicine *Standards of professional behaviour for medical clinical faculty* (Appendix 3.6.a_1) articulates the medical school's expectations of how medical students (including visiting medical students) should be treated while participating in the medical education program. These Standards include a section regarding professional behaviours and characteristics that clinical faculty should strive to demonstrate as well as a section regarding behaviours and characteristics they should not demonstrate, including behaviours that contribute to the creation of hostile learning environments, discrimination, harassment, and other forms of student mistreatment.

3.6 b
There are multiple routes for students to discuss/disclose/report experienced and/or observed incidents of harassment, abuse, or other concerning behaviours in the learning environment. In essence, a "no-door-is-the-wrong-door" philosophy is employed. Procedural details, including the identification of designated MD Program leaders who are well positioned to received disclsoures/reports, are articulated in the MD Program *Protocol for addressing incidents of discrimination, harassment, mistreatment and other unprofessional behavior* (Appendix 3.6.a_2).

3.6 c
All Faculty of Medicine faculty members are informed of the *Standards of professional behaviour for medical clinical faculty* (including a hyperlink to the actual document) in standardized offer of appointment letters. Medical students, faculty members, administrative staff and other stakeholders are informed of the *Standards* via the Academic Calendar, which is published annually. The Standards are also publicly available on the MD Program's policies webpage.

3.6 d
In the *Protocol*, "Retaliation to disclosures, reports or investigations of discrimination, harassment or mistreatment" is explicitly listed as type of mistreatment. Mechanisms in place to protect students form retaliation include the option for anonymous reporting via an online Event Disclosure Form (EDF), respect for student confidentiality, the option for students to withdraw from the process, and the option to delay taking action/escalation to preserve anonymity and minimize risk of retaliatory behavior by the individual responsible for the concerning behaviour. Operationalization of the *Protocol* is supported by designated MD Program leaders who are not in an evaluative role.

3.6 e
Medical students are informed of the *Protocol* via the Academic Calendar, which is published annually. The *Protocol* is also referenced on the landing page for the MD Program's 'Student Assistance' button that appears in the top right-hand corner of all MD Program webpages and on Elentra, the program's learning management system. In addition, medical students are oriented to the *Protocol* at "O [orientation] week" and as part of the Year 3 Transition to Clerkship (TTC) and Year 4 Transition to Residency (TTR) courses.

3.6 f
AFMC GQ data (Table 3.6-1) shows generally high awareness among respondents; in 2019 three academies were 87.2% or higher. The lowest responses were for MAM 2019 – 77.5% (decreasing over three years), and WB 2018 – 74.6%, but up to 92.9% the following year.

ISA data (Table 3.6-3) shows very high awareness across all four academies and in years 1, 3 and 4, ranging from

100% to 84.3%. Year 2 is generally lower, and below 80% awareness at FG and PB. In aggregate, awareness of policies is high: Year 1 – 91.45%, Year 2 – 80.97%, Year 3 – 97.16%, Year 4 – 89.38%

3.6 g
AFMC GQ Data (Table 3.6-2) show decreasing awareness among respondents of reporting procedures, ranging from 73.8% to 66.7% across all academies in 2019.

ISA data (Table 3.6-4) show a similar unawareness of reporting procedures. In aggregate, awareness of reporting procedures is low: Year 1 – 56.51%, Year 2 – 37.65%, Year 3 – 71.56%, Year 4 – 72.57%

3.6 h
The *Protocol* behaviour provides approximate timelines for the review of disclosures/reports of experienced or witnessed discrimination. Designated MD Program Leaders are expected to review event disclosures as soon as possible, and always within 24 hours of receipt. If the Designated MD Program Leader is away for longer than 5 days, the person responsible for assuming her or his duties will review the submission (ensuring timely review). The *Protocol* provides assurances that reports are reviewed within 24 hours, but cannot specify how long it will take to address and resolve the issue. The MD Program understands that some incidents will be more complicated and will take longer to resolve so an upper limit on resolution of an incident may not be possible in all cases. Supplemental Appendix 3.6.f provides a de-identified report that summarizes all mistreatment reports received by the Associate Dean, Health Professions Student Affairs in 2016 and 2017, including actions taken.

3.6 i
AFMC GQ, "Voice of" surveys, course evaluation, and individual reporting of incidents of mistreatment are collected and reviewed at multiple levels in the MD Program.

The Vice Dean, MD Program; Associate Dean, HPSA; and Director, Evaluations receive survey data reports and ensure that data is reviewed at Curriculum Committee, MD Executive Committee, and the MD Program Evaluation Committee. These individuals and committees are empowered to implement changes to the program and make recommendations to department heads where necessary.

3.6 j
The MD Program monitors reasons students choose not to report mistreatment by utilizing the feedback mechanisms described in element 3.5. The example provided in DCI Element 3.5 shows that the MD Program used qualitative data from evaluations and surveys to determine the primary barriers that students experience to reporting student mistreatment.

3.6 k
Faculty-wide educational campaigns and MD Program-specific programming on learner mistreatment have been enacted in recent years to raise awareness of student mistreatment, harassment, and discrimination in the learning environment. Additional, more targeted faculty development efforts are in development in the 2019-2020 academic year.

3.6 l
AFMC GQ Data (Table 3.6-5) on student mistreatment experiences show that incidences of several forms of mistreatment either remain the same or have increased over the last three years. In some cases the numbers are low but still alarming (e.g., increase in "Threatened with physical harm")

ISA Data (Table 3.6-6) show that incidents of mistreatment increase each year in the MD Program. Overall: Year 1 – 4.83%, Year 2 – 8.50%, Year 3 – 15.64%, Year 4 – 33.19% (142 out of 953 total respondents)

B) **Continuous Quality Improvement Recommendations for this Element**

The MD Program should redouble efforts to inform students about what constitutes mistreatment and who should be approached to disclose and/or report mistreatment.

Implement faculty development to provide both preventive and remedial training on violations of professional standards that may affect the learning environment (see also Elements 3.4 and 3.5).

More systematic accountability reporting should be undertaken to provide all Faculty of Medicine stakeholders, including students and clinical faculty, with de-identified information regarding the number and types of mistreatment disclosures/reports submitted by MD students and Post-MD learners over the past two years, including a summary of responsive actions. (See also Elements 3.4 and 3.5.)

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STANDARD 4
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.

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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.

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School must complete sections A and B:

G)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

4.1 a

The total number of faculty in the basic science and clinical departments in Table 4.1-1 provides evidence of a large number of basic science and clinical faculty in each academic year, with growth over time in each cohort. For example, there were 1384 basic science and 6760 clinical faculty in 2016-17. These numbers grew to 1407 and 7028 respectively in 2017-18.

Table 4.1-2 demonstrates that teaching responsibilities within our medical school are well distributed among basic science and clinical departments, and that there are sufficient numbers of faculty within each of these departments that are involved in the delivery of required learning experiences. In some instances, the faculty involvement is nil because no curriculum is delivered to the MD program by these departments.

Basic/Clinical Faculty totals have continually increased, while MD Program enrollment has been stable.

4.1 b

Table 4.1-3 demonstrates that protected time (ranging from 0.1FTE to 0.3FTE) has been allotted to directors of required learning experiences, hospital site directors and campus site directors at all academies. The Vice Dean, MD Program is the Co-Chair of the Curriculum Committee, along with an Education Scientist from the Wilson Centre, and duties of this role are included within the respective job descriptions.

4.1 c

The basic and clinical science departments have robust short and long range recruitment plans, taking into account a multitude of objectives, including enrolment expansion, retirement planning, improvement of clinical care, and an increased focus on diversity.

H)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

4.2 a

The publication counts in Table 4.2-1, along with the extended publications in Supplemental Appendix 4.2.b demonstrate significant publications in specific clinical disciplines and sub-disciplines, basic science subject areas, as well as cognate research areas such as medical ethics and medical education.

The Synopsis of Research Activities in Supplemental Appendix 4.2.a demonstrates a significant amount of scholarly productivity in the Faculty of Medicine as evidenced by research funding, which was in excess of $700M in fiscal years 2016 and 2017 and is approximately $821M for the 2018 fiscal year.

4.2 b

The Faculty of Medicine Office of the Vice Dean, Research & Innovation (VDRI) works to foster and support research activities in all areas of the Faculty and affiliated research institutes. In addition to central services, many of the Faculty's academic departments provide additional services directly to their faculty members.

There is also a standing sub-committee of the Toronto Academic Health Science Network (TAHSN), the TAHSN Research Committee (TAHSNr) co-chaired by the Vice Dean, Research & Innovation.

B)   Continuous Quality Improvement Recommendations for this Element

Efforts should be made to highlight available research support for part-time, distributed faculty members. The Centre for Faculty Development could be a partner to engage faculty members at non-TAHSN affiliated sites.

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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

4.3 a
The University of Toronto and Faculty of Medicine policies included in Appendix 4.3a contain detailed information on initial appointment, renewal of appointment, promotion, granting of tenure, remediation and dismissal.
These policies follow the relevant legal framework and regulations, are easy to understand, are user friendly, and are complimentary.
The implementation of the policies on appointment are further supported by the use of procedure manuals, developed by the University and the Faculty of Medicine to ensure that policies and process regarding appointments are easy to follow and implement.

4.3 b
Information about terms of appointment and responsibilities, privileges and benefits, and performance evaluation and remediation are provided at initial faculty appointment via the Chair's letter of Offer for all faculty appointment categories. These letters of offer include reference to all applicable policies, and a position description is enclosed.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

4.4 a

All faculty members receive a departmental review as indicated in their initial letters of offer (described in Element 4.3 and Supplemental Appendices 4.3.a through 4.3.e) after a probationary period of at least 3 and not more than 5 years. At the discretion of each department chair, a review at the end of the first and second years of the probationary period may also be conducted. For clinical faculty members who pass their initial probationary review, a continuing annual appointment is recommended, and an annual activities report is requested for review and feedback by the department chair prior to the annual renewal of the appointment.

Departmental promotions committees provide faculty with feedback and guidance regarding progress toward promotion.

Teaching evaluation data are gathered electronically in the Medical Student Information System (MedSIS) and are aggregated into reports including numeric scores and narrative feedback. Each teacher has direct access to evaluation data through a secure login on MedSIS.

In accordance with the University of Toronto *Policy and Procedures on Academic Appointments* (Appendix 4.3.a), newly appointed tenure-stream faculty members receive feedback during a third year review, which is conducted by a faculty committee, and includes feedback from the academic department regarding scholarly activity, teaching,

and service completed during the probationary period.

4.4 b
Completion of annual reviews is mandatory for all clinical faculty members to renew both university and hospital appointments. Hospital clinical chiefs must report any faculty members not in compliance with the requirement. The MD Program's Office of Assessment and Evaluation generates teaching evaluation reports centrally for dissemination to departments for use in annual reviews.

B)   Continuous Quality Improvement Recommendations for this Element

Continue working to integrate MD and Postgraduate POWER (Postgraduate Web Registration System)teacher evaluations reports to streamline feedback to faculty. Combining evaluations from MD and Postgraduate teaching activities could result in more timely feedback to teachers. Additionally, there is a Teacher Assessment working group, chaired by Vice Dean MD and Associate Dean PGME, to support provision of feedback more quickly.

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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.

4.5 e   ~~There are individuals with the requisite expertise and formal activities at the medical school, departmental or university level to assist faculty in enhancing their skills in curriculum design, instructional methods or program evaluation.~~

4.5 f   ~~There are individuals with the requisite expertise and formal activities at the medical school, departmental or university level to assist faculty in enhancing their skills in research methodology, publication development, or grant procurement~~.

Requirements 4.5 e and 4.5 f have been deleted, as they do not align with the DCI. This was confirmed in a communication with the CACMS Secretariat on May 9, 2019.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

4.5 a
Faculty Development is overseen by a Director Faculty Development (1.0FTE), reporting directly to the Vice-Dean, MD Program, and by a Coordinator (1.0FTE). While the current Director is on leave, the Office of Faculty Development (OFD) is being supported by an Interim Faculty Lead for Faculty Development. The OFD works in collaboration with Course Directors, curriculum leads and faculty members to improve teaching skills and with the Test Committee to support assessment skills.

The Centre for Faculty Development provides FD opportunities for the entire Faculty of Medicine community. The CFD has 15 team members and is a collaborative unit supported by the Faculty of Medicine and St. Michael's Hospital.

The Centre for Teaching, Support and Innovation is a central University of Toronto resource providing assistance to all U of T faculty. Department-level FD is also available.

4.5 b

The OFD, in consultation with Course Directors, Component and Theme Leads and faculty, conducts an annual needs assessment to identify FD needs by
- reviewing evaluations from FD event attendees
- assessing impact on teaching tasks and roles during curriculum changes
- receiving recommendations and referrals from committees
- analyzing backgrounds and experiences of tutors within specific roles and at specific sites
- participating in MD program and Departmental committees to identify faculty development needs

4.5 c

Faculty are informed of activities through emails, promotional flyers, communication from Course Directors and Leads, and the OFD website. A tailored communication plan for each role and/or academy is devised and information is available in the Academic Calendar and course-specific tutor guides.

The FD program is centrally and collaboratively designed and tailored to each site and campus. OFD delivers a blended learning model for FD including print resources, videos, podcasts, e-learning modules, webinars and face-to-face orientation, and teaching skills sessions. To ensure accessibility, face-to-face sessions are delivered at all academies.

4.5 d

Problems with an individual teacher's performance are often identified by the review of the Teaching Effectiveness Score (TES) by course directors, academy directors, department chairs, and/or clinical chiefs. In some instances, a teacher may self-identify, or receive direction to seek assistance by a course director or other individual responsible for teaching activities. Teachers are generally referred to an appropriate faculty development offering, or in cases of more serious issues, the course director and/or department chair may prescribe a specific plan of remediation.

Beginning in the 2018-2019 academic year, a Faculty Teaching Performance Working Group was struck to develop recommendations for an approach to faculty teachers who are identified as performing below expectations and to provide a more consistent and transparent process across the Faculty of Medicine and affiliated sites. In Fall 2019, the working group presented its proposed *Process for Assessment of the Faculty Teacher in Difficulty*. This is currently under governance review by the Faculty of Medicine.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

4.6 a

The Vice Dean, MD Program chairs and is advised by the MD Program Executive Committee, which is tasked with strategic planning, operational delivery of educational activities, governance structure and organization of the MD Program, and determining program-level decision- and policy-making processes and procedures.

The Vice Dean, MD Program participates in the Dean's Executive Committee, chaired by the Dean of the Faculty of Medicine and comprised of key Faculty-level executive leadership. The Dean's Executive Committee is responsible for advising the Dean on the overall management of the Faculty of Medicine.

Governance of the MD Program rests with the MD Program Curriculum Committee, which is responsible to the Faculty of Medicine Faculty Council, by way of the Education Committee of Faculty Council.

B)   Continuous Quality Improvement Recommendations for this Element

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STANDARD 5
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.

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5.1 ADEQUACY OF FINANCIAL RESOURCES

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

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.

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School must complete sections A and B:

I)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.1 a
Table 5.1-1 shows an upward trend in operating revenues over the last three fiscal years, with the University allocation to the Faculty increasing from $94.9 million to $109 million. Research grant revenue has decreased slightly but is generally stable over time. Endowments have increased and new endowments have nearly doubled in the last three years. These facts, combined with a stable revenue mix of operating and research revenues, indicate that the past and present financial resources are sufficient to sustain the operations of the MD Program.

5.1 b
Operating funds revenue is expected to increase by 2.3% from 2019-2020 to 2022-2023, while research revenue should remain relatively stable. Debt service payments will decrease from $2.2 million in 2019-2020 to $2.1 million in 2022-2023. Operating reserves increased in 2019-2020 to an overall reserve of $49.3 million.

5.1 c
There is currently no anticipated decrease in financial resources of the MD Program.

5.1 d
The Dean of Medicine has full authority over the revenue/expense budget of the Faculty of Medicine, including all budget units (one of which is the MD program). Within the Faculty of Medicine, every academic and administrative unit prepares a revenue/expense budget with a five-year projection that is reviewed and approved by the Dean. Every department and program budget, including the budget for the MD program, is reviewed by the Dean, the Chief Administrative Officer, and the Chief Financial Officer who must be assured that the academic and administrative plans of each unit align with the strategic priorities and the fiscal framework and related assumptions of the Faculty and the University. The current and projected capital needs in terms of physical

infrastructure are addressed through the Department of Facilities Management and Space Planning (FMSP) working closely with the Chief Financial Officer (CFO) and the Chief Administrative Officer (CAO), 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. Deferred maintenance is managed by central University's Facilities and Services Department, with input from the Faculty's FMSP. Under the authority of the Dean, the FMSP works closely with the CAO and CFO to identify projects and funding to continuously renew and meet new and changing requirements of the Faculty, both academic and administratively.

5.1 e

The MD Program and the Faculty of Medicine do not compile separate financial statements from those of the University of Toronto. The University of Toronto's audited financial statements (Appendix 5.1b) demonstrate that resources are sufficient to sustain the University's and the Faculty of Medicine's full commitment to a financially viable and well resourced MD Program.

J)   Continuous Quality Improvement Recommendations for this Element

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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.

<u>Requirements</u>

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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.2 a
The Dean has ultimate authority over the budget for the entire Faculty of Medicine. The Dean delegates budgetary responsibility for the MD Program to the Vice Dean, MD Program, who represents the MD Program in the annual budget review and approval process of the Faculty of Medicine.

5.2 b
The Vice Dean, MD Program has 60% FTE protected in her schedule to attend to the management and evaluation of the MD Program.

5.2 c
The Vice Dean, MD Program submits annually a revenue/expense budget with a five-year projection for approval by the Dean. The participation of the Vice Dean in the Faculty's budget process in recent years has resulted in an increase to the budget model for the MD Program to ensure adequate resources are in place for maintenance and

innation. A recent remodeling of the Anatomy Labs to support the Foundations Curriculum is a tangible outcome of this process.

5.2 d
There is a large team of 79 individuals supporting the Vice Dean, MD Program in the delivery and evaluation of the MD Program.

All of the administrators listed in DCI 5.2 d are either accountable directly to the Vice Dean, MD Program, or indirectly through another individual listed on the table.

5.2 e
The administrative team includes associate deans, academy directors, senior curriculum directors, faculty curriculum leads, program evaluation specialists, and senior administrative staff members.

For faculty administrators who do not have 100% FTE appointments in their roles, appropriate salary support and/or protected time to complete their duties in the MD Program have been negotiated with the appropriate departments.

5.2 f
Funds are distributed in the annual budget by the Dean to individual departments for their teaching activities in the MD Program. The distribution of funds is based on the budget model derived from the process described in DCI 5.2 a. The Chief Administrative Office, Chief Financial Officer, Vice Dean, MD Program, and MD Program Operations Director meet on a quarterly basis to ensure that the needs of the MD Program are being met throughout the fiscal year.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

5.3 a

The size of the entering medical class for all Ontario medical schools is set by the Ontario Ministry of Training, Colleges, and Universities, in cooperation with the Ministry of Health and Long-Term Care. Based on Ministry enrolment numbers, the Dean, in cooperation with MD Program leadership, submits an enrolment plan to the University of Toronto to ensure adequate access to teaching facilities and resources for each year. Supernumerary seats in the incoming class are approved when resources permit. In the current year, those supernumerary seats are capped at 13.

5.3 b

Table 5.3-1 shows that the percentage of incoming students without government funding over the last three years has been very low, between 0% and 1.5%.

The Faculty of Medicine and MD Program budget model ensures that the MD Program is fully funded to deliver the program each year. Funding is allocated so that the MD Program is not dependent on supernumerary tuition.

B)   **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.4 a
Shared educational spaces, such as the large lecture halls in the Medical Sciences Building, are prioritized for the MD Program in scheduling on the St. George campus. At the UTM campus, there are dedicated rooms under MD Program control in the Terrence Donnelly Health Science Centre, shared only with Occupational Science & Occupational Therapy. Academy-based medical education offices ensure that shared spaces at affiliated clinical sites are reserved and booked to accommodate all required MD Program learning activities.

There have been no recent challenges on either campus to booking teaching space.

5.4 b
All academy-based facilities provide either dedicated space or priority booking for teaching and assessment of students' clinical and procedural skills.

5.4 c
There has been no increase in class size since 2011-2012.

5.4 d

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The MD Program does not anticipate a class size increase in the next three years.

5.4 e
Core facilities at the Medical Sciences Building include 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 through the full and associate members of the Toronto Academic Health Science Network (TAHSN).

5.4 f
ISA data contained in Table 5.4-1 shows very high overall satisfaction across years and types of facility.,

Adequacy of lecture halls and large group rooms on campus is above 90% for all academies in all years. Adequacy of space for clinical skills teaching at academy sites is also well above 90% for all academies and years, except for Year 2 FitzGerald, where it is still high at 89.5%.

Adequacy of small group teaching spaces is generally above 80% for all academies and years, with a high of 97.8% for Mississauga Year 3. The exception on this question is the Peters-Boyd academy in Years 1 and 4. The ISA comments and students participating in the MSS report that this difference in satisfaction is likely due to the additional travel time required to reach some of the Peters-Boyd sites for small group learning (e.g., Sunnybrook Health Sciences Centre).

B)   Continuous Quality Improvement Recommendations for this Element

Encourage the Peters-Boyd academy director to investigate the source of lower satisfaction for small group teaching spaces.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.5 a
Each required Clerkship course across all four academies has multiple inpatient teaching facilities available for student assignment during required rotations.

All four academies utilize both University-affiliated hospital clinics and community-affiliate hospital clinics for ambulatory learning experiences in Clerkship courses, with the single exception of the Psychiatry course at Mississauga, which exclusively uses the community affiliate hospital clinic.

The Clerkship Committee, in setting the required clinical encounters and procedures (Case Logs) for the Clerkship, ensures that students at each academy are assured the appropriate numbers and types of patients at each site where they may be assigned. Each individual course has outlined a strategy for ensuring students at each inpatient and ambulatory site are able to complete their Case Logs with the required number and types of real patients.

5.5 b
AFMC GQ data in Table 5.5-3 shows that in the most recent year (2019) agreement that students had sufficient access to the variety of patients and procedures required was very high, ranging from the lowest satisfaction of 87.2% (Peters-Body Family Medicine) to several 100% agreement (FitzGerald Family Medicine, MAM Family Medicine, and Wightman-Berris Psychiatry). This level of agreement has remained high over the last three years and has increased slightly in some disciplines and academies.

ISA data in Table 5.5-4 confirms agreement with the statement that students had sufficient access to the variety of patients and procedures required to complete the Case Logs demonstrated by the GQ data. In Year 3, agreement ranges from 83.9% at Wightman-Berris Surgery to 100% agreement for several sites and rotations.

5.5 c
ISA data in Table 5.5-5 shows very high satisfaction with space in ambulatory care clinics among students of all

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academies and years. FitzGerald students report 88.4% to 98.0% satisfaction; Peters-Boyd students report 92.2% to 97.8%, and Wightman-Berris reports 91.4% to 97.2%. MAM Year 2 is the outlier on this question, reporting 77.4% satisfaction. The source of this discrepancy is unclear, as the facilities used in Year 2 are the same as those for other years. Notably, MAM Year 3 reports 100% satisfaction, and Years 1 and 4 report 83.3% and 89.6%, respectively.

B)   Continuous Quality Improvement Recommendations for this Element

Investigate lower satisfaction among Year 2 students at MAM to determine if there is an issue with a particular space.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.6 a
Student evaluations of required courses have identified no recent difficulties with information resources or instructional facilities at the anchor clinical facilities associated with each academy. The Academy Directors, in cooperation with Clerkship course directors, oversee the annual completion of a Clinical Site Checklist (Supplemental Appendix 5.6.a), which ensures that each site has sufficient teaching space and access to information technology resources, among other site requirements.

5.6 b
ISA data in Table 5.6-1 show student satisfaction with academy-based education/teaching space is very high 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%).

5.6 c
ISA data in Table 5.6-1 show student satisfaction with accessibility of information resources at academy-based facilities is also very high: FitzGerald 94.7% to 98.1%; Peters-Boyd 88.7% to 96.5%; Wightman-Berris 87.7% to 95.8%. Year 3 MAM shows the highest satisfaction at that academy at 97.8%, followed by Year 4 (93.8%) and Year 2 (87.5%). Year 1 MAM is the lowest at 74.1%. Students in the MSS indicate that this may be due to the fact that WiFi access at THP requires additional steps that not all first years at MAM may have been aware of at the time of the ISA survey.

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B) **Continuous Quality Improvement Recommendations for this Element**

Ensure early orientation and instruction on accessing information technology resources at Trillium Health Partners for new students.

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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.

<u>**Requirements**</u>

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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.7 a

i. The following security measures are in place on campus during regular classroom hours:

Medical Sciences Building (MSB) – Access to the building is controlled and programmed by schedule; building is patrolled 24/7 (building patrol officer remains in contact with the campus police via two-way radio); high-profile/traffic areas are maintained under video surveillance; perimeter security alarms on all access points; restricted card system for the medical student lounge.

Centre for Cellular and Biomolecular Research (CCBR) – Physically linked to MSB and the consolidation of access control system onto one system in 2011 means that the building patrol, video surveillance and management through campus police is now comprehensive.

Health Sciences Building and Medical Student Study Space at 263 McCaul Street – The medical student study space within the Health Sciences Building has curved security mirrors and push-button-activated emergency call boxes to connect instantly to Campus Police.

Terrence Donnelly Health Sciences Complex (TDHSC) – At the University of Toronto Mississauga (UTM) campus 24-hour security coverage is in effect.

ii. The security measures in place on campus outside of regular classroom hours include:

MSB/CCBR – Access to the building is controlled and programmed by schedule with restricted access from 6pm-7am and throughout the weekend permitting only authorized users (includes medical students) through two access-controlled perimeter doors. All perimeter doors are alarmed after hours to ensure they remain closed and locked; the system was upgraded in 2011 and is managed by Campus Police. High-profile/traffic areas are under video surveillance, there is restricted card system for the student lounge, and the building is patrolled (MSB) 24/7.

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Health Sciences Building and Medical Student Study Space at 263 McCaul Street – After-hours perimeter and floor access security with card key. In addition, the study space has curved security mirrors and push-button-activated emergency call boxes to connect instantly to Campus.

Terrence Donnelly Health Sciences Complex – At the UTM campus, card-key entry is enforced in the TDHSC outside of business hours and 24-hour security coverage is in effect.

iii. All facilities used for scheduled teaching apart from the campus facilities described in DCI 5.7a (1.& 2.) are hospitals or other clinical sites that have appropriate security systems in place to address the needs of patients, staff, and medical students. These include code alerts, security cameras, security personnel, locked areas, and other typical security infrastructure for health care facilities, such as walk-safe programs to the parking lot or nearest subway station.

All academy anchor sites and specialty hospitals used by MD students have confirmed that these security systems are in place for each.

5.7 b

MD students are provided the same level of protection that is provided to all staff at the hospitals or other learning sites. However, as there is recognition that in exceptional circumstances students may be confronted by a dangerous situation, students are prepared for this type of experience during the Transition to Clerkship course where students receive specific training on managing potentially violent patients, de-escalation strategies, and personal protection.

Students are also provided with personal alarms and/or panic buzzers during their psychiatry rotation. Additional training on handling potentially dangerous or violent individuals is also conducted at the start of the Emergency Medicine rotation.

5.7 c

All UofT students, faculty and staff, including those in the medical school, are made aware of this information through an invitation to subscribe to the University's mass notification tool. This tool provides information as appropriate to faculty, staff and students during a crisis. The U of T *Policy on Crisis and Routine Emergency Preparedness and Response* were included in the DCI as supporting documentation (Appendix 5.7a).

This policy is made known to all medical students and faculty via the Academic Calendar which is published annually. An email message is sent in mid-August regarding the release of the Calendar for the academic year. One of the MD Program's registration requirements is that all medical students annually complete and submit a statement of acknowledgement and confirmation that they have reviewed the Academic Calendar.

Information regarding emergency preparedness and crisis management (including policies and plans) is also publicly available on a centralized UofT website.

5.7 d

All U of T students, faculty and staff are made aware of this information through an invitation to subscribe to the University's notification tool. This tool provides information as appropriate to faculty, staff and students during a crisis. This tool allows for messaging to be sent out via email, text, SMS, RSS, to the University's home page, desktops on the University network, electronic screens across campus, and office lines and mobile phones. Information regarding emergency preparedness and crisis management (including policies and plans) are publicly available on a centralized University of Toronto emergency preparedness website. The *Policy on Emergency Preparedness and Crisis Management Plan* is included in the DCI as supporting documentation (Appendix 5.7b).

This policy is made known to all medical students and faculty via the Academic Calendar which is published annually.

5.7 e

ISA data in Table 5.7-1 show that student satisfaction with safety and security at all instructional sites is very high. Year 1 students report 100% satisfaction with security. Other Years range from a low of 92.9% (FitzGerald Year 2) to 100% (MAM Year 3 and Peters-Boyd Year 3).

B) **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.8a
University of Toronto Libraries (UTL) librarians are aware of information resources and data systems that are available. UTL librarians are encouraged to participate in professional development activities; they attend multiple workshops and conferences annually to stay up to date on information resources available and search skills. Additionally, for in-depth data or statistical questions there are over five librarians, a GIS analyst, 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. GSIC librarians work closely with the collection development team at UTL to provide access to information resources for the medical school.

The Gertstein (GSIC) and Mississauga (UTM) libraries are members in the UofT's network of 41 libraries that offer a free interlibrary loan service for print materials. Both libraries are members local, provincial, national, and international associations that support access to an extensive set of resources and expertise

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

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5.8c

DCI 5.8b describes how electronic resources are networked and licensed for remote access by faculty, staff and students whether they are on campus, in the hospitals, at home, or elsewhere with appropriate authorization (UTORid or library barcode). Electronic resources can be accessed through a wide variety of devices including desktop computers and mobile devices.

DCI 5.8d provides the library hours for the Gerstein, Robarts, and the UTM libraries. These libraries provide ample access to physical and electronic documents every day, with extended hours during exam times.

5.8d

DCI 5.8 Table 5.8-2 provides the satisfaction scores for each campus. All academies have an aggregate score of greater than 80% for all years

5.8e

DCI 5.8 Table 5.8-2 provides the satisfaction scores for each campus. All academies have an aggregate score of greater than 80% for all years. Since the Gerstein Library is available to all MD Students, regardless of campus assignment, the slightly lower satisfaction with UTM library services may reflect a need to ensure that referrals to the Gerstein are handled appropriately by UTM Librarians.

B)   Continuous Quality Improvement Recommendations for this Element

MAM Academy director should investigate the slightly lower satisfaction with library support among students at MAM.

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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).

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.9a
Table 5.9-3 shows that at both campuses, there is a wireless network on campus, and that it is available in all classrooms and study spaces.

5.9b
IT services are offered and used by the MD Program in the areas of curriculum planning, delivery, developing instructional materials, curriculum management and supporting faculty. There are staff totaling 15.5 FTE that provide information technology (IT) services used by the MD Program, which includes 5 FTE supporting videoconferencing.

5.9c
- i. Discovery Commons (DC), the IT service for the Faculty of Medicine, supports the planning and delivery of curriculum through its direct support of platforms like CPlan, Elentra,, AV used for lectures and other academic activities, and technical advising for third party vendors.
- ii. DC provides support to faculty members who wish to produce videos, eModules, and other web-based learning materials for their courses
- iii. The MD Program's curriculum map and its search features are housed in the Elentra platform, which is supported by a team of developers and support staff in DC
- iv. DC provides a total of 5 FTE staff who support videoconferencing between St. George and Mississauga campuses, as well as other distributed sites with videoconference capabilities

5.9d
Table 5.9-1 contains the data from the AFMC Graduation Questionnaire (GQ). Based on averaging data from 2017-19, it shows that access to computers has an average of > 90% for all academies. The lowest satisfaction in any year was still > 80% (Peters-Boyd was 82.4% in 2017). Based on averaging data from 2017-19, the GQ shows that access to internet has an average of >93% for all academies, and the lowest satisfaction in any year was still > 80% (Peters-Boyd was 88.6% in 2017).

5.9e
Table 5.9-2 contains the data from the Independent Study Analysis (ISA) demonstrating that each requirement:
  i) has an average >80% for all Years and for all Academies
  ii) has an average of >80% for all Years and for all Academies, with the exception of Wightman-Berris
  iii) This is addressed by element 5.11

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.10 a
The MD Program does not admit transfer students into any curriculum year of the program.

Visiting students cannot be placed at a clinical site until the site has agreed that adequate capacity and resources exist. Visiting electives data is reviewed by the electives office at least annually, departments where capacity is decreased are notified, and efforts are made to increase recruitment in these departments.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.11 a
Table 5.11-7 demonstrates that both campuses and all affiliated hospital sites have small rooms for group study and classrooms that may be used for study when free. Some hospital sites and campus libraries also include individual study rooms.

5.11 b
Table 5.11-1, using data from the AFMC Graduation Questionnaire (AFMC-GQ), shows that at least 89.7% of graduating UofT medical students from all academies in 2019 were satisfied/very satisfied with study space at the medical school campus.

Table 5.11-2, using data from the 2019 Independent Student Analysis (ISA), shows that over 80.0% of students from almost all years and academies were satisfied/very satisfied with study space at each medical school campus. The exception is Year 2 students from Fitzgerald Academy, with a satisfaction rate of 76.8%.

5.11 c
Table 5.11-3, using data from the AFMC GQ, shows that at least 81.6% of graduating UofT medical students from all academies in 2019 were satisfied/very satisfied with availability of relaxation space.

Table 5.11-4, using data from the 2019 ISA, shows that students from most years and academies were satisfied/very satisfied with adequacy of relaxation space at each medical school campus. The exceptions are as follows: Year 1 students from Fitzgerald Academy (75.5%), Year 1 students from WB Academy (75.8%), Year 4 students from Fitzgerald Academy (74.5%)

5.11 d
Table 5.11-5, using data from the 2019 ISA, shows that students from all years and academies were satisfied/very satisfied with adequacy of secure storage space in medical school buildings. The exception is Year 4 students from Fitzgerald Academy (79.6%).

Table 5.11-6, using data from the 2019 ISA, shows that students from all years and academies were satisfied/very satisfied with adequacy of secure storage space at clinical sites. The exception is Year 3 students from PB Academy (79.2%).

5.11 e
Table 5.11-8, for every hospital where call is a component of at least one clinical learning experience, call rooms are available for medical students.

5.11 f
Table 5.11-9, using data from the 2019 ISA, shows that students from almost all years and academies were satisfied/very satisfied with on-site call rooms for required clinical learning experiences. The exceptions are Year 3 and 4 students from Wightman-Berris Academy (78.9% and 74.0%, respectively).

B)   Continuous Quality Improvement Recommendations for this Element

Both campus and clinical sites should investigate the outlier data.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

5.12 a

Table 5.12-1 shows that there were 205 students admitted to the St. George campus, and 54 or 55 students admitted Mississauga, from 2012-2013 through 2017-18. The only increases in admitted students occurred in 2018-2019 and 2019-2020. In 2018-1029, the increase at St. George was 2% (6 students) higher than in 2012-2013, and in 2019-2020, the increase was 5% (11 students) higher than 2012-2013.

5.12 b

The MD Program engaged in 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 the CACMS, and the transmittal letters are included in Appendix 5.12 a.

The MD Program also initiated a trial Longitudinal Integrated Clerkship, which has since been discontinued. The transmittal letters regarding the introduction of the LInC are included in Appendix 5.12 a.

B)   Continuous Quality Improvement Recommendations for this Element

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STANDARD 6
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.

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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.

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School must complete sections A and B:

K)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

6.1 a

Table 6.1-1 lists the MD Program's program-level objectives, known as "Key Competencies," written in terms of the competencies needed by an MD graduate to enter a residency program.

6.1 b
The MD Program Competency Framework (CF) replaced the former MD program objectives in 2016. The Competency Framework has since been reviewed and revised in 2019. The MD Competency Framework and subsequent revisions were approved by the MD Program Curriculum Committee.

6.1 c
The Key Competencies and their associated enabling competencies are directly linked to the seven roles of the CanMEDS framework. In adapting the CanMEDS 2015 and CanMEDS-FM frameworks for undergraduate education, the MD Program also consulted the MCC Blueprint and objectives as well as the AFMC Entrustable Professional Activities.

6.1 d
The assessment modalities listed in Table 6.1-1 are sufficient in number and specificity to assess students' progress in attaining the Key and Enabling Competencies over the four years of the MD Program. Assessments are mapped to learning objectives and to the CF. The assessment outcomes displayed in the MD Learner Chart are aligned with the CF and allow students and faculty members – particularly Academy Scholars, who conduct progress reviews with individual students – to monitor progress over time.

The Student Assessment and Standards Committee (SASC) supports the MD Curriculum Committee by reviewing assessment modalities for appropriateness to ensure program outcomes are met. The Office of Assessment and Evaluation utilizes a program evaluation framework to ensure that overall program goals are being achieved using data from the assessments included in Table 6.1-1.

6.1 e
The CF is highly publicized and is made known in the *MD Program Academic Calendar*, which is published annually. The CF is also available for review on the MD Program website. Students are required to review the *Academic Calendar* each year. The CF has also been integrated into the MD Learner Chart, which students use to track their academic progress through the program.

Faculty members with leadership roles in the curriculum are oriented directly to the CF by the Foundations and Clerkship Directors. Teaching faculty, residents, and others involved in MD student training are asked to review the CF in the *Academic Calendar* and have access to the comprehensive curriculum map feature in the Elentra, the program's learning management system.

6.1 f
Learning objectives for each MD Program course are included in each course website in the Elentra platform. All teaching faculty, residents, and others with a need to be informed of course objectives are provided with access to the Elentra.

Students are enrolled in their course website each year of the program and can review objectives for the whole program using the curriculum search feature.

Supplemental question in ISA: awareness of learning objectives in Clerkship – aggregate response above 70% and most above 80%

L)   Continuous Quality Improvement Recommendations for this Element

Ensure that Post-graduate program directors advise and remind all PG learners of the competency framework at least annually.

Leverage the user management capabilities of the Elentra platform to ensure that all residents and any other non-faculty receive seamless access to MD Program materials, including learning objectives and competencies

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.

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School must complete sections A and B:

A) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

6.2 a
The Case Logs Quick Reference Guide (Supplemental Appendix 6.2.a in place of Table 6.2-1) clearly outlines the required clinical encounters and procedures.

The clinical setting is generally implicit given that the lists are course-based and most courses have specific settings (e.g., Emergency Medicine). Where the course and Clerkship committees have determined that context specificity is not important, encounters/procedures are annotated on the case logs list as achievable in more than one course (e.g., Well care of the newborn may take place in either Paediatrics or Family Medicine).

6.2 b
The Case Logs Quick Reference Guide (Supplemental Appendix 6.2.a) clearly outlines which encounters and procedures must be observed (A), performed with assistance (B), or performed independently (C).

6.2 c

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Course committees developed and review annually the lists of required encounters and procedures, the settings in which they need to be completed, and the level of responsibility at which they needed to be completed.

Changes to the Case Logs list must be approved by the Clerkship Committee and reported to the Curriculum Committee.

The course committees refined the lists based on a close examination of the fundamental nature of their course, the course's learning objectives, and the competencies measured on the common Clerkship ward/clinical performance evaluation form. The course committees' work is discussed, reviewed and approved by the Clerkship Committee, where overlaps and gaps were deliberated, as well as topics such as the expected level of student responsibility, the role of simulation opportunities, the importance of setting, and the differences in the number of required encounters and procedures between courses.

The fundamental determination of whether to include an item on a course's list rests on whether it would be inappropriate for a student to complete and receive credit for the rotation in question without having experienced that encounter/procedure. The list continues to be reviewed annually by the Clerkship Committee, where any desired changes must be brought with an accompanying rationale.

6.2 d
The MD Program's *Required clinical experiences* policy (Supplemental Appendix 6.2.b) sets the expectation that the required clinical encounters and procedures should all be experienced through interaction with real patients. At least 80% of required encounters in each course and 80% of required procedures in Year 3 Clerkship overall must be completed with real patients.

Some encounters and procedures are identified in each course as "Must be real" because they are critical patient encounters that have been judged to be encounters or procedures that cannot be adequately replaced by simulation. For other required encounters and procedures, simulations are used only to remedy gaps, such as when a given experience with a real patient is unavailable (e.g., in the case of seasonal illness or certain less common presentations).

6.2 e
In the event of an incomplete encounter or procedure, students are required to work with the course director to make an action plan to remedy any remaining gaps, with follow-up from the course director. This may include completing simulated cases (where deemed appropriate by the course director) or being brought back into the clinical environment. Examples of alternative experiences are listed in Element 8.6.

6.2 f
Students are informed about Case Logs by the Director of Evaluations at a presentation at the beginning of Year 3, in the Transition to Clerkship course. Additionally, they are re-oriented at the start of each course. Information about the Case Logs is also included on each course website on Elentra and in the Case Log in MedSIS. Faculty members and residents are informed of the patient encounters and procedures required for a course by the relevant course director and/or faculty site leads.

B)   Continuous Quality Improvement Recommendations for this Element

Develop further communication plans to ensure awareness of case logs with teaching faculty and residents at all sites.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

6.3 a
Case Based Learning (CBL) is a core teaching tool used throughout Year 1 and Year 2 of the curriculum. CBL uses an authentic, online virtual patient case which has been uniquely designed for each week of the curriculum with the goal of providing students with a clinical context in which to learn, apply and integrate medical knowledge. The sequence as outlined for this requirement is achieved through highly structured CBL exercises, described in DCI 6.3.

6.3 b
The curriculum in the first two years is organized to include the equivalent of a full day each week of scheduled time for self-learning.

6.3 c
The Foundations curriculum is organized and delivered in accordance with the MD Program's *Standards for time spent in required learning activities in the Foundations Curriculum*, which were adopted in July 2016. Those *Standards* limit the total hours that may be scheduled per week to 28, and the total number of hours that may be scheduled in any one day to seven. It further states that seven hours may be scheduled only twice per week, with the maximum for the remaining days being six. Foundations teaching is never scheduled in the evenings or on weekends.

B)   Continuous Quality Improvement Recommendations for this Element

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.

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School must complete sections A and B:

A)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

6.4 a

Table 6.4-1 indicates that all required clinical courses in the Clerkship include a balance of ambulatory and inpatient settings, as appropriate for the discipline. The ranges of time spent in each setting vary among academies as a result of the distributed nature of the sites used by each academy. All students are exposed to both ambulatory and inpatient settings, regardless of academy affiliation.

6.4 b

Data from the AFMC GQ show very high agreement in the most recent year (2019), with 95% – 100% agreeing/strongly agreeing that they have the knowledge and skill to care for patients in a hospital setting, and 95% – 98% agreeing/strongly agreeing that they have the knowledge and skills to care for patients in an ambulatory setting.

B)   **Continuous Quality Improvement Recommendations for this Element**

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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 underserviced 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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

6.4.1 a
Development and ongoing review and revision of the Foundations curriculum development is driven by generalist principles. In reviewing CBL content in particular, the Department of Family and Community Medicine developed the Toronto Generalism Assessment Tool (T-GAT) to ensure that all case material included in the curriculum was approached with a generalist lens.

In the Foundations curriculum, all students complete a mandatory Family Medicine Longitudinal Experience (FMLE) component. In Clerkship, all students complete mandatory 6-week courses in Family Medicine (FCM310Y) and Paediatrics (PAE310Y), as well as an 8-week course in general Internal Medicine (MED310Y).

6.4.1 b
Data from the 2019 ISA show that, in aggregate, 91.5% of Year 3 Students and 89.5% of Year 4 Students indicate that the curriculum provided them with broad exposure to and experience in generalist care.

Academy-specific responses are high, ranging from 88.6% (Peters-Boyd) to 97.3% (FitzGerald) in Year 3 and, 87.8% (Peters-Boyd) to 92.2% (FitzGerald) in Year 4.

6.4.1 c
Data from the 2019 ISA show that, in aggregate, 93.5% of Year 3 Students and 83.8% of Year 4 Students indicate

that the curriculum provided them with broad exposure to and experience in family medicine, specifically.

Academy-specific responses are generally high, from 82.9% (Peters-Boyd) to 98.3% (Wightman-Berris) in year 3, and 76.0% (Peters-Boyd) to 87.5% (Mississauga) in Year 4. The source of lower Year 4 Peters-Boyd agreement is unclear, as all Family Medicine curriculum is organized centrally to ensure equivalency across sites.

6.4.1 d
Core Clerkship courses utilize the associated specialty and community hospitals within each academy network, in addition to anchor tertiary care hospitals.

"Underserved communities" in the context of the University of Toronto's location are represented by the vulnerable populations served by all affiliated clinical sites, including community affiliates, doctors' offices, and within academic family health units.

In Family and Community Medicine (FCM310Y), it is mandatory for students to complete a rotation with a preceptor in an academic and/or community site. The Medicine course (MED310Y) includes a required Person-Centered Care assignment, which focuses on providing care for patients in the vulnerable populations served by the clinical site.

In the required Transition to Residency course (TTR410Y), 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.

Rural placements are available to all MD students as optional placements in FCM310Y (through an agreement with the Rural Ontario Medical Program), as well as in electives and selectives offered through U of T and its partner agencies (such as ROMP, NOSM, and ERMEP).

6.4.1 e
Reponses to the ISA survey regarding setting of required and elective clinical learning experiences shows generally low agreement that MD Students' clinical learning experiences "took place in more than one setting" – 71.01% in Year 3, and 77.48% in Year 4. The Wightman-Berris Academy showed the highest level of agreement – 81.7% in year 3, 82.2% in year 4, along with Year 4 FitzGerald – 82.4%. The remaining academies report agreement below 75%.

Given the variety of settings where clinical learning takes place across the curriculum (including in Foundations), it is surprising to see that students do not feel their learning experiences reflect the variety required by the element. It is possible that the timing of the survey (in February) would mean that half the respondents would not have experienced certain parts of the curriculum. It is also possible that the language of the survey question did not adequately reflect the context of clinical learning at the University of Toronto and its clinical affiliates.

B)   Continuous Quality Improvement Recommendations for this Element

Encourage the compilation and distribution of Academy-specific descriptions of populations served at associate sites and emphasize the variety of contexts for students entering the clinical environment.

A more detailed survey of Clerkship students should be undertaken using language that more closely reflects the context of clinical learning at the University of Toronto to determine if their learning experiences occur in a variety of clinical settings with diverse patient populations.

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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 purse their individual academic interests.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

6.5 a

In Year 4 of the MD curriculum, medical students are required to complete supplementary learning experiences as follows:
- ELV410Y – Electives course (13 to16 weeks of electives)
- TTR410Y – Transition to Residency course (8 weeks of selectives)

Elective and selective opportunities are available to U of T students within departments and divisions of both fully affiliated sites (TAHSN and TAHSN associates), as well as community affiliated sites, and urban and suburban practices in the Greater Toronto Area. Additionally, programs such as the Rural Ontario Medical Program (ROMP) provide rural elective and selective experiences for students.

Students are also permitted to undertake electives at other Canadian and US medical schools, as well as approved international sites. Research-based electives and selectives are also available.

A new Year 3 elective block has been introduced in the 2019-2020 Academic Year. The first cohort of students will undertake these electives in Spring/Summer 2020 to encourage earlier career exploration through electives.

B)   Continuous Quality Improvement Recommendations for this Element

Ensure that a review of the new Year 3 home elective period is conducted to review student satisfaction and preparation. Review advising activities that were employed to address the new earlier home elective to ensure

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alignment with the career advising system.

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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).

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

6.6 a
There are mandatory service-learning experiences within the core curriculum. Integrated Clinical Experience - Health in the Community (ICE:HC) provides two short-term community experiences in Year 1 (home visits and IDD visits), supported with preparation and reflection which takes place during tutorial sessions.

ICE-HC provides a long-term Community-Based Service-learning (CBSL) placement in Year 2, consisting of community field experiences sustained throughout the academic year, supported with preparation and reflection in tutorial sessions. CBSL requires students to *participate, observe, contribute* and *advocate*, with a semi-structured curriculum that guides engagement within a community-centred context.

6.6 b
ISA data in Table 6.6-1 indicates that years 1-4 in all academies have participation rates between 88.0 and 98.2%. It should be noted that this data is student self-reported data. All students are required to participate as part of mandatory curriculum.

6.6 c
All students in the MD Program participate in curricular service-learning as part of ICE-HC, which is mandatory.

6.6 d

All students in the MD Program participate in curricular service-learning as part of ICE-HC, which is mandatory.
The medical school supports service-learning activities through:
- the provision and development of faculty (physicians and allied health) as tutors
- development of community partners as co-educators
- development and maintenance of partnership agreements and memoranda of understanding
- leadership and administrative support:
    - Health in Community Director – 0.3 FTE
    - Experiential Learning Lead – 1.0 FTE
    - Administrative support – 1.0 FTE

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

6.8 a
The MD Program includes a total of 147 weeks of instruction, not including breaks.

B)   Continuous Quality Improvement Recommendations for this Element

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STANDARD 7
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.

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7.1 BIOMEDICAL, BEHAVIORAL, SOCIAL SCIENCES

The faculty of a medical school ensure that the medical curriculum includes content from the biomedical, behavioral, and social sciences to support medical students' mastery of contemporary 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.

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School must complete sections A and B:

M)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

7.1 a
All course content is selected by course committees, chaired by course directors, in accordance with the curriculum change processes described in Standard 8.

Content for required MD courses is selected to align with the MD Program's Competency Framework (see Element 6.1) and utilizes the MCC presentations to select specific content for inclusion.

During the development of the Foundations Curriculum, the specific content of each week was explicitly chosen to ensure appropriate inclusion of biomedical, behavioral, and social science concepts. The content was reviewed by a Primary Care Group (see Element 6.4.1) to ensure relevance to generalist practitioners, and by Clerkship course directors to ensure alignment with Clerkship content. The list of topics in the table in Supplemental Appendix 7.1.a demonstrates an appropriate mix of topic areas. Clerkship course committees include content identified by national groups representing clinical disciplines, and by clinical presentations required by the Medical Council of Canada.

7.2 b
The content covered in the Health Science Research component of the Foundations Curriculum focuses on research methods, research ethics, critical appraisal, evidence-based medicine and knowledge translation skills critical to the role of an informed clinician. These concepts are integrated into weekly CBL cases in both years of the Foundations curriculum.

7.2 c
A report on the MCC Presentations in the MD Program Curriculum Map in Elentra confirms that 100% of current MCC presentations are covered in the MD curriculum.

The MD Program's Key and Enabling Competencies (Competency Framework) are all mapped to the AFMC Entrustable Professional Activities. The Elentra Curriculum Map demonstrates that all learning activities are mapped to the Competency Framework, and a link to EPAs can be demonstrated.

7.2 d
Each of the populations identified in Table 1.1.1-1 (Indigenous peoples, Black Canadians, and members of the LGBTQ2S+ community) have a corresponding Theme Lead. Theme leads are faculty leaders responsible for ensuring the integration of learning objectives and appropriate content and student assessment relative to the theme area throughout all four years of the MD Program.

The Integrated Clinical Experience (ICE) Health in Community (HC) component exposes Foundations students to the social determinants of health, the role of the physician in society, and community engagement. Community-based Service Learning (CBSL) is designed to increase awareness among students of the role physicians play in caring for marginalized populations.

7.1 e
The examples provided in DCI 7.1.e – the resilience curriculum, medical cannabinoids, and the creation of the Black Health theme – are all demonstrative of the MD Program's responsiveness to changes in the practice of medicine and medical education, changes in the legal landscape, and awareness of the needs of the populations the Faculty of Medicine has a responsibility to serve. These changes were made, respectively, in response to a recognition of the need to encourage greater wellness and resilience among medical learners and practising physicians, the federal legalization of cannabis, and the evidence of disparities in the health outcomes of Black Canadians.

N)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

7.2 a
Content
Each organ system is explicitly addressed over the two pre-clerkship years that comprise the Foundations curriculum. They are taught in the corresponding course that addresses the underlying physiological process, in tandem with the relevant anatomy labs, in addition to other learning modalities such as e-modules and CB. Each phase of the human life cycle is also explicitly covered in the Foundations curriculum, from embryology and

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paediatrics to geriatrics and palliative care.

Clinical experiences
The clinical skills relevant to each organ system are learned concomitantly in the Clinical Skills component of the Foundations curriculum. The human life cycle is taught through Clinical Skills sessions as well as patient panels. Students also have supplementary clinical experiences touching on organ systems and the human life cycle through their Enriching Educational Experiences (EEE) and the Family Medicine Longitudinal Experience (FMLE) clinics.

In Clerkship, the Year 3 clinical rotations ensure coverage across all organ systems. The Human Life Cycle is also covered throughout Year 3 Clerkship, in particular through Paediatrics, Psychiatry, Obs/Gyn, Family Medicine and Internal Medicine. They are supplemented through seminars, simulations and clinical assessments.

Primary care, preventive care (including harm reduction and health promotion), continuity of care, acute care, chronic care, rehabilitative care, and end of life care are each mapped in terms of where they are delivered in the curriculum through CBL, Foundations courses, lectures, self-learning modules, Clinical Skills sessions, workshops, FMLE, and Year 3 Clerkship (including Case Logs lists).

7.2 b

i.   In addition to preventive care (including harm reduction and health promotion) described in the previous section, the Public Health Theme is integrated throughout the four years of the curriculum. As part of the Health in Community curriculum, there is in depth (25+ hours) exploration of the determinants of health. Students are able to practise these skills in Clerkship both through their clinical rotations as well as through interactive seminars and e-modules in clerkship. Table 7.2-1 shows that 96% of students agree/strongly agree that they "feel prepared to integrate the social determinants of health into an appropriate management plan".

    Physician Wellness is a longitudinal topic in the MD Program. It is addressed through online modules and the Portfolio Course, the latter of which also has integrated components of the Resilience Curriculum

ii.   As students learn about each disease process in Foundations, they learn about the typical historical features, presenting symptoms and clinical findings through lectures and self-learning modules. The CBL cases are designed to help them practise working through the presentation of a patient with an unknown condition, and to use their knowledge to recognize clinical symptoms and signs and arrive at a diagnosis. Questions are asked through CBL cases to guide the students in how to use what they have learned to "diagnose" the patient. The weekly quizzes give students opportunity to self-assess their understanding of presenting symptoms and signs. Students see undifferentiated patients during their FMLE rotation and have an opportunity to practise these skills. In their FMLE assignment they are asked to reflect on undifferentiated and ambiguous symptoms they saw and to outline strategies to do this.

    Throughout the two years of Clerkship students are practising these skills on a daily basis, with opportunities for direct observation, feedback, and assessment. They also practice these skills in interactive seminars that are a part of each Clerkship course, as well as in e-modules in a number of courses.

iii.   Over the two years of the Foundations curriculum, students progress from a limited differential diagnosis for symptoms to a wide differential diagnosis by the time they reach Complexity and Chronicty (CNC). Cognitive maps for undifferentiated complaints (e.g., back pain, shortness of breath) and the related symptoms, signs, investigations and management are introduced in Introduction to Medicine (ITM) and revisited in CNC. In FMLE, students are asked to develop a differential diagnosis and treatment plan and have case reports and reflections they must submit. This provides an explicit opportunity for feedback on these skills. (Many students provide written feedback that FMLE is a wonderful opportunity for this kind of synthesis of knowledge)

    Each Clerkship course provides course objectives for developing approaches to various presentations, for which they develop a practical approach during their clinical time, as well as supplemented by interactive seminars in each course and e-modules in a number of courses.

    From Table 7.2-1, for the last two years, 100% of student respondents agree/strongly agree that they could

develop an appropriate differential diagnosis and 96.6% (2018) and 98.3% (2019) agree/strongly agree that they could develop an appropriate management plan.

iv.   Health in the Community 1 provides field experiences and classroom content that helps students recognize how socioeconomic and behavioural factors impact health. In FMLE, students are asked to reflect on accommodations to a treatment plan for a patient they saw based on individual factors in that patient.

In Clerkship, students see the reality of the health-related impact of behavioural and socioeconomic (SES) factors on patients on a daily basis. Students have opportunities in rotations such as Internal Medicine to work with an multidisciplinary health care team which includes discharge planners, Local Integrated Health Network coordinators, etc. where they get a sense of the complex interplay of medicine and behavioural/SES factors. Students also have an opportunity to complete an advocacy project for a patient they see in Family Medicine. These issues are also highlighted in seminars in each Clerkship course and in e-modules in a number of courses.

From Table 7.2-1, for the last two years 96% (2019) and 97.7% (2018) of student respondents agree/strongly agree that they feel prepared to integrate the social determinants of health into an appropriate management plan

v.   In Foundations, students are taught how to address health-related issues with patients through the role modeling of patient counselling as well as health promotion dialogue between patients and physicians in their CBLs, through their own role-playing in Clinical Skills, and some weeks there are patient panels that provide insight from a patient's perspective

In Clerkship, students are able to practise these skills in each course during their direct patient contact time as well as through interactive seminars and e-modules.

7.2 c

With the exception of a single data point of 79.1 in 2017 for interpreting imaging results (which has subsequently climbed to 86-87% in the last two years), all other data points were above 80% and generally going up over the last three years. The most recent year, 2019, had values ranging from 86-100% for these questions.

B)   **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

7.3 a

Table 7.3-1 indicates that there are learning objectives addressing the following elements in multiple courses, as part of the Health Sciences Research (HSR) component of these courses:
- instruction in the scientific method – MED120H, MED130H, MED200H, MED210H
- scientific and ethical principles of clinical and translational research – MED120H, MED130H, MED200H, MED210H
- how such research is conducted, evaluated, and explained to patients, and applied to patient care – MED120H, MED130H, MED200H, MED210H

7.3 b

HSR Year 1 consists of e-modules and large group sessions and the curriculum focuses on basic foundational research knowledge. This foundational knowledge prepares the students for HSR Year 2, where they have an opportunity to build upon this knowledge and apply critical appraisal skills and other research knowledge and skills to patient care activities through small group tutorials and a longitudinal exercise. HSR is highly integrated into the Foundations curriculum and prepares students to be good consumers of research with ability to apply the best available evidence in the day-to-day care of the patients and populations they care for.

In Year 2, students engage in an independent and personalized practicum exercise (PE) intended to address a component of the human translational pathway from one of the four Canadian Institutes of Health Research (CIHR) pillars.

B) Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

7.4 a
Table 7.4-1 clearly shows that all six Foundations courses and all required Year 3 Clerkship courses include learning objectives that are taught and assessed on:
  i.   clinical decision-making skills (with the exception of MED100H – Introduction to Medicine),
  ii. application of the best available information to the care of patients, and
  iii. medical problem-solving skills.

7.4 b
 i.   Reason clinically:
       GQ data show very high agreement, increasing from 95.4% in 2017 to 100% in 2018 and 98.9% in 2019.

 ii.   Incorporate evidence-informed decision-making into patient care:
       GQ data show very high agreement, increasing from 92.2% in 2017 to 97.1% in 2018 and 96.0% in 2019.

iii.   Access evidence-informed treatment guidelines:
GQ data show very high agreement, increasing from 94.1% in 2017 to 97.7% in 2018 and 96.6% in 2019.

iv.   Use technology to access information at the time of a patient encounter (just in time/point of care) if needed:
GQ data show very high and increasing agreement, from 90.8% in 2017 to 91.4% in 2018, and 95.4% in 2019.

B)   Continuous Quality Improvement Recommendations for this Element

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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 (2019-2020)

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.

These requirements align with older versions of the DCI, but not the version of the DCI published for 2019-2020.

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Requirements (2020-2021)

7.5 a   The faculty of a medical school ensure that required learning experiences address the diagnosis, prevention, appropriate reporting, 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.

These requirements align with the DCI published for 2019-2020.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

Using the 2020-2021 Requirements

7.5 a
The MD Program makes use of longitudinal curricular themes, each of which has a faculty lead and associated theme committee. Themes include Health and Humanities, Indigenous Health, Black Health, LGBTQ2S Health, Geriatrics, and Public Health, among others. The 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, including instruction on the social determinants of health, and the role of the physician in identifying and addressing common societal problems. All curricular changes are overseen by the MD Program Curriculum Committee, as detailed in Standard 8.

7.5 b
The examples of recent curriculum changes included in DCI 7.5.b demonstrate that the process used to add a change to the curriculum related to common societal problems is informed by gap analysis within the program and among the program's peers (e.g., Nutrition-related problems), a need for more instruction in specific problems (e.g., family violence), and in reaction to changing legal contexts (e.g., Bill C-14, Medical Assistance in Dying).

B) **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

7.6 a
Curricular theme leads for Indigenous, LGBTQ2S, and Black health integrate learning objectives across all four years of the MD curriculum, particularly in the required Foundations courses.

Indigenous Peoples of Canada:
Supplemental Appendix 7.6.a provides a comprehensive overview of required learning activities in the Foundations Curriculum that address the unique healthcare needs of the Indigenous Peoples of Canada.

Cultures:

Early in Year 1, students attend a required Cultural Safety & Equity lecture with accompanying workshop, and later in Year 1 reflect on concepts of cultural safety and equity in their Portfolio groups. In Year 2, Intersectionality and Equity week provides required curricular content focusing on the needs of Black, Indigenous, and LGBTQ2S populations. In Clerkship, the Transition to Residency course includes large group sessions and panel discussions on Cultural Safety and Indigenous Health.

Genders:
Year 1 includes a gender and health module, and the Year 2 Life Cycle course includes robust coverage of concepts related to gender identity. ICE: Clinical Skills includes instruction in history-taking for people of diverse gender expression. The Transition to Residency (TTR) course in Clerkship includes a large group session and panel discussion on LGBTQ2S health, including provision of comfortable and equitable health care to individuals of diverse genders and sexual identities.

Races:
As above, concepts related to Black and Indigenous health are integrated throughout the Foundations Curriculum, including Cultural Safety & Equity lectures and workshops, as well as Intersectionality & Equity week in Year 2. A large group session in ICE: Health in the Community addresses determinants of health with race as a specific example, with first-hand accounts from community practitioners and staff.

In addition to cultural safety sessions in TTR mentioned above, there is a large group session on Black Health in Year 4 discussing systemic racism as a social determinant of health and driver of health and social disparities.

Belief Systems:
In Clerkship, in the Transition to Residency course, there is an Alternative Health and Integrative Medicine (2 hours) 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 role of traditional medicine providers is explored in Intersectionality & Equity week. The TTR sessions on Cultural Safety and Indigenous Health, Global Health, and Immigrant and Refugee Health, as described above, also contain material relevant to belief systems.

Additional curriculum addressing the needs of patients who adhere to specific belief systems is under development and is anticipated to be introduced into the curriculum in the 2020-2021 academic year.

7.6 b
The Cultural Safety & Equity sessions early in the Foundations Curriculum, described under 7.6.a above, allow students to develop an awareness of their own assumptions about other cultures/ races/genders/beliefs, of their own biases, and of the importance of these to the patient-physician relationship. These sessions also introduce the cultural safety framework and the concept of being an ally. This content is revisited in the Intersectionality and Equity week, including concepts such as allyship and implicit bias. Racism and health is specifically addressed in lecture and self-learning modules in this week, including a case that explores how racism may affect clinical decision-making regarding Children's Aid Society involvement.

In the Internal Medicine Clerkship, students undertake a mandatory assignment related to a patient who encountered barriers to obtaining optimal/equitable health care based on bias, racism or other structural inequities. In reflecting on an actual encounter, they are encouraged to apply many of the core principles learned in Foundations related to this content area in practice.

Many sessions within TTR (including the Cultural Safety and Indigenous Health, Global Health, Immigrant and Refugee Health, and LGBTQ2S Health sessions discussed in 7.6.a above, as well as the Poverty, Ability in Intellectual Disability, and Increasing Accessibility sessions) encourage students to think about and question their own belief systems and assumptions pertaining to individual patients from diverse backgrounds, including such aspects as sociocultural background, race, gender identity, sexual orientation, economic status, and physical or developmental differences.

7.6 c
Many of the relevant knowledge and abilities (e.g., an understanding of the process of systemic and individual

discrimination on the basis of culture/race/gender/beliefs/Indigeneity, the development of reflexivity, knowledge of specific challenges faced by groups within the Toronto area) are covered in the sessions described in 7.6.a, such as the sessions on Cultural Safety & Equity in year 1, the weeks dedicated to Intersectionality and Equity and to Global Health in year 2, topics related to LGBTQ2S health in cardiology and endocrinology weeks, and the sessions in TTR about Cultural Safety and Indigenous Health, Global Health, Immigrant and Refugee Health, and Black Health.

In addition to the material in these sessions, the ICE Clinical skills sexual health session includes practical recommendations regarding taking an appropriate sexual history; second-year lectures on LGBTQ2S terminology and on inclusive history-taking revisit these concepts.

7.6 d
In the first year, the determinants of health are explored in one large-group session, five tutorial sessions, and two short-term field experiences. Social determinants of health and health disparities within marginalized populations are addressed in a number of weeks in Year 2, particularly Intersectionality and Equity week and Global Health week.

The 2.5 hour small-group Poverty and Health onboarding session in Transition to Clerkship provides students with insights, strategies, and hands-on proactive engagement with various tools for recognizing poverty as well as for optimizing care for, and advocating on behalf of, their patients living in poverty. There are multiple sessions and activities in TTR that relate to identifying and addressing health disparities.

7.6 e
Although the vast majority of respondents to the AFMC GQ as well as the aggregate of all students in each year, of all students at each academy, and of all students in the program overall in the ISA agree with this statement, we note that at some academies a substantial minority (20-30%) of first-year (and, in one case, second-year) students do not agree that they are satisfied with their education in this area. However, the vast majority of all groups of third-year and fourth-year students are satisfied with their education in this area. This is not surprising as, while there is important introductory material related to Cultural Competence presented in Year 1, the majority of this material is in the last Foundations course towards the end of Year 2 (which would have taken place after the ISA survey), in TTC, and in TTR, as well as within clerkship rotations.

B)   **Continuous Quality Improvement Recommendations for this Element**

Continue the development and implementation of additional curriculum related to patients of different belief systems.

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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.

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School must complete sections A and B:

A)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

7.7 a
The curriculum table included in DCI 7.7.a shows that there are a host of learning activities (large group lectures, small group seminars, panel discussions and patient panels) throughout required courses in the preclinical and clinical years that cover the learning objectives related to medical ethics and human values.

7.7 b
AFMC GQ results in Table 7.7-1 show that 98.3% of students in 2019 agree/strongly agree that they understand the principles that govern ethical decision-making and the major ethical dilemmas that arise in medicine. This number is generally in keeping with 2018 and an increase from 94.7% in 2017.

7.7 c
There is a graduated response to students who have received low professionalism scores, beginning with a check-in with the Course Director. If the matter is serious and/or persistent, the student may be asked to meet with the Foundations or Clerkship Director, or the Faculty Lead, Ethics and Professionalism. The student may be asked to complete a Focused Professionalism Learning Plan. In the most serious cases, students may be presented to the Board of Examiners, which may require a period of remediation.

B)   **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

7.8 a
Table 7.8-1 shows that there are explicit learning objectives in each of the three domains listed in the requirement in required courses across all four years of the MD curriculum.

7.8 b
The AFMC GQ data reflected in Table 7.8-2 show very high rates of agreement in each of the five domains of communication skills addressed by the survey. In 2019, two domains showed 100% agreement (Communicate effectively with patients and their families; Communicate with other health professionals); two domains showed agreement above 90% (Discuss options with a patient and/or family members who request unnecessary tests or procedures; Communicate with other physicians). The final domain – Discuss the health practices of a patient using alternative therapies – showed 80.7% agreement, which was an increase from the 2017 response of 77.1% agreement.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

7.9 a

Table 7.9-1 links the MD Program's Key and Enabling Competencies to the learning objectives for required courses in each of the four years of the program, organized under the Collaborator curricular theme. The narrative response gives three course examples with linked learning objectives.

7.9 b

The three examples listed in the DCI narrative response itemize the various health professional programs whose students are being taught together with MD program students.

Responses to non-required ISA questions on IPE provided some concerns that have been provided to the Centre for Interprofessional Education for follow up. The current IPE curriculum and materials are reviewed on an ongoing basis. Although concerns in the ISA comments appear to be "one-off ", each reported incident is investigated by the Center for Interprofessional Education (CIPE) to determine what can be done to mitigate the issue on an ongoing basis.

A Toronto Academic Health Sciences Network Education Committee learner engagement survey asked learners to evaluate their interprofessional experiences. Responses to that survey support presence of relevant curricula.

7.9 c

Table 7.9-1 and the narrative response show the linkage of the learning objectives to the development of collaborative competencies and include a description of the method of assessment for each example.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

7.10 a
Table 7.10-1 lists the Key & Enabling Competencies (MD Program objectives) specifically dealing with professional attributes. There are 15 enabling competencies, mapped to four Key Competencies.

7.10 b
The Competency Framework is published in the MD Program's *Academic Calendar,* and on the MD Program website. Incoming students are provided an orientation to expectations and assessment of professionalism in the Curriculum. Faculty members are informed of standards for professionalism and assessment expectations through faculty development mechanisms (Primer on Assessing Student Professionalism with eModule). All professionalism objectives are included in Elentra course websites. Residents and other non-faculty have access to these resources as well.

7.10 c
Table 7.10-2 lists each course/component where these topics are taught and assessed. There are courses with learning objectives in each topic area in each of the four years of the MD Curriculum.

7.10 d
Table 7.10-3 shows that student agreement that each of the physician tasks listed were emphasized in the MD Curriculum is very high, and generally increasing year over year.

In 2019, the most recent survey, students who agreed/strongly agreed ranged from 91.5% to 98.9%
The lowest-rated tasks in 2017 have each increased in the subsequent two years:
- Commitment to advocate 85.0% to 95.4% to 96.0%
- Threats posed by conflicts of interest 75.7% to 90.9% to 91.5%
All others have remained in the >90% range for all three years.

B)   Continuous Quality Improvement Recommendations for this Element

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STANDARD 8
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.

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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).

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School must complete sections A and B:

O)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

8.1 a
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.

8.1 b
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 and its subcommittees (Appendices 8.1.b and 8.1.c) 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

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the curriculum. The PEC also submits reports to the MDCC for review of program evaluation initiatives, including course reports, and important outcome measures (see Element 8.4). 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.

8.1 c
The Program Governance organizational chart (Appendix 8.1.a) clearly 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.

8.1 d
Appendix 8.1.e includes the minutes of two meetings of the MDCC for each of the last two academic years (2018-19 and 2017-18). 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).

P)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

8.2 a
The *Guidelines for making curriculum changes* (Supplemental Appendix 8.2.a) clearly states that "The MD Program Curriculum Committee (MDCC) is responsible for oversight of all changes to the program curriculum." Explicit guidelines are given for major changes, which require approval by the MDCC. Minor changes must be approved by the Foundations Committee or Clerkship Committee and reported to the MDCC for information prior to implementation. The Co-chairs of the MDCC have the authority to review minor changes reported by subcommittees to determine if additional discussion and/or approval by the MDCC is warranted.

Any changes to learning objectives or content in any course or curriculum year must be reviewed in reference to the MD Program's Competency Framework. Sponsors of curriculum changes must complete and submit a Curriculum Change Form (Supplemental Appendices 8.3.g and 8.3.h), and must indicate that a review of the Curriculum Map has been conducted to ensure appropriate linkage and coverage of the MD Program Key and Enabling Competencies.

8.2 b
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.

8.2 c
The *Guidelines for Making Curriculum Changes* (Supplemental Appendix 8.2.a) 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 (i.e. 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 Curriculum Change Forms (Supplemental Appendices 8.3.g and 8.3.h) 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.

8.2 d
Appendix 8.2.a provides 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. The 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 Elentra platform.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

Previous accreditation findings (2012):
The MD Program was initially rated as 'Compliance with Monitoring' for standard ED-35. The initial finding was: "There is low student satisfaction and identified deficiencies in the DOCH courses and in the Surgery, Family Medicine, Ophthalmology, ENT clerkships. Efforts are underway to correct these issues but there is no evidence yet of the effectiveness of change." After submission of follow-up reports, this remained 'Compliance with Monitoring' in October 2013 and then changed to 'In Compliance' in October 2015.

8.3 a
The *Guidelines for Making Curriculum Changes* (Supplemental Appendix 8.2.a) ensure that all changes to objectives for courses are.

Course and theme committees develop, review, and propose changes to course-level learning objectives. Course committees' membership includes faculty leaders and teaching faculty from relevant academic departments. For Foundations courses (Years 1 & 2), this includes representatives from the relevant basic science departments. For Clerkship courses (Years 3 & 4), this includes representatives from the relevant clinical departments from across major clinical teaching sites.

8.3 b
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 Curriculum Change Forms (Supplemental Appendices 8.3.g and 8.3.h) 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 Elentra system, which ensures ongoing alignment with the MD Program Competency Framework.

8.3 c
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.

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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.

8.3 d
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.

The following designated individuals/groups receive TES reports for teachers under their supervision:
- Foundations and Clerkship Directors
- Course Directors
- Academy directors
- Clinical teaching site leads
- Departmental Chairs and Vice Chairs of Education

8.3 e
Students are asked to complete course evaluations, which are then analyzed in aggregate by PEC. Course evaluation data is 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.

8.3 f
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.

8.3 g
The sample review forms provided (Appendix 8.3.a) 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.

8.3 h
Submission of a standardized curriculum change form (Supplemental Appendices 8.3.g and 8.3.h) 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. This process ensures that content and priority topics are not over- or under-represented throughout the curriculum as a whole and helps to support alignment and integration across the curricular years.

8.3 i
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

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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*.

8.3 j

In addition to open access to course websites for all required learning experiences, MD Program faculty can also conduct targeted searches of the whole curriculum. 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.

Elentra's Curriculum Search feature takes advantage of a robust curriculum mapping process that tags individual learning activities to several searchable taxonomies. In addition to a simple text string search, users may search the entire MD curriculum using a set of curriculum tag sets, which include: Key and Enabling Competencies; Foundations Weekly Objectives; Themes and Priority Topics; Foundations Curriculum Components; MCC Presentations; and keywords. Search results can be filtered by academic year, course, and learning modality. Search results may also be exported and downloaded as spreadsheet files to allow for additional manipulation and review outside of the Elentra system.

B)   Continuous Quality Improvement Recommendations for this Element

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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:
- i. the vast majority of graduating respondents agree/strongly agree (aggregated) that they have developed the clinical skills required to begin a residency program
- ii. the vast majority of graduating respondents rate the quality of the medical education program as good/very good/excellent (aggregated), and
- iii. 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 ~~Relevant outcome measures are used by the medical school/'curriculum committee' to evaluate the extent to which the medical education program objectives, in the domains of knowledge, skills and behaviours, are being met.~~

8.4 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.

Original requirement 8.4.d has been removed from the MSS Evaluation Form, based on communication with the CACMS Secretariat on July 4, 2019.

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School must complete sections A and B:

A) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

8.4 a
All outcome indicators specified in Table 8.4-1 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.

8.4 b

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.

The Co-chairs of the Curriculum Committee and the MDCC itself are empowered to require action and follow-up on any items presented to the MDCC that demonstrate a shortfall in any of the metrics in Table 8.4-1, or other program evaluation criteria identified by the OAE or PEC.

8.4 c
i.   AFMC GQ data in Table 8.4-3 indicates 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 indicate between 95-100% of respondents rate the quality of the MD Program as Good, Very good, or Excellent.

iii. ISA data in Table 8.4-5 indicates that, in aggregate, approximately 78% of third- and fourth-year students are satisfied/very satisfied with the effectiveness of the pre-clerkship curriculum as 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, and in Year 4 at the Mississauga Academy. 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.

8.4 d
The proportion of students passing the MCCQE-Part 1 has been lower than our own target of > CMG pass rate. Several interventions have been undertaken (fusion week lectures, practice exams, introduction of progress testing).

Student CaRMs match rate and satisfaction with Career Planning is lower than desired. Several initiatives undertaken (e.g., Matchchannel, CAP course, practice interviews, OHPSA scheduled meetings). Satisfaction rates improved with 9% increase in proportion of students being satisfied.

B)   Continuous Quality Improvement Recommendations for this Element

Further analysis needed to determine reasons for and plans to address the variety of responses regarding satisfaction with pre-clerkship as preparation for clinical learning in Clerkship.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

8.5 a

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. Data regarding learning activities is also collected through student representatives on course committees, the Foundations and Clerkship committees, MD Program Curriculum Committee. The MedSoc Class presidents also gather students' input and then share it with program leadership.

Students are also required to 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

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using the MedSIS.

8.5 b
The majority of students complete the end of course evaluations. Response rate variates between 20-98% for Foundations, and 83-99% in Clerkship.

To determine the reliability of course evaluation data, the OAE analyzes the response rate in each set of evaluations. For courses in which the response rate is below 70%, OAE analyzes the gender distribution of the respondents (i.e., male, female, undefined) to determine if the respondents' subset maintains a similar gender distribution compared to the whole cohort. Results have generally shown that for all courses in which the evaluation response rate is below 70% the gender distribution of the respondents is consistent with the gender distribution of the cohort overall.

To ensure sufficient responses for data reliability, the MD Program has implemented the following initiatives for 2019-2020:
• "You said, we heard" bulletin
• Refined MedSIS platform that enables students to complete the evaluations directly by clicking on a link embedded in the email reminders
• Just-in-Time Evaluations for Foundations learning activities
• Evaluation forms reviewed and revised to include only essential, actionable items
• Informational video around the importance of feedback, how their evaluation data is used, and impact of student evaluations on curricular changes, faculty development and faculty remediation as needed

8.5 c
As per DCI 8.5b narrative response, the Introduction to Medicine (ITM) course is a clear example of how evaluation data was used for refinement. End of course evaluations, weekly QA meeting and debriefs with the Course Director, Foundations Director, and Vice Dean revealed student concerns regarding the structure and sequence of this course. The proposed solution was to include a new 'histology' week. The proposed changes were presented and approved at the course committee, Foundations Committee, and the MDCC. Implementation was approved in August 2019 for the 2019-20 academic year.

8.5 d
The 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.

8.5 e
Students are required to 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 individual teaching formats. Students are notified about completing these forms at the end of each learning activity using the MedSIS platform. Students may also complete on-demand teaching evaluations for teaching faculty and residents in the clinical environment in Clerkship courses.

8.5 f
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 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.

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

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and other department uses. The top decile of teachers in each department receive an individualized letter of thanks for the 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 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 the scores to division heads and clinical chiefs.

B)   Continuous Quality Improvement Recommendations for this Element

Additional communication is needed to ensure that students are aware of requirements for the submission of course and teacher evaluations. End-of-course evaluations should be highlighted and made easily distinguishable from weekly evaluation forms, and other forms students receive throughout Foundations courses.

Follow-up on all new initiatives and proposed changes to course evaluations should be made available as soon as possible for MD Program Curriculum Committee review to ensure that changes are having the desired effect.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

8.6 a
Table 8.6-1 shows that over the previous 3 academic years, 100% of required patient encounters and procedures (Case Logs) have been completed for each graduating class.

8.6 b
As detailed in Element 6.2 (Supplemental Appendix 6.2.b – *Required clinical experiences in the core clerkship rotations: Responsibilities of students, faculty, and MD Program Curriculum Leaders*), students must complete 80% of all Case Logs in each required Clerkship course with real patients, and 80% of all Case Logs across Clerkship as a whole must be completed with real patients.

Table 8.6-2 and Supplemental Appendix 6.2.a (Case Logs Quick Reference) show that most required Clerkship courses only have less than three required patient encounters/procedures that are not required to be completed with real patients.

For the following courses the number of Case Logs that must be completed with real patients is slightly lower than the others: Emergency Medicine – 10 of 19 Case Logs; Paediatrics – 11 of 22 Case Logs; Psychiatry – 6 of 19. In all of these courses, the minimum 80% real patient threshold must be met.

8.6 c

To ensure patient safety while still providing high quality learning for clinical clerks, courses provide high fidelity simulations, online cases/videos, completion of theoretical cases with physician supervisors, and additional reading materials to students where a Case Log requirement is not mandated to be completed with a real patient. In some clinical courses, such as Emergency Medicine, additional clinic time may be scheduled for students to address any identified shortfalls.

8.6 d

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.

8.6 e

All physicians who supervise a medical student must discuss the Case Logs with the student at the mid-point of the rotation and submit a standardized Interim Feedback Form (Supplemental Appendix 9.7.a). Each Clerkship course director and administrator reviews the progress of all students on completing the Case Logs on an ongoing basis, and at least at the end of each course rotation block. The Clerkship Director monitors overall completion rates to identify trends and any issues that require action.

B)   Continuous Quality Improvement Recommendations for this Element

For cases where students do not complete a Case Log with a real patient, a description of the remediation applied to the situation is currently optional in the MedSIS interface. It is recommended that the Case Logs system require this information or something similar to it, to improve reporting and analysis for effectiveness of the Case Logs process.

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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 DCI Tables 6.0-1 through 6.0-3 and DCI Tables 9.4-3 through 9.4-6 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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

8.7 a
Course content and corresponding assessments are developed centrally for each course in both Foundations and Clerkship, as indicated in Tables 6.0-1 through 6.0-3, and 9.4-3 through 9.4-6.

The delivery of course content in Foundations is the same for both the St. George Academies and the Mississauga Academy. The content and delivery of didactic material in Clerkship courses is the same for students in all four academies, regardless of clinical site. Requirements for clinical learning are set by the course, and are the same for all students, regardless of academy or site.

8.7 b
All course objectives are available on the course website in the Elentra platform, and teaching faculty are given access to Elentra to review objectives and materials for the courses in which they teach. Clinical skills curriculum is the same across all sites in Foundations. In Clerkship, the course director chairs a committee which includes site leads. Site leads are responsible for ensuring that teaching faculty are familiar with learning objectives and Case Logs, and that delivery of content is consistent at all sites.

8.7 c
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.

8.7 d
Course directors submit an annual course report. The Office of Assessment and Evaluation (OAE) provides course directors with student evaluation data, which highlights any differences that exist among academies or sites. Site-specific course evaluation data is also reviewed by Academy Directors and the Associate Dean, Medical Education (Regional) annually.

Assessment forms are the same across all academic sites, and the same data management system(s) are used across all sites, regardless of academy affiliation.

8.7 e
Student performance and student evaluation of rotations are reviewed by course directors in their annual course reports. Course reports are reviewed and audited by the Program Evaluation Committee (PEC). The Foundations and Clerkship directors, as well as Academy Directors, review the audited reports and are made aware of any disparities across sites.

All audited course reports are provided to the MD Curriculum Committee (MDCC). The Chair of the PEC provides updates to the MDCC, and highlights any site-specific issues or disparities across academies. The Co-Chairs of the MDCC and the members of the MDCC are empowered to recommend additional action to correct any issues that are identified.

8.7 f
The examples from the 2018-2019 Academic Year provided in DCI Narrative 8.7.c show that course directors, Academy Directors, and the Clerkship Director have acted in response to student feedback on site-specific issues to resolve specific issues of capacity and the ability to recruit a sufficient number of patients for students to complete Case Logs (see also Element 5.5). In these examples, the issues were resolved in a timely manner and focused on ensuring ongoing satisfactory performance.

B) **Continuous Quality Improvement Recommendations for this Element**

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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 h 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 time 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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

Previous accreditation findings (2012):
The MD Program was initially rated as 'Not in Compliance' for standard ED-38. The initial finding was: "A policy limiting daytime duty hours for clerks was recently implemented. Some students are not following this policy. Furthermore, some students, supervising residents and junior faculty are unaware of this new policy." After submission of follow-up reports, this changed to 'Compliance with Monitoring' in October 2013 and then to 'In Compliance' in October 2015.

8.8 a
The *Standards for time spent in required learning activities in the Foundations Curriculum* (Appendix 8.8.a) specifies that a maximum of 28 hours per week can be dedicated to in-class teaching (lectures, seminars, labs, CBL) and a maximum of 10 hours per week may be allotted to self-directed learning (e.g. completion of online modules). The *Standards* also articulate details such as the maximum number of daily and/or consecutive class hours permitted.

8.8 b
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. Medical students are required to submit an acknowledgement form saying they have reviewed the Academic Calendar.

8.8 c
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 this data at the end of each Foundations Course, and include commentary in their course reports. Course reports, including commentary on time spent in educational activities are reported to the MD Curriculum Committee.

8.8 d
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*. If any breaches are reported, this information is sent to the Foundations Director to be reviewed and addressed.

8.8 e
ISA data in Table 8.8-1 show 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 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.

8.8 f

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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.

8.8 g
The *Standards* are aligned with existing 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. Faculty members and residents are notified of these Standards via communication from course directors, and through their inclusion in teaching materials and course websites.

8.8 h
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.

8.8 i
Data is collected from students' rotation evaluations and reviewed by course directors twice annually at Clerkship Committee meetings. If aggregate and/or site-specific data fail to meet established benchmarks for compliance, course directors work with sites to address process and educational issues as relevant. DCI narrative 8.8f shows that course directors receive informal and formal (e.g. student course representatives) feedback on duty hours. Students are encouraged during orientations to report violations to site directors, course directors, and/or academy directors. The Clerkship Director is involved as needed.

After the 2012 accreditation survey, a Duty Hours Working Group was struck to address the concerns noted at that time. 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.

8.8 j
ISA data in Table 8.8-1 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. This was considered by students to be a strength of the medical education program in the ISA report.

B)   Continuous Quality Improvement Recommendations for this Element

More in-depth analysis is needed to understand why student reported satisfaction among MAM students for time spent in educational activities in Foundations is lower than that of students at the St George Academies.

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STANDARD 9
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.

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9.1 PREPARATION OF RESIDENT AND NON-FACULTY INSTRUCTORS

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

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.

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School must complete sections A and B:

Q)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

9.1 a
DCI Table 9.1-1 shows the 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.

9.1 b
DCI Table 9.1-2 shows that all residents are 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. The table also summarizes program- and department-specific program(s) available to residents to enhance their skills in teaching and assessing medical students. U of T residents are also invited to attend faculty development activities through the Centre for Faculty Development and MD Office of Faculty Development.

9.1 c

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. Residents must achieve a passing score to receive credit for the module. Completion is monitored and tracked by the PGME office to ensure 100% compliance for PGY1 residents in all programs.

R)   Continuous Quality Improvement Recommendations for this Element

Leverage the user management features of the Elentra system to ensure automatic access to MD course websites for all Post-graduate residents and fellows to ensure they have access to all materials pertaining to the courses in which they may teach.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

9.2 a
The *MD Program Academic Calendar* states that any physician who supervises, teaches, and assesses and MD student must have a faculty appointment. 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.

9.2 b
Table 9.2-1 shows that in each required MD course, the number of individuals supervising and assessing without a faculty appointment is very low. 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.

9.2 c
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.

B)   Continuous Quality Improvement Recommendations for this Element

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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

9.3 a
The following rotations involve a multi-level team in many or most cases: Internal Medicine, Obstetrics & Gynaecology, Paediatrics, Psychiatry, and Surgery. Part of each of these rotations is spent with a single attending faculty physician supervisor. The remaining rotations are almost exclusively organized such that a student on any given day is supervised by a single faculty physician: Anesthesia, Emergency Medicine, Family & Community Medicine, Ophthalmology, and Otolaryngology. In both instances medical students are appropriately supervised at all times to ensure patient and student safety.

9.3 b
The *Faculty of Medicine/Affiliated Institutions Guidelines for Ethics & Professionalism in Healthcare Professional Clinical Training and Teaching* (Appendix 9.3.a_1, section B) describes the expectations of clinical faculty members who supervise medical trainees, with specific consideration of both student and patient safety

The College of Physicians and Surgeons of Ontario (CPSO) policies on learner supervision also address the need for

studend and patient safety and are provided to all faculty members in all departments by the Office of the Dean each year.

Medical students are carefully supervised on every clerkship rotation. Specific examples for each required clinical course are provided in the DCI. Students are either assigned directly to a single faculty supervisor or to a multi-level team that includes a staff physician and one or more resident physicians.

Students are never on-call by themselves. Orders are not carried out until they have been verified by either the supervising resident or attending physician. The Case Logs (see Element 6.2) specify the level of responsibility for each patient encounter and/or procedure.

9.3 c
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. 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. Students are strongly encouraged to report serious concerns (i.e. student mistreatment) through the reporting options accessible in the Student Assistance button on the MD Program website and Elentra (see Element 3.6).

9.3 d
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.

Students are asked to provide feedback about the level of responsibility they had on each rotation in the end-of-course evaluations. When serious concerns are identified, appropriate corrective action is taken by either the Site Director or Course Director or Clerkship Director as required.

9.3 e
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.

9.3 f
AFMC GQ data in Table 9.3-1 show the following percentage of respondents agreed/strongly agreed that the level of supervision:
o   ensured their safety: 92.3-100% in 2018-2019
o   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:
o   80.6-100% in 2018-2019, except in Surgery at FitzGerald Academy in 2018 (66.7%) and Surgery at MAM in 2019 (76.5%)
o   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).

B)   Continuous Quality Improvement Recommendations for this Element

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.

<p style="text-align: center;">* * * * * * * * * *</p>

School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

Previous accreditation findings (2012):
The MD Program was initially rated as 'Not in Compliance' for standard ED-27. The initial finding was: "A system for ensuring direct observation of history and physical examinations was not consistent across all core clerkship rotations. The CGQ, independent student analysis, institutional self-study and comments from residents identified some continuing issues, especially in Surgery. Processes to correct these deficiencies were initiated but are not yet fully effective." After submission of follow-up reports, this changed to 'Compliance with Monitoring' in October 2013 and then changed to 'In Compliance' in October 2015.

9.4 a
Tables 9.4-3 through 9.4-6 show detailed assessment plans for each course within each year, according to modality. These modalities are reflective of the outcome measures indicated in table 6.1-1. Each assessment in the MD Program is mapped to learning objectives and the MD Program Competency Framework, which is centrally monitored and reflected in the MD Learner Chart.

9.4 b
Tables 9.4-3 through 9.4-6 shows a variety of assessment modalities across all four years of the curriculum, including written exams, presentations, observed performance assessments (by a faculty/resident preceptor), professionalism assessments, and OSCEs.

9.4 c
The methods outlined in Tables 9.4-3 through 9.4-6 and described in the DCI narrative are present in each Foundations course in Years 1 and 2. All clinical Clerkship courses include formal assessment in history taking, physical examination, communication skills, and clinical decision-making. Supplemental Appendix 9.4.a is a template form for the Observed History and Physical for Foundations (ICE: Clinical Skills), and Supplemental Appendix 9.4.b is the template Clinical Performance Evaluation Form for Clerkship, both of which include ratings for history taking, physical examination, clinical judgement, and communication skills.

9.4 d
The program requires a Year 1 mid-term formative Clinical Skills assessment and OSCEs in Years 1 and 2. The Clerkship integraged 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).

9.4 e
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. More granular detail on the role of course committees in assessment plans, as well as the membership of SASC, is included in Element 9.6.

9.4 f
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.

9.4 g
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). The organization of Clerkship written assessments is undertaken by clerkship course directors (who report to the Clerkship Director) at the distributed sites. There is centralized organization of progress tests for all four years.

9.4 h

DCI Table 9.4-1 AFMC GQ data for 2019 show very high agreement that respondents were observed taking a history, ranging in all disciplines from 84.6% to 100% except in Obstetrics & Gynaecology at FitzGerald (77.8%) and in Surgery at Mississauga (76.5%), Peters-Body (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 in Table 9.4-2 show similarly high levels of agreement in history taking across academies. 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.

9.4 i

AFMC GQ data in Table 9.4-1 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 in Table 9.4-2 also demonstrate generally high agreement with regards to direct observation of a student undertaking a physical examination. Some courses report 100% agreement that respondents have been observed completing a physical exam, with the significant outliers being 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%).

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

9.5 a
All MD Program courses include a written description of the medical student's performance as a component of assessment for some portion of the required course.

All Foundations courses provide narrative, formative assessment to students, which is used as part of the final grade (summative assessment) in the course. Students receive narrative feedback on small group student evaluations and on student contribution forms, which are marked and must be satisfactory.

Narrative feedback is provided on the Clerkship Interim Feedback Form (Supplemental Appendix 9.7.a) at the mid-point in all clinical courses of four weeks' duration or longer. The form requires that strengths, areas of improvement and action plan/recommendations provided to students. All Clerkship courses that involve clinical supervision provide narrative feedback as part of the final Clerkship ward/clinical skills evaluation form.

For Portfolio – both as a component in the Foundations courses and as stand-alone Clerkship courses (PFL310 and PFL410) – students receive formative feedback from their Academy Scholars. All Portfolio sessions are small group learning seminars, and all students receive narrative feedback on written assignments, thematic reflections and progress review reports, which focus on the students' achievement of the CanMEDS intrinsic roles.

All iOSCE examiners are encouraged to provide narrative feedback for all stations of the iOSCE. In the case of a failure of a station the examiner must provide written justification for the rating.

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For all required courses, the professionalism assessment includes opportunity for narrative feedback. Low scores require narrative feedback to justify the rating.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

9.6 a

Course committees are responsible for setting assessment plans for their respective courses. The 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 course. All SASC recommendations 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.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

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

Table 9.7-1 shows 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.

9.7 b
The MD Program follows a programmatic assessment model, which informs the design of each course to ensure ongoing, low-stakes 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. Formative assessment data is available in a Learner Chart that allows students and faculty members to review progress and obtain formative feedback in a timely and centralized manner.

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 (Supplemental Appendix 9.7.a) in order 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.

9.7 c
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 (Supplemental Appendix 9.7.a) 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.

9.7 d
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.

9.7 e
In Ophthalmology and Otolaryngology/Head and Neck Surgery, 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.

Anesthesia provides mid-point feedback to all students. Students also work one-on-one with a staff anesthesiologist and complete an entry and exit simulation day, which includes observed clinical skills with immediate feedback.

9.7 f
The ISA survey data in Table 9.7-4 shows 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 this 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 80% to 100%. The main exceptions to this are in Surgery at all academies (except Wightman-Berris in 2018-2019) and Ob/Gyn at FitzGerald (decreasing from 83.3% to 76.2% to 75.0%).

The administrative report from MedSIS 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.

Table 9.7-2 shows 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.

9.7 g
This requirement is not applicable to MD Program.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

Previous accreditation findings (2012):
The MD Program was initially rated 'Compliance with Monitoring' for standard ED-30. The initial finding was: "The school recently enhanced its system for the timely reporting of clerkship grades. The school and faculty report 100% success in timely grade reporting over the past three clerkship rotations." After submission of a follow-up report, this changed to 'In Compliance' in October 2013.

9.8 a
Table 9.8-1 shows 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, all Clerkship courses provided final grades to students at both campuses well within the six week maximum. Since the program was ruled "In Compliance" with ED-30 in in October 2013, there has been continued improvement for Clerkship courses. There are still some outliers for the maximum time to receive grades, but numbers of students who fall into this category are quite low.

9.8 b
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.

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The Clerkship Committee reviews grade availability data for all courses on a twice annual basis. If course-specific issues arise, data is 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* (Appendix 9.8.a).

9.8 c
The MD Program abides by the *Standards for timely completion of student assessment and release of marks* (Appendix 9.8 a), approved and reviewed on an ongoing basis by the MD Curriculum Committee.

B) **Continuous Quality Improvement Recommendations for this Element**

Ensure that all students at least receive an IPR and communication regarding any issues that may prevent delivery of final grades.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

9.9 a
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 (Supplemental Appendices 9.6.a, 9.6.b and 9.6.e). In accordance with those *Standards* and *Guidelines*, each MD Program course has clearly articulated assessment requirements that apply across all locations.

9.9 b
Satisfactory completion of each assessment is defined by the Foundations and Clerkship course committees, and is the same for all students, regardless of academy or site. Marking rubrics are provided to standardize assessment where judgement is required.

9.9 c
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.

9.9 d
The Foundations and Clerkship *Guidelines for the Assessment of MD Students in Academic Difficulty* (Supplemental Appendices 9.6.c and 9.6.d) and *Guidelines for the Assessment of Student Professionalism* (Supplemental Appendix 9.6.e) describe processes for notifying 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.

9.9 e
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.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

9.10 a

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

- Appendix 9.10.a_1 – COFM Immunization Policy
- Appendix 9.10.a_2 – COFM Blood Borne Viruses Policy
- Appendix 9.10.a_3 – Guidelines Regarding Infectious Diseases and Occupational Health for Applicants to and Learners of the Faculty of Medicine Academic Programs
- Appendix 9.10.a_4 – Regulations for Student Attendance and Guidelines for Absences from Mandatory Activities
- Appendix 9.10.a_5 – Regulations and Guidelines for Leaves of Absence from the MD Program
- Appendix 9.10.a_6 – Faculty of Medicine Expert Panel on Infection Control Terms of Reference
- Appendix 9.10.a_7 – MD Program Protocol for Incidents of Medical Student Workplace Injury and Exposure to Infectious Disease in Clinical Settings
- Appendix 9.10.a_8 – University of Toronto University-Mandated Leave of Absence Policy

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

9.10 b

Medical students are informed of the polices 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)

9.10 c

Table 9.10-1 shows that the vast majority of respondents *across all years and academies* know that the U of T 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 97.8% in Year 3 at Mississauga Academy.

B)   Continuous Quality Improvement Recommendations for this Element

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STANDARD 10
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.

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10.1 PREMEDICAL EDUCATION/REQUIRED COURSEWORK

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

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.

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School must complete sections A and B:

C)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

10.1 a
Course prerequisites for admission are two full-course equivalents in the life sciences, and one full-course equivalent in the humanities, social sciences, or languages.

Education (e.g., degree) requirements are the completion of a minimum of 3 years of undergraduate studies (equivalent of 15 credits) towards a university bachelor's degree; and, if applying from outside of Canada, completion of a non-medical degree equivalent to a CDN 4-year university bachelor's degree

Definitions of course prerequisite categories are quite broad to allow for diverse educational experiences.

10.1 b
The MD Admissions Committee has established the minimum education requirements above, and considers those courses to be necessary for successful completion of the MD degree. Overly restrictive course prerequisites have been omitted from the MD Program's entrance requirements.

10.1 c
All admissions requirements are reviewed each year, including education requirements. The admissions requirements were last reviewed and revised in April 2019.

D) Continuous Quality Improvement Recommendations for this Element

It is recommended that in promotional and recruitment materials that the MD Program emphasize that an applicant's choice of undergraduate program (i.e. the choice of a non-science-based program) will not affect chances of being admitted. Information to this effect should be included in admissions materials, particularly on the web.

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10.2 FINAL AUTHORITY OF ADMISSION COMMITTEE

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

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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

10.2 a
The MD Admissions Committee Terms of Reference (Appendix 10.2.a) 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 list of committee members in Table 10.2-1 and the description of the composition of the committee demonstrate 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

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admissions process.

10.2 c

The MD Admissions Committee Terms of Reference (Appendix 10.2.) 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.

10.2 d

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 materials are available to all members of the Admissions Committee.

10.2 e

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

No offers of admission have been challenged, overruled, or rejected in the previous three admissions cycles.

10.2 f

There are clear conflict of interest policies and procedures for the admissions process. Every Admissions Committee member signs a confidentiality and non-disclosure agreement at the beginning of each admissions cycle. (Supplemental Appendix 10.2.a) Any member(s) with confirmed conflicts will be recused from any relevant deliberations and, in rare cases, from the committee work as a whole for the affected admissions cycle(s).

10.2 g

Admissions decisions are made by committee members, who are conflict-of-interest free. In the past, there have been documented instances where committee members have stepped down from their appointment when it appeared that conflicts of interest that would have prevented the member's objectivity in the decision-making process.

An online conflict-of-interest form is used to support the timely submission of potential or actual conflicts of interest during the admissions process (Supplemental Appendix 10.2.b).

B)   Continuous Quality Improvement Recommendations for this Element

It is recommended that all members of the MD Program Admissions Committee must undergo *mandatory* unconscious bias training at least once during their tenure on the Committee.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

10.3 a
All admissions policies, procedures, and criteria for medical student selection are developed and approved by the MD Admissions Committee. All approved selection criteria, policy, and procedural changes must be reviewed and approved by the MD Program's Executive Committee. Major changes in the selection criteria, policies, and procedures must be further reviewed and approved by the Faculty of Medicine's Education Committee.

10.3 b
Selection policies, procedures and criteria are communicated through the MD Admissions website, blog, and social media accounts; through videos and townhalls; and through information fairs and publication on the Ontario

Medical School Application Service (OMSAS) application guide. Major changes are announced at least one cycle in advance, using various modes of communication tailored to various stakeholders, to provide sufficient time for prospective applicants to inquire about and prepare for any new policies, procedures and criteria.

10.3 c

Evaluations and decisions are made using a standard scoring rubric and scale developed for the MD admissions file review and interview processes.
  i. Interview selection decisions are made based on the applicants' file review score (including academic and non-academic scores).
  ii. Approximately 640 applicants are interviewed/assessed using the Modified Personal Interviews (MPI) format.
  iii. Admissions decisions are made based on the applicants' final rank (total score = file review score 50% + interview score 50%)
  iv. On the second Tuesday of May, admissions decisions (offer, refusal, waitlist notification) are sent to applicants via email and posted on the OMSAS portal.

10.3 d

The authority and composition of the Student Progress Committee and the Board of Examiners and their rules of operation are specified by the Terms of Reference of those two bodies (Appendix 10.3.b_1 and Appendix 10.3.b_2).

10.3 e

Each advancement committee is comprised of appropriate voting and non-voting members to maintain objectivity and arrive to informed decisions.
  o 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.
  o 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.

10.3 f

The policies for the assessment, advancement, and graduation of medical students and policies for disciplinary action are made know to students and teachers via the Academic Calendar, which is published annually. There is a section in the Calendar devoted to student assessment, including the program's standards for grading and promotion and guidelines for students in academic difficulty. All of those documents are also publicly available on the MD Program's policies webpage. Any student who has been identified as being in 'academic difficulty' or 'professionalism difficulty' based on the MD Program's advancement standards and guidelines are informed orally and/or in writing of the associated processes by the relevant education leaders.

10.3 g

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).

B)   Continuous Quality Improvement Recommendations for this Element

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.

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School must complete sections A and B:

A)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

10.4 a
The MD Program has identified characteristics necessary for applicants to become competent physicians that are considered during the admission process. These characteristics have been distilled down to four themes of personal attributes: Intelligence, Ethics, Resilience and Leadership.

10.4 b
The list of characteristics were last reviewed by the MD Admissions Requirements Working Group from January 2017 to November 2018 (and subsequently approved by the MD Admissions Committee). The membership of this working group was comprised of a diverse group of faculty members, students, education scientists, and admissions officers.

10.4 c
All interviewers are given access to the online training modules and can attend on-site training workshops. On the day of the interview, every interviewer must also attend a training presentation by the Director of Admissions.

B)   **Continuous Quality Improvement Recommendations for this Element**

Provide written document/materials on unconscious bias on-site for interviewers.

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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.

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School must complete sections A and B:

A)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

10.5 a
All Ontario medical schools must adhere to the Council of Ontario Faculties of Medicine (COFM) Essential Skills and Abilities Required for Entry to a Medical Degree Program Policy (Appendix 10.5.a).

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

10.5 c
Applicants first encounter the COFM Essential Skills on the OMSAS website when they begin their application to any Ontario medical school. Medical students entering first year at the University of Toronto must review the COFM Essential Skills and complete a statement of acknowledgement before enrolment in the MD Program. The COFM Essential Skills are also made know to all students and teacher via the Academic Calendar, which is published annually, and are publicly available on the MD Program's policies webpage.

B)   **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

10.6 a
 i.   The material contained in the *Academic Calendar* is reviewed by responsible faculty and staff, and revised as needed on an annual basis, prior to the start of the academic year in August. 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 webpages.

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ii.   The "Degree Requirements" section of the *Academic Calendar* contains the requirements, and provides additional reference to ongoing registration requirements (e.g., immunization) in the "Registration Requirements" section of the *Calendar*. There is a single combined degree program: MD/PhD. The requirements for the MD portion are identified as the same for all MD students, and a reference (and webpage link) to the School of Graduate Studies requirements for the PhD degree is included in the *MD Academic Calendar*.

iii.   There is a single curricular option for all University of Toronto MD students. The session dates, including start/end dates and major holidays, breaks, and University closures are published in the "Key Dates and Holidays" section of the *Academic Calendar*.

iv.   Each required course for all four curricular years is listed in the *MD Academic Calendar*, along with its description. Course descriptions are clustered according to the curricular year in which they take place.

10.6.b

All admissions and recruitment information is publicly available at all times online at the http://applymd.utoronto.ca webpage. MD admissions information is also available via the central University admissions office, under the banner of "Professional and Graduate Programs." The MD Program also makes use of social media to disseminate important admissions and recruitment information on a just-in-time basis.

Print materials are available for pick-up at the Enrolment Services office in the Medical Sciences Building, as well as central admissions and visitors offices at the St. George, UTM and UTSC campuses. Print materials are also available to potential and actual applicants at recruitment events and in-person meetings held on and off-campus.

B)   Continuous Quality Improvement Recommendations for this Element

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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 Table 10.7-1 of 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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

10.7 a
The *MD Program Academic Calendar* and the MD Admissions website clearly state that the MD Program does not accept transfer students or admit students with advanced standing.

10.7 b
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.

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

10.7 d
Table 10.7-1 shows that no students have been admitted to any year of the MD Program in the previous two academic years. Assessment of credentials is therefore not applicable.

10.7 e
Table 10.7-2 shows that no transfer students from any program type have been admitted to the final year of the MD Program since the last site visit in 2012.

B)   Continuous Quality Improvement Recommendations for this Element

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10.8 Currently, there is no element 10.8

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 joint 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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

10.9 a
After submitting an application through the AFMC Electives Portal, an administrator at the applicant's home school must submit a Home School Verification form, which includes a description and verification of the applicant's credentials and completed coursework. The U of T Visiting Electives Administrator – and Electives Director where necessary – reviews the credentials of the visiting student to ensure no discrepancies or concerns exist. The standardized AFMC Immunization form is required and is reviewed for completeness by the Visiting Electives Administrator.

10.9 b

As above, the Visiting Electives Administrator – and Electives Director where necessary – review the 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 U of T 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.

10.9 c

Evaluation of all applicants for visiting electives is conducted by centralized administrative personnel, i.e. a Visiting Electives Administrator. 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.

10.9 d

The central visiting electives office consults with clinical sites prior to approving a visiting elective placement. Clinical sites must verify capacity by taking into account needs of current core (i.e. U of T) learners, historic numbers, and anticipated changes in resources. Visiting elective requests at sites where capacity is of concern are declined.

10.9 e

Visiting students are assessed using forms provided by their home schools, and thus much of the responsibility for ensuring completion of the assessment forms falls to the visiting student. Upon request from the home school, 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.

10.9 f

All visiting electives applicants must use the AFMC Electives Portal. The Electives Portal captures personal information for the applicant (including education, immunization, police record check), as well as details of the requested elective. All tracking and confirmation of visiting electives placement takes place in the Electives Portal. The Visiting Electives Administrator uses the data collected on potential and confirmed visiting electives students to manage applications and ensure that all requirements have been met before a placement may proceed.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

10.11 a
Upon application to the MD Program, students may apply to either the St. George campus or the UTM campus, or both. The admissions committee makes an offer of admission to a particular campus, based on student preference in the application and capacity at each campus.

The MD Program does not have any parallel curricula.

10.11 b
Once an offer of admission to a campus has been accepted, students at the St. George campus rank their preference for one of the three St. George academies. A random selection of all first choice academies is carried out, based on capacity at each academy, followed by a selection based on second and then third choices until all students have been assigned. Students who accept an offer of admission to the UTM campus are assigned to the Mississauga Academy of Medicine; this assignment is based on preference expressed in the application for admission.

10.11 c
The MD Program's guidelines for consideration of academy transfers are published in the *MD Program Academic Calendar*. The guidelines allow for an educational transfer, an academic transfer, and a personal transfer, each of which requires a specific rationale. In each case, MD Program faculty leadership (the Associate Dean, Health Professions Student Affairs and Academy Directors) review the receiving academy's capacity and determine whether or not a transfer will have a negative impact on the requesting student's educational experience, or that of the student's peers.

B)   Continuous Quality Improvement Recommendations for this Element

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STANDARD 11
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.

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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 provided in Table 11.1-4 of the DCI show that only a small percentage of first year medical students and of all medical students at each campus withdrew or were dismissed from the medical school in the last three academic years.

11.1 g   The data provided in Table 11.1-5 of 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.

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School must complete sections A and B:

E) Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

11.1 a

The MD Program incorporates both formal and informal components into its academic advising system. Different resources are available and can be personalized for students who have a specific area of weakness (e.g., difficulty mastering a particular subject) or more systemic learning issues.

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.

For more systemic or global issues, students are encouraged to consult with the Associate Dean, Health Professions Student Affairs (HPSA).

11.1 b

The Foundations (Years 1 and 2) curriculum employs formal multipoint assessments (both marked assessments and unmarked learning activities) and informal assessment-based observations by tutors as well as conversations between students and tutors, administrative staff, and others. The Clerkship (Years 3 and 4) curriculum employs marked assessments, final clinical evaluations, and/or non-marked learning activities to determine whether a student is performing below expectations. The multiple evaluators and evaluations and the use of the Learner Chart allow for the early detection and support of a student in academic difficulty. These mechanisms, summarized in the DCI 11.1a narrative (with particular attention paid to how and when students are identified as being in academic difficulty), are delineated in detail in the Foundations- and Clerkship-specific *Guidelines for the assessment of MD students in academic difficulty*.

11.1 c

Policies and procedures governing the determination of "academic difficulty" are available at all times on the MD Program website, and are referenced with links to policies in the *MD Program Academic Calendar*.

Students are informed of the various advising programs individually, on a case-by-case basis whenever they are identified as being in academic difficulty, and as cohorts. Details on 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 of classes are also introduced to/reminded about academic coaching at the various orientation and transition junctures (I.e. "O week", Transition to Clerkship).

Students can self-refer, and/or education leaders can connect students with the Office of Health Professions Student Affairs (OHPSA) via email or via a "Recommendation for OHPSA Services" form.

11.1 d

The Associate Dean, HPSA, and the academic coach are available to meet with students individually on both the St. George and the Mississauga campuses. The academic coach also coordinates a series of near-peer learning strategy sessions (PREP: Peer-facilitated Review Enrichment Program) as well as the AACE-IT (Achieve Academic and Clinical Excellence) and SCORE (Structured Clinical Observation, Reflection, and Evaluation) programs, both which offer targeted non-evaluative content or clinical skills coaching. PREP and AACE-IT provide services on both campuses. Arrangements for remote appointments can be made with the Associate Dean, HSPA and the academic coach as well as with AACE-IT and SCORE coaches for those students for whom in-person appointments are not a feasible alternative.

Table 11.1-3 indicates that academic advising is available at each campus and, for students off-site by telephone and or video counselling.

11.1 e

The Associate Dean, HPSA, along with staff members in OHPSA, provide confidential academic advising, direction, and support for students in academic difficulty. The Associate Dean position has been carefully

established to have no evaluative (academic or clinical) role for any student. No OHPSA staff counsellors or academic advisors have any role in the assessment or advancement of medical students.

11.1 f
Table 11.1-4 shows that in 2018-2019, only 0.16% of students in all years at the St. George campus withdrew or were dismissed from the MD Program. In 2016-17, no students withdrew or were dismissed, and in 2017-18, less than 1% in all years at each campus withdrew or were dismissed.

11.1 g
Table 11.1-5 shows that 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 who fell into the categories included in Table 11.1-5, 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, but the numbers do seem to increase in Year 3. This could be due to the transition from a very supervised, structured educational program in Foundations to the more workplace-based experience in Clerkship with the need to balance clinical responsibilities with ongoing attention to academic success.

11.1 h
In 2019, the overall graduation rate for the St. George Campus was 97.76% and for Mississauga was 98.1%. The percentage of 2019 graduates who completed the program at the expected time was 94.14% for St. George, and 97.75% for Mississauga.

11.1 i
The AFMC GQ data contained in Table 11.1-1 show low or decreasing satisfaction with academic advising over the last three years in the following cases:
o   FitzGerald student satisfaction is low at 60.6%, 66.7%, and 64.9%
o   MAM student satisfaction goes up from 75.9% in 2017 to 83.3% in 2018, but decreases in 2019 to 68.6%
Student satisfaction increases over three years at both Peters-Boyd (69.7% to 80.6%) and Wightman-Berris (77.1% to 94.1%).

The ISA data contained in table 11.1-2 shows 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 the satisfaction reported by Year 4 students in the FitzGerald academy (69.1%).

F)   Continuous Quality Improvement Recommendations for this Element

Ensure ample assistance is available to students who are transitioning into Clerkship. Ensure that time is available in the Year 3 student schedule to access services when needed.

Review any academy-specific programming (particularly at Wightman-Berris) to determine if there are best practices that can be applied to all academies. Investigate differences in perceptions among students with focus groups and other activities.

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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.

<p align="center">* * * * * * * * * *</p>

School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

Previous accreditation findings (2012):
The MD Program was initially rated as 'Compliance with Monitoring' for standard MS-19. The initial finding was:
"An inclusive system to assist medical students in choosing elective courses, evaluating career options, and

applying to residency programs was enhanced to encourage the participation of all medical students. Preliminary feedback and high participation rates from 4th year clerks are positive, but results are not yet available for more junior students." After submission of follow-up reports, this remained 'Compliance with Monitoring' in October 2013 and then changed to 'In Compliance' in October 2015.

11.2 a
Career counsellors, the Director, Career Advising System and the Associate Dean, Health Professions Student Affairs (HPSA) all make themselves available for in-person, telephone or Skype appointments to students in each Academy. Academy Directors provide career advising directly, organize more large-scale career advising events for their academies, and arrange for faculty and resident mentorship of medical Students.

A career counsellor is available at the Mississauga campus for one day each week. As MAM students are approximately 20% of the total student body, the time available at the UTM campus is proportional to that available to St. George students. Some MAM students choose to access OHPSA services – including career advising – at the St. George campus offices.

11.2 b
Table 11.2-5 provides a breakdown of both required and optional career advising activities that take place over the four years of medical school. The Mississauga Academy implemented a mandatory career counselor appointment in 2017, but the program was not received well and was discontinued.

Didactic sessions pertaining to electives, career exploration, and CaRMS are mandatory components of the curriculum. Career-focused components, such as Enriching Educational Experiences (ICE:EEE), Portfolio, and the Transition to Residency course are integrated into each curriculum year.

One-on-one career counselling appointments are optional and are in all cases confidential.

11.2 c
Tables 11.2-5 and 11.2-6 show that 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.

11.2 d
The Director of Electives is responsible for all aspects of the Year 4 Electives course (ELV410Y), and provides orientation and large group information sessions 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 those students who are at distributed sites that make on-campus meetings difficult.

11.2 e
Table 11.2-7 indicates that the percentage of unmatched students after the second iteration of the CaRMS match was 5.06% in 2016-17, 7.25% in 2017-18, and 2.75% in 2018-19. This is consistent with nation-wide trends in unmatched rates, but still quite low. In 2017-18, 16 students who remained unmatched after the second iteration matched in May 2018 as part of a third iteration.

11.2 f
The AFMC GQ data in Table 11.2-1 show low, but stable levels of overall satisfaction with career planning services. In the most recent year, 2019, the rate of satisfaction ranges from a low of 56.4% at the FitzGerald Academy to a high of 85.7% at the Wightman-Berris Academy, where it increased significantly from previous years (67.3% and

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66.1%).

Table 11.2-2 shows some difference in student satisfaction with the adequacy of career advising. Aggregated across academies, satisfaction is highest in Year 1 at 86.2%, with 73.4% in year 2, 75.8% in Year 3, and 71.6% in year 4. Lower satisfaction across Years 2 to 4 is particularly pronounced at FitzGerald (66.1%, 72.1% and 64.7%) and Mississauga (75.0%, 69.6%, 60.4%) academies. Peters-Boyd academy students report higher satisfaction across all four years (87.1%, 77.2%, 87.2%, and 84.0%).

The low rates of satisfaction with career advising are reflective of nationwide trends, and may be linked to uncertainty among students around matching, and to ongoing healthcare human resource/staffing issues nationally.

11.2 g

AFMC GQ data show student satisfaction with guidance when choosing electives has fluctuated over the last three years, but has remained generally 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 shows slightly higher, but still low satisfaction rates. The aggregated satisfaction for Year 3 is 57.8% and for Year 4 is 49.5%.

Student members of the MSS report that difficulties experienced in the process of booking electives as well as the expense involved in participating in electives may be influencing overall satisfaction with electives advising on the survey.

B)   Continuous Quality Improvement Recommendations for this Element

Investigate the feasibility and sustainability of the ISA recommendation to provide mandatory individual career counselling appointments.

Develop and reinforce expectations of Portfolio scholars to provide career exploration and advice. Implement targeted faculty development for Academy Scholars to improve their ability to provide career advice.

Expand the presence of the Electives Director at the UTM campus, or identify a MAM-specific faculty member to advise on electives choice.

Academy Directors should review academy-specific activities to determine best practices that could be shared across all academies.

Improve communication with students as to resources available to provide career and electives advising outside of OHPSA and formal advising opportunities. Determine the best way to involve more residents in the process of career and electives advising.

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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 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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

11.3 a

All extramural electives placements occur at institutions that are affiliated with and approved by an accredited Canadian medical school. 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.

11.3 b

Most elective experiences that fall into this category occur as selectives in the MD Program's Year 4 Transition to Residency (TTR) course, and take place in locations outside of North America.

i. All international electives are reviewed centrally by the MD Program's Electives Director. Applications are reviewed to ensure that the geographic location meets government of Canada travel advisory recommendations. Areas rated as "avoid non-essential travel" or "avoid travel" are not approved.

ii. Students are provided specific information by the placement site on how to seek care in an emergency situation and are advised how to ensure adequate healthcare coverage during pre-departure training for international placements. The signed student placement agreement (Supplemental Appendix 11.3.a) details the responsibilities of the placement site in ensuring the health and safety of students while at the placement.

iii. Regions where there is ongoing political instability or epidemics are not approved for extramural electives. Students who are given approval for extramural electives in areas that are somewhat volatile are warned that the situation may evolve and deteriorate after the approval process, possibly before they depart or even during their placement. Should this occur they will either not be allowed to depart or will have their return home facilitated.

iv. All students participating in electives outside of Canada, no matter the destination or its level of perceived risk, must participate in pre-departure training at the medical school, participation in safety abroad curricula at the University level and debriefing upon return. All students also 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.

v. The level and quality of supervision is evaluated as part of the approval process of a proposed international elective/selective. The institution's credentials, U of T faculty recommendations based on personal experience, previous students' experience and evaluation of the institution are also considered. Expectations of supervision and supervisors for international placements are also included in the student placement agreement.

vi. Ethical challenges are addressed during pre-departure training where students are provided common ethical scenarios and then guidance to work through them. The student placement agreement (Supplemental Appendix 11.3.a) requires that the international placement site abide by the University of Toronto policies and procedures that govern student placements including all relevant policies relating to appropriate professional behaviour (section 3.2), comply with applicable human rights and equity legislation (section 3.5), and comply with applicable legislation with respect to privacy laws (section 5.1).

11.3 c

All students who travel outside of Canada for an elective or selective, no matter the destination or its level of perceived risk, are provided with a pre-departure check list, must complete the University's Safety Abroad Office online pre-departure training modules, and attend a faculty-led pre-departure training session.

11.3 d

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.

11.3 e

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.

This does not occur commonly as extramural electives are usually very highly rated. Student data and reflections on extramural electives within Canada are also shared within the National Electives Network. This helps to drive national and AFMC portal quality improvement efforts.

B) **Continuous Quality Improvement Recommendations for this Element**

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

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

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

11.5 a
Implementation of the MD Program's *Access to student academic records* policy (Appendix 11.5.a_1) is in accordance with the University of Toronto *Undergraduate Student Records Retention Guideline* (Appendix 11.5.a_2) and University of Toronto *Guidelines Concerning Access to Official Student Academic Records* (Appendix 11.5.a_3). The MD policy and U of T guidelines are in compliance with Freedom of Information and Protection of Privacy Act (FIPPA) regulations.

11.5 b
The UME Enrolment Services Office is responsible for maintenance of student academic records. All current MD students' academic records are stored in ROSI, MedSIS, Learner Chart, and digital student files maintained by the UME Enrolment Services office.

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 Ontario Personal Health Information Protection Act (PHIPA).

11.5 c
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.

B)   **Continuous Quality Improvement Recommendations for this Element**

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.

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School must complete sections A and B:

A)   **Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)**

11.6 a
The MD Program's *Access to student academic records* (Appendix 11.6.a_1) policy permits any current student to review their academic records, specifically those components they cannot access through electronic student information systems (ROSI, MedSIS, Learner Chart), excluding their admissions files, in particular documents submitted by a third party, such as Letters of Reference. As noted in the *Access* policy, students may review their academic records by arranging an appointment with the Faculty Registrar.

11.6 b
Assessment information and clinical evaluations are 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.

11.6 c
  i.   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. They may challenge the mark on an individual assessment or for a course in accordance with the MD Program's *Assessment Rules and Regulations* (Appendix 11.6.a_3).
  ii.   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

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from MedSIS, OASES and ExamSoft. Students may challenge the mark on an individual assessment in accordance with the MD Program's *Assessment Rules and Regulations* (Appendix 11.6.a_3).

iii.   Students can review the final grades for required learning experiences on ACORN. Students may challenge the mark on an individual assessment in accordance with the MD Program's *Assessment Rules and Regulations* (Appendix 11.6.a_3).

11.6 d

The MD Program's *Access to Student Academic Records* (Appendix 11.6.a_1) and *Assessment Rules and Regulations* (Appendix 11.6.a_3) 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.

B)   Continuous Quality Improvement Recommendations for this Element

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STANDARD 12
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.

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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 of respondents at each campus are satisfied/very satisfied (aggregated) with financial aid administrative services, and overall educational debt management counselling.

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School must complete sections A and B:

G)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

Previous accreditation findings (2012):
The MD Program was initially rated as 'Compliance with Monitoring' for standard MS-23. The initial finding was: "Financial aid and debt management counseling were enhanced with new programs and more staffing. Data regarding program effectiveness are currently being collected." After submission of follow-up reports, this remained 'Compliance with Monitoring' in October 2013 and then changed to 'In Compliance' in October 2015.

12.1 a
The Financial Services staff in UME Enrolment Services provide at least one non-mandatory opportunity for financial aid counseling in each year of the MD Program curriculum. Mandatory debt management counseling is required whenever the Financial Services office determines that a student has taken on higher than normal educational debt.

The MD Program Curriculum Committee has approved inclusion of a mandatory financial literacy session in the Year 2 core curriculum (week 60), effective starting the 2020-2021 academic year.

12.1 b
In general, medical students are not away from campus for longer than six weeks. If necessary, however, financial aid counseling is available from Student Financial Services staff by teleconference.

Students who are on an approved leave of absence also have ongoing access to counseling from the Student Financial Services office, and receive periodic check-ins from personnel during the leave.

12.1 c
Student Financial Services does not invite or allow any for-profit organizations to provide counseling or information on student loads or financial debt management.

12.1 d
DCI Table 12.1-6 shows that the MD Program has disbursed significant funds in the form of bursaries, grants, and scholarships. The program does not extend financial aid in the form of loans.

12.1 e
Since the MD Program's full accreditation survey and visit in 2012, the medical school and university have engaged in significant fundraising activities, most notably the U of T's Boundless Campaign. Over the course of the campaign, the Faculty of Medicine has received in excess of $16 million in donations to provide approximately $600,000 each year in student financial support.

The Faculty of Medicine Office of Advancement has appointed a dedicated senior development officer specifically for the MD Program to facilitate fundraising activities to support the program, including for student financial support.

12.1 f
The University limited tuition increases to a maximum of 5% for the period 2014-2015 through 2018-2019. For 2019-2020, tuition decreased by 10% to $23,090. Tuition increases and decreases are limited by envelopes mandated by the Government of Ontario.

12.1 g
DCI Table 12.1-7 shows that students at the FitzGerald and Peters-Boyd Academies have average amounts of debt similar to the national average of $100,000. Students at the Mississauga and Wightman-Berris Academies have slightly higher-than-average total debt of $130,000 and $120,000, respectively. Two academies have a smaller percentage proportion of the student body with debt in excess of $200,000, and two are within one percentage point of the national average of 13.6%.

12.1. h
AFMC GQ data in DCI Table 12.1-3 show that in the most recent year, students across all four academies were highly satisfied with financial aid administrative services. The highest rate of satisfaction (1005%) was from students at the Peters-Boyd Academy. The lowest rate (83.3%) was from students at the Mississauga Academy. Each academy shows a three-year trend of increasing satisfaction, except for Mississauga, with a decrease between 2018 and 2019 (but still above 80%).

ISA data in Table 12.1-4 show overall satisfaction with financial aid service in each year of the program above 80%. There are some inconsistencies among years and academies, but no clear differences between St. George-based Academies and Mississauga. In 2019-2020, Financial Services Staff will increase their physical presence on the UTM campus from one day per week to two days per week.

AFMC GQ data in Table 12.1-3 show that in 2019 there was a greater than 90% satisfaction rate with debt management counseling from students at the Peters-Boyd and Wightman-Berris Academies, with lower satisfaction rates from from students from the FitzGerald and Mississauga Academies (75% and 70%, respectively).

ISA data in Table 12.1-4 show that overall satisfaction with debt management counseling is below 80% in each year of the program. There is once again variability among academies and program years. All academies and years report satisfaction at or below 80%.

Debt management counselling is available from the Financial Service Staff during the academic year. Staff are often available to see students on demand, and are available for appointments. As noted above, debt management counseling is mandatory when excessive debt is flagged by Student Financial Services. Inclusion of a mandatory financial literacy session in the Year 2 core curriculum (week 60) has been approved by the Curriculum Committee, effective starting the 2020-2021 academic year.

H)   Continuous Quality Improvement Recommendations for this Element

Determine what type and frequency of debt management counseling students would find useful, and look for ways to integrate new debt management counseling in each year of the curriculum.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

12.2 a
The University of Toronto's tuition refund policy (Appendix 12.2.a) applies to students enrolled in the MD Program. The policy is operationalized through a Tuition Refund Schedule that is set by each academic unit and published annually prior to the start of the academic year.

The 2019-2020 Tuition Refund Schedule (Supplemental Appendix 12.2.a) is aligned with University policy and allows students to withdraw from coursework at various points in the semester with minimal financial penalty.

12.2 b
All incoming and returning students receive e-mails from the Office of Enrolment Services and Faculty Registrar prior to the commencement of studies in late August. These e-mails specify registration requirements and include links to information on making payments, payment due dates, and the tuition refund schedule. Refund schedules are also referenced in the *MD Program Academic Calendar*.

Individual students who miss fees deadlines are sent individualized reminders. The University's Student Accounts office also communicates directly to registered students regarding their tuition payments and tuition refund schedules.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

<p align="center">* * * * * * * * * *</p>

School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

12.3 a
Personal counselling is provided utilizing different modalities, including in-person, Zoom, telephone-based. Counselling services are offered during both business and evening hours. Expedited psychiatric services are accessible via the U of T Health and Wellness Centre. No students are away from the program for more than six months for a longitudinal integrated clerkship, distributed rotation-based clerkship, etc.

A resilience curriculum is embedded into the core MD Program curriculum across all four years. The "Check Your Pulse" (CYP) program reaches out to students in all years in the fall and spring to offer an appointment to check in with a personal counsellor.

12.3 b
Information about availability of personal counselling services is provided to students through presentations during all years of the curriculum as well as through a variety of electronic platforms, including the program's website and learning management system. Student driven programmes, such as Student Health Initiatives and Education (SHINE), are also communicated by multiple mechanisms through the Office of Health Professions Student Affairs (OHPSA) and via student supported venues such as Facebook, email, and newsletters.

12.3 c
Aggregate data for general satisfaction of personal counselling services for all of the MD program students is above 80%. There ISA data shows strong student satisfaction with personal service confidentiality and availability of services.

Low GQ student satisfaction from Mississauga Academy students may be due to the availability of an on-site OHPSA counsellor one day a week. Steps to better understand why there are lower satisfaction rates among Mississauga Academy students are being taken (i.e. focus groups) as well as efforts to raise awareness about the services and supports specifically available to Mississauga Academy students.

12.3 d

GQ data indicates less than appropriate student satisfaction with programs to manage stress and support a healthy life balance. ISA data indicates that current students are better supported in these areas, with lower scores noted from Mississauga Academy students.

The narrative responses indicate that there are both program-wide and individual supports/programs across both campuses. These include the program's longitudinal resiliency curriculum, the "Check Your Pulse" (CYP) check-in program, and other workshops and panels offered throughout all four years of the program.

B)   Continuous Quality Improvement Recommendations for this Element

Increase communication to faculty and tutors about resilience curriculum and other personal counselling services that are available to students.

Prioritize re-branding/re-structuring of the Office of Health Professions Student Affairs (OHPSA) website to more effectively highlight and promote available services.

Ensure that Academy-based staff and administrators are aware of available counseling services and how to promote/inform students about available services.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

12.4 a
In addition to access to health services through provincial health insurance plans, medical students may access diagnostic, preventive, and therapeutic health services through the University of Toronto's Health and Wellness Services, with locations at both the St. George and UTM campuses. The MD Program has also arranged for access to family health teams in the Greater Toronto Area for students who are in need of a new primary care provider.

12.4 b
Medical students are informed about the availability of health and wellness services, including on- and off-campus options, at orientation in Year 1, through the Resources Hub on the OHPSA website, and in the Elentra (the program's learning management system). This information is included in the *MD Program Academic Calendar*, which is disseminated annually prior to the start of the academic year.

12.4 c

The MD Program's *Regulations for student attendance and guidelines for absences from mandatory activities* (Appendix 12.4.a) explicitly permit and support absences from mandatory learning activities for the purposes of seeking necessary health care services.

12.4 d

The *Regulations* are published in the *MD Program Academic Calendar* and are publicly available on the MD Program's Policies webpage. Students are oriented in-person to the policy during orientation in year 1, and receive a refresher in the Year 3 Transition to Clerkship course in preparation for Clerkship. The *Regulations* are also accessible through the 'Student Assistance' button on the MD Program website and in Elentra.

Faculty members and other teachers are oriented to the policy through course-specific communication, and through the course directors of the course in which they teach.

12.4 e

The AFMC GQ data in Table 12.4-1 show that a large majority of respondents were satisfied with health services. The rates of satisfaction range from 88.0% at Mississauga to 100% at Wightman-Berris in 2019. The level of satisfaction has increased for each academy over the last three years.

ISA data in Table 12.4-2 show generally high satisfaction with student health services. In aggregate, students in all academies in each year of the curriculum report above 80% satisfied with student health services. The exceptions to the high satisfaction rates occur in Years 1 and 4 at the Mississauga Academy. Satisfaction with the same services among students in Years 2 and 3 are 81.3 and 84.9%, respectively.

The AFMC GQ data in Table 12.4-1 show that 2019 satisfaction with mental health services ranges from a low of 68.0% at the FitzGerald Academy to a high of 91.9% at Wightman-Berris. Satisfaction with mental health services has fluctuated in many academies over the last three years, except at Wightman-Berris, where the level of satisfaction seems to have increased. All mental health services are provided centrally and are not academy specific.

ISA data in Table 12.4-2 show aggregated satisfaction with the availability of mental health services for students of all academies between 82.2% and 87.9%. The lowest proportion of students satisfied with mental health services are in Mississauga Years 1, 2, and 4, and Wightman-Berris Year 4. The latter is a direct contradiction of GQ data cited above.

The differences among academies are difficult to discern, as student health services and mental health services for students are generally delivered centrally. Low numbers at Mississauga may be reflective of a large proportion of MAM students who live elsewhere, and who do not necessarily access services at UTM or in Mississauga.

B)   Continuous Quality Improvement Recommendations for this Element

Conduct a review of available mental health services that are similar to OHPSA services to determine what the differences are, and inform students of wider availability of services.

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

12.5 a
The MD Program's *Procedure for Conflicts of Clinical and Educational Roles* (Appendix 12.5.a) explicitly states that a provider of health and/or psychiatric/psychological services to a medical student must have no current or future involvement in the academic assessment of, or in decisions about, the advancement of that student.

12. b
Medical students, faculty and residents are informed of the *Procedure* via the *MD Program Academic Calendar*, which is published annually. An email message is sent to all medical students and teaching faculty in mid-August regarding the release of the *Calendar* for the academic year.

12.5 c
Section 2 of the *Procedure* articulates guidelines with respect teachers assigned to supervise a medical student previously cared for or currently being seen as a patient while Section 3 articulates guidelines with respect teachers asked to provide care to a current or former student. Both sets of guidelines are informed by principles of student safety and confidentiality. If there has been a breach of the *Procedure*, wherein a student is assessed by a health care professional who provides or has provided care to the student, students are encouraged to submit an "Event Disclosure Form", available on the student assistance button on the MD Program website and Elentra. Receipt of a "Event Disclosure Form" will prompt a review of the potential breach by the appropriate program leader, with

subsequent reminder to the teacher of the MD Program Procedure.

12.5 d

Within OHPSA, the Titanium system is used. There are technical and process protections in place to ensure that user data is fully safeguarded and that only personal counsellors are allowed to access the personal counselling records unless there is documented student consent to release otherwise. Confidentiality is further secured as the electronic medical record (EMR) at OHPSA is not tied to any other EMR system.

Service providers must comply with provincial legislation with regards to the privacy of health care information, for which they are considered the Health Information Custodians and can only release health information accordingly. All OHPSA staff who have access to the EMR record system sign a confidentiality agreement upon employment. The U of T privacy officer is consulted around any questions/concerns regarding record management and/or EMR related issues. Health records are maintained for 10 years, in compliance with College of Physician and Surgeons of Ontario recommendations.

12.5 e

There is appropriate documentation pertaining to the security, privacy, confidentiality and accessibility of medical student health records:
- Appendix 12.5.b_1 (Ontario Personal Health Information Protection Act (PHIPA))
- Appendix 12.5.b_2 (University of Toronto Health and Wellness Privacy and Confidentiality Statement)
- Appendix 12.5.b_3 (MD Program Access to Student Academic Records policy document)

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

12.6 a
All enrolled University of Toronto students have extended health, dental, vision, and travel insurance coverage for services not covered by provincial health care plans through a plan provided by the University of Toronto Students' Union (St. George) and the UTM Students' Union (UTMSU).

12.6 b
Students are automatically enrolled in the supplemental insurance coverage, and charges are applied to their student accounts. Students are informed of the availability of this coverage by the students' unions, the University of Toronto Student Accounts Office, and during individual financial counseling within the MD Program.

12.6 c
Disability insurance is not provided by the University or its students' unions, and is not mandatory for all MD students. Students are encouraged to apply for disability insurance during their first year. Students can obtain disability insurance from the Ontario Medical Association or through private insurance providers or banking institutions.

12.6 d
Students are encouraged to apply for disability insurance during first-year orientation, and are advised of this availability in individual financial counselling appointments. Insurance providers are on-site during orientation. Students in Year 4 are also advised of the availability of disability insurance as they approach residency.

B)   Continuous Quality Improvement Recommendations for this Element

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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.

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

12.7 a
The immunization requirements for U of T medical students are in compliance with AFMC and Council of Ontario Faculties of Medicine (COFM) requirements. Seasonal influenza vaccinations are also required for clinical learning environments.

12.7 b
All vaccinations are available to enrolled students at the University of Toronto Health and Wellness Centres at both the St. George and Mississauga campuses.

12.7 c
UME Enrolment Services uses a tracker to ensure that immunizations are verified and uploaded to MedSIS, the program's student information system. Occasionally there is a slight delay between verification by staff and the upload of that verification within MedSIS, but UME Enrolment Services staff monitor compliance on an ongoing basis and notify students and academies as needed.

B)   Continuous Quality Improvement Recommendations for this Element

Work to decrease the delay between verification of vaccination by UME Enrolment Services staff and final verification within MedSIS.

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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".

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School must complete sections A and B:

A)   Overall Evaluation of the Element (Taking all of the Requirements and Related Evidence into Consideration)

12.8 a
 i.   Section 6.7 of the Faculty of Medicine *Guidelines Regarding Infectious Diseases and Occupational Health for Applicants to and Learners of the Faculty of Medicine Academic Programs* (Appendix 12.8.b) states that "The Faculty of Medicine and its teaching sites are jointly responsible for ensuring that learners are adequately instructed in infection control", with further details regarding Faculty of Medicine and hospital education responsibilities. These education requirements and responsibilities are also articulated in the

University-Hospital affiliation agreements, Section III.4.6, Specification of the Responsibility for Safety Instruction, Treatment, and Follow-Up in the Event of Student (including Undergraduate Medical Student) Injury or Exposure to an Infectious or Environmental Hazard.

ii. The MD Program *Protocol for incidents of medical student workplace injury and exposure to infectious disease in clinical settings* (Appendix 12.8.a_1) articulates procedures for care and treatment for students who are injured or potentially exposed to infectious disease in a clinical setting. This *Protocol* also includes a definition of financial responsibility

iii. The Faculty of Medicine *Guidelines Regarding Infectious Diseases and Occupational Health for Applicants to and Learners of the Faculty of Medicine Academic Programs* (Appendix 12.8.b) 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 (section 6.3) and guidelines regarding learners' participation in care of patients with infectious diseases (section 6.4).

12.8 b

Year 1 medical students are required to complete a Worker Health and Safety Awareness module by mid-September that focuses on rights and responsibilities as a medical student under Ontario's Occupational Health and Safety Act, and how injuries and illnesses can be prevented by following workplace safety. Year 1 and Year 3 medical students are required to complete e-learning modules between mid-August and mid-September that focus specifically on hand hygiene, sharps safety, and Workplace Hazardous Materials Information System (WHMIS). Students are informed of the relevant medical school policies and procedures related to exposure to infectious and environmental hazards as part of these education modules. Visiting medical students complete the same modules.

Two of the learning objectives of the Year 3 Transition to Clerkship (TTC) "Academy days" are: (i) Apply the principles of infection control, and (ii) Describe the Occupational Health and Safety services available in the hospital. Students are made aware of the relevant medical school policies and procedures as part the Academy-based clinical education sessions during TTC.

12.8 c

Prior to participation in patient-care activities, medical students are informed of the relevant medical school policies and procedures related to exposure to infectious and environmental hazards as part of the education modules and "Academy Days" summarized above. Medical students are also informed of the policies and procedures via the *Academic Calendar*, which is published annually.

12.8 d

Medical 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 as part of the education modules and "Academy Days" summarized above. Medical students are also informed of the procedures via the *Academic Calendar*, which is published annually.

12.8 e

The AFMC Graduation Questionnaire indicated that students are broadly satisfied with the education about exposure to and prevention of infectious diseases from 2017-2010 (84.9-96.6%), as well as across academies (80.4-100%).

12.8 f

The AFMC Graduation Questionnaire indicated that students are aware of what to do if exposed to an infectious or environmental hazard (range 94.3-100% across the 3 years and academies).

B)   Continuous Quality Improvement Recommendations for this Element

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Throughout the MSS review of the Data Collection Instrument, the following issues were identified as concerns that are not restricted to a single standard or element:

Learner mistreatment
The levels of student mistreatment reported by medical students at the University of Toronto is consistent with national level, but that does not make it any less of a concern. Addressing the impact of this phenomenon on the learning environment for all learners is a top priority for the medical school, as reflected in the Faculty of Medicine Academic Strategic Plan 2018-2023. Many of the steps already taken and plans for further processes and systems have been informed by and are intended to address barriers to reporting mistreatment identified in student surveys. Given the systemic nature of learner mistreatment (i.e. it takes place at all clinical teaching sites and is experience by learners from across the medical education continuum), the creation of Faculty leadership positions who will be well positioned to work with our clinical affiliates was endorsed by the MSS Steering Committee as an important step.

Diversity among faculty and education leaders
Greater equity, diversity and inclusion (EDI) continues to be an important aspiration for the MD Program and the Faculty of Medicine. Since the last accreditation survey in 2012, the MD Program has made great strides in achieving greater diversity among its student body. Achieving the same kind of diversity among the faculty and senior leadership is a longer-term endeavor. Ensuring the implementation of EDI principles in the recruitment and hiring of individuals to teach in MD and Post-MD programs requires improved recruitment and retention policies and practices both within the medical school and at our affiliated clinical sites. The medical school has limited control over practices at its clinical affiliates, but is committed to advocating for greater inclusion, including by adopting EDI-informed recruitment and retention policies and practices for its faculty and education leadership positions.

Career and electives advising
Residency matching and the CaRMS process continue to be a stressor for medical students. The MD Program provides a robust centralized system of career counseling and electives advising for its students. The CaRMS stress experienced by medical students may contribute to student satisfaction data regarding career advising in general and electives advising in particular especially if considered in light of the ongoing career advising quality improvement initiatives put in place over the last eight years. That said, the MD Program is employing strategies to increase local career advising support at the academies and associated clinical training sites to supplement centrally delivered counseling and advising activities. In addition, the MD Program is building upon existing curriculum to provide students with an integrated, longitudinal career advising and preparation curriculum that spans all four years, focused on providing relevant and developmentally appropriate education and skills development.

Communication with and among distributed clinical training sites
In the 2012 accreditation survey, the visiting team identified the academy structure as a great

strength of the MD Program. That strength was enhanced with the introduction of the Mississauga Academy of Medicine as the program's fourth academy in 2011. The highly distributed nature of clinical learning in the MD Program ensures that our learners are exposed to the appropriate variety of patients to achieve the learning objectives of a generalist medical program, and that their training takes place in settings and with patient populations that are as diverse as the city itself.

There are challenges involved in delivering a distributed program.   There are multiple committees that enable and support ongoing collaboration between the medical school and its affiliated clinical partners, such as the Toronto Academic Health Science Network (TAHSN) and Hospital-University Education Committee (HUEC). Further, the MD Program communicates widely with all individuals involved in required learning experiences. Local modes of communication are relied upon to ensure that information relevant to the delivery of the MD Program is distributed in a meaningful way to all faculty members, residents and fellows who may be involved in teaching medical students.

Academy-based data on centralized services
Across standards and elements that rely heavily on AFMC GQ and ISA data, it can be challenging to understand student satisfaction data reported by academy, particularly when the survey questions ask about centrally delivered curriculum or services. In several instances, there are unexpected variances among academies that are not easily explained by location. Wherever possible, aggregate data has been used to determine overall satisfaction with centralized services. For those items where a single academy appears as an outlier, Academy Directors have been instructed to review the issue and determine if there are best practices that can be shared among all academies to address differences in student satisfaction with central MD Program services.

APPENDIX TO THE MSS

Medical School Self-study Steering Committee

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Curriculum Design, Development, and Content (Standards 6 & 7)

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Program Evaluation and Student Assessment (Standards 8 & 9)

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Medical Student Selection and Services (Standards 10, 11, and 12)

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