

EXTERNAL REVIEW

THE OFFICE OF ADMISSIONS, EQUITY AND DIVERSITY PROGRAM

FACULTY OF MEDICINE, MCGILL UNIVERSITY

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There were two triggers for this external review. Within the Faculty of Medicine, a cyclical review process exists for many programs which would not normally include the Office of Admissions, Equity and Diversity (AED) of the medical school, but is nevertheless applied to AED, due to its anticipated marked influence on future prospective McGill faculty, and to the passions which are invariably engendered in student selection. Secondly, concerns have been raised through various media that have called attention to the vision, messaging and process of the Admissions Committee and of the Office of Admissions, Equity and Diversity.

With the gracious facilitation of the fine staff of Dean Eidelman, and provision of extensive materials in the self-study by the Office of AED, we had the pleasure of spending a fascinating day meeting with many of the key stakeholders. As the external reviewers, we met with the Dean of the Faculty of Medicine, the Assistant Dean of AED and Admissions Chair and Multiple Mini-Interview (MMI) chair, the Administrative Director of AED, the administrative staff of AED, the chair of the Widening Participation Committee, a staff representative from the Faculty of Medicine, the leaders of the McGill Simulation Centre team, the chair of the Advisory Committee on Admissions Best Practices, 14 student representatives from both the pre-med and medical school programs, at various levels of matriculation, and completed the process with debriefings with the Assistant Dean of AED and the Dean of the Faculty of Medicine. Throughout we were struck with the thoughtfulness and concern of everyone we met. Every single individual cares deeply in a program which is fair, rigorous, and transparent, and are highly invested in not only keeping it so, but continually seeking ongoing improvements.

It is our hope that this report accurately reflects the information provided by these individuals, and that its recommendations for your perusal take into sufficient account the unique challenges at McGill University and its environs. For sake of readability, the report has been constructed thematically, based upon the themes most consistently repeated over the course of the day of the external review. The five identified themes are the sense of stakeholder vulnerability, the intrusion of external stresses, the

visions for the future of AED specifically and loco-regional healthcare generally, the importance of constructive messaging, and the streamlining and clarity of process.

A VULNERABLE STATE

The unique historical, cultural and political nature of McGill, Montreal, and Quebec produces a situation in which every stakeholder group, without exception, feels vulnerable. Francophones may represent the demographic majority of the province, but the province is surrounded by majority Anglophone populations in all directions, and is exposed to North American media rooted primarily in English language and culture. The resultant sense of vulnerability is acute in Montreal and at McGill University, where the usual Quebec Francophone majority is absent. Anglophones in Quebec feel vulnerable to the provincial Francophone majority. Historically, the majority Anglophone presence at McGill University generally and in the medical school specifically has felt vulnerable to the surrounding Francophone-majority regions. To some Anglophones, the medical school at McGill is a bastion of opportunity for a medical career, as other doors to a medical practice career in Quebec are only narrowly ajar – the other three Quebec medical schools require fluent French, and out-of-province and out-of-country medical schools will only infrequently produce graduates able to return to Quebec, due to the historically, culturally, and politically derived inbred nature of McGill faculty. Alumni and potential donors, recalling the McGill medical school demographics of a generation ago, before the intrusion of more recent stresses, will sense a vulnerability of their nostalgic medical school, to an uncertain future. Present faculty members are even more invested in the medical school, sensing the future of loco-regional healthcare, and the august academic supremacy of McGill medicine at risk. Francophone students within the medical school have voiced a sense of vulnerability to media statements questioning whether they were welcome at McGill. Under-represented groups (blacks, rural origin, First Nations Meti and Inuit, and low socio-economic status) have historically felt vulnerable.

The Deanery, as is seminally true at all Canadian universities and colleges, must maintain and raise the academic standing of the institution on a shoestring budget, making them vulnerable to demands from potential donors. Faculty and staff of the Office of AED feel their positions vulnerable due to demands in media and in alumni letters. In a handful of documented cases, due to a unique sense of interpersonal vulnerability, prospective applicants have provided false information regarding the admissions process, with resultant unintended negative consequences.

It is not merely so that every stakeholder group feels vulnerable; it is also so that every stakeholder group has good reason to feel that way. The sense of vulnerability for each group is based not just upon perception, but upon reality. At the best of times, all stakeholder groups can interact comfortably and cordially. Recently, however, there have been a number of intrusions from the world external to McGill that have made the ground rife for dissent.

A VEXATIOUS INTRUSION

Over the last several years, changes external to McGill have introduced stresses new either in degree or in kind. The accreditation standards of the Liaison Committee on Medical Education and Committee on Accreditation of Canadian Medical Schools (LCME/CACMS) have changed, with the relevant sections of MS-8 and IS-16 calling for significant changes in the expectations in recruitment and selection, and of faculty presence of greater diversity, respectively. To be accredited, McGill medical school must meet these standards. While driven to a greater extent by the historical and racial imperatives regarding African-Americans and Hispanic-Americans in the United States, MS-8 in particular leaves no wiggle room for Canadian schools in terms of meeting that standard:

MS-8. A medical education program must develop programs or partnerships aimed at broadening diversity among qualified applicants for medical school admission.

Because graduates of U.S. and Canadian medical schools may practice anywhere in their respective countries, it is expected that an institution that offers a medical education program will recognize its collective responsibility for contributing to the diversity of the profession as a whole. To this end, a medical education program should work within its own institutions and/or collaborate with other institutions to make admission to medical education programs more accessible to potential applicants of diverse backgrounds. Institutions can accomplish that aim through a variety of approaches, including, but not limited to, the development and institutionalization of pipeline programs, collaborations with institutions and organizations that serve students from disadvantaged backgrounds, community service activities that heighten awareness of and interest in the profession, and academic enrichment programs for applicants who may not have taken traditional pre-medical coursework.

Due to this imperative, the Nicholas King Report was commissioned, and the Office of the AED followed the recommendations of that report. As a derivative of this standard, with respect to the Medical College Admissions Test (MCAT), two arguments can reasonably be made. The inclusivity argument posits that requiring high-functioning English language skills to score well on the MCAT and be competitive constrains Francophone applicant chances, thus limiting diversity and having a negative impact on producing physicians competent in the culture of much of the province. The accessibility argument posits that the school should avoid any assessment tool that introduces a significant expense to all applicants (cost for the test for all; cost for travel and accommodation to Montreal for anyone living elsewhere in Quebec; cost for prep courses for those willing to pay) while providing relatively small incremental validity above and beyond Grade Point Average (GPA). Indeed, the incremental validity provided by MCAT is likely lower in Canada than in the U. S., given far greater heterogeneity in post-secondary institutional quality in the United States. Of the two arguments, the accessibility argument is the more cogent, but stakeholders have, given their sense of vulnerability, understandably but unfortunately focused on the less cogent argument of inclusivity, to the detriment of all parties. A second derivative of the new LCME standards is the implementation of a research-based survey of applicants, conducted through the Association of Faculties of Medicine of Canada, whose lead researcher is also the Assistant Dean of the Office of AED, and the Chair of the Admissions Committee.

Secondly, the financial supports for McGill are under threat. Historically, the province has been extremely supportive of McGill, which in turn has gained a well-earned international reputation for academic and clinical excellence. Austerity measures seem increasingly likely through much of the upcoming provincial budgets, making maintenance of existing programs more challenging and dependence on happy alumni and donors ever greater.

Thirdly, the ratio of applicants to medical school seats has trebled in the last ten years, realizing mounting demands on the resources of the Admissions Committee. The level of competition for spots is thus much higher.

Fourthly, social changes have raised public expectations of greater transparency in how admissions decisions are made. Married to the advent of a more populated toolbox of reliable and valid assessment measures, and the resultant adoption of the MMI, definitive scores leave less discretion in making admissions decisions. The external reviewers are at pains to point out that they fully support the concept of the adoption of assessment measures that are feasible, acceptable, reliable and provide incremental predictive validity, thus reducing the size of the perceived “black box” of admissions decisions. We do not denigrate this development, but merely note its emergence.

Fifthly, in both lay press and internet media, two changes – the establishment of the Office of Admissions, Equity and Diversity, and the removal of the MCAT as a requirement – have been presented by external viewers as intending to further the selection of Francophone applicants at the expense of Anglophone applicants. These articles and weblogs have precipitated reactions, sometimes measured, sometimes not.

Finally, the Government of Quebec, under the leadership of Parti Quebecois, has recently proposed a charter of values, suggesting new legislation that would prohibit the wearing of conspicuous religious symbols by workers in public institutions.

All these external factors have exacerbated the pre-existing sense of vulnerability in stakeholder groups. The mandated response to the altered accreditation standards has been interpreted, quite correctly, as a move to favour groups not traditionally represented well at McGill medical school, which can only occur at the expense of groups traditionally represented well at McGill medical school. Whether the factors influencing withdrawal of the MCAT were the cost to applicants (accessibility) or the sense of unfairness to applicants less fluent in English (inclusivity), or both, the result is the same. Anglophones no longer hold that relative MCAT advantage over non-Anglophones. Members of groups traditionally well represented at McGill naturally wonder why demographic surveys would be done unless there is intent to alter those numbers. Provincial austerity measures make it increasingly difficult for the Deanery, and hence the Admissions Committee, to ignore any alumni and potential donor demands. The increased applicant number, and the resultant higher level of competition for admission, has also had an impact. A McGill medical school graduate of a generation ago, based upon their experience, will not readily understand why their child, equal or better than them in intelligence, diligence, and professionalism, would not similarly be admitted to the school, or even fail to get an interview. The appropriate move towards transparency erases the ability to make backroom decisions to admit applicants with lower assessment scores, a wholly positive development which limits the discretion (nefarious or otherwise) of the selection team. The writers of certain newspaper articles and weblogs

would not have felt as certain that they were writing for a receptive audience, if that sense of vulnerability was not generally felt within those stakeholder groups, a sense of vulnerability which now feeds upon itself through reactions precipitated by those media articles. In terms of ensuring a greater sense of vulnerability in stakeholder groups, and therefore a greater tendency to react strongly to any action by the Office of AED, the coup de grace has been provided by the proposed charter of values.

One concern expressed was the lack of medical students and thereafter residents who were sufficiently devoted to their chosen profession and specialty that they would willingly sacrifice the hours required to become national and international leaders. This is a significant concern, and should not be ignored, though what assessment tool could be envisioned to address the metric of “dedication” is difficult to imagine. Another related concern, was the perspective that selection based upon meritocracy would be sacrificed in the name of “social justice”. The most common concern related to changes and vulnerabilities was the shift to provide a greater avenue of admission to Francophone applicants at the expense of Anglophone applicants. Despite that much-ballyhooed concern, in the data describing the proportion of Anglophones, Francophones, and other first language speakers admitted to McGill medical school between 2003 and 2012, the Anglophone proportion has remained static, while the Francophone proportion has risen 11%, albeit all at the expense of the “other first language speakers”. Data for 2013 is not available at this time.

A PASSIONATE VISION

The Faculty of Medicine of McGill University is blessed with individual members who are passionate in their desire and dedicated to their mission to maintain and enhance the institution’s international reputation for academic and clinical excellence. Outside of his clinical responsibilities, Dr. Razack wears many hats, including his roles as Assistant Dean of Admissions, Equity and Diversity, Chair of the Admissions Committee, and Chair of the MMI Committee. Further, he is available within 10 minutes of any calls put to him, according to the Chair of the Widening Participation Committee (WPC). The Director of the Office of AED is no less dedicated to her role. She and her staff believe in what they are doing, working within their resources, happy with the support granted them by the Dean, while at the same time imagining what further programs they might muster with greater resources. This understanding is mirrored by the Chair of the WPC. Part-time staff members of the Office of AED and the WPC Chair are responsible for Outreach programs and campus mentorship programs, reaching out to groups identified as target groups – blacks, rural, First Nation Inuit Metis, and lower socio-economic status. Data from the Ministry of Education, when it was available in past years, and local Montreal data regarding the proportion of students falling within those target groups is used to identify which elementary and high schools receive local visits, entry into Explore! Careers in Health Educational Camp, and access to websites describing the educational and clinical tracks in the health professions. Based upon the Meyerhoff program at the University of Baltimore, undergraduate students already on the McGill campus who come from any of the target groups, can be matched with appropriate mentors to their preferred health profession in a campus-wide mentor system already in place. In another program, volunteers can be set up in hospitals. While all health professions are represented in these

programs, and each health profession has representation on the WPC, medicine is the only financial contributor at this time. The WPC has not been in existence long enough to judge success. Nevertheless the WPC Chair has the understanding that her vision will be supported by the Office of AED. Her vision is no less than all the healthcare schools at McGill, including the medical school, will have student bodies accurately reflecting the community at large, to better serve that community.

How can the reticence to sacrifice student selection based on individual meritocracy coexist with the concept of diversity in the student body enhancing overall excellence? This question is particularly challenging in a setting which historically has very much favoured the former over the latter, a sentiment still held by a significant proportion of faculty. The judicious approach taken by the Office of AED has been to divide the two, applying individual meritocracy to student selection and diversity to pipeline programs. Simply described, prospective students at the grade school, high school, or undergraduate post-secondary school levels are open fodder for recruitment on the basis of equity and diversity, up to the point of submitting an application. For targeted groups, the pipeline programs may well enhance the applicant pool, but once they have applied to medical school, individual meritocracy rules. The five guiding principles for student selection – excellence, inclusivity, alignment, fairness, and transparency - generated by the Admissions Board Members’ retreat of December 2011 is a case in point. Strictly speaking, the five guiding principles do not all deal with selection per se. More to the point, excellence deals with selection based on individual meritocracy, inclusivity is represented by pipeline programs, alignment with the medical school curriculum, fairness with professional interactions with applicants, and transparency with process. By intent, the principles of excellence and of inclusivity do not intersect.

As intimated, the vision of inclusivity is not shared by all stakeholder groups, to the same extent as it is held by the Chairs of Admissions Committee and WPC. This is particularly challenging when the school is financially increasingly beholden to alumni and donors, a vital group, which does not unanimously share that vision. There is one other vital stakeholder group which should also be taken into account, however. In meeting with the student representatives, many suggestions for adjustments to the admissions process to address challenges were proposed. Some student comments were more positive (e.g. the interviews are less stressful and much more appropriate than the Francophone schools’ MMI), some more negative (e.g. despite improvements in class diversity, McGill still lags behind University of Toronto on that front, likely related to Toronto being a more multicultural city than Montreal); some comments were more frivolous (e.g. not clear how best to game the applications process) , some more serious (e.g. MED-P students who fail to advance have no future recourse to apply to other Canadian medical schools); some comments were more fanciful (e.g. have the admissions office rather than the applicants enter the data for GPA), some more realistic (e.g. exclude physics as a requirement for admission eligibility). The students were however unanimous on two subjects: they were proud of the vision and the actions taken by the Office of AED, proud of its name, wanted to volunteer more time to outreach programs, and when asked how they would vote on the continued abolishment of the MCAT, yea or nay, every hand shot upwards immediately to vote yea. One poignant comment was that the admissions program was perceived as being ahead of the rest of the medical school, with curriculum judged as needing to catch up.

Parenthetically, as external reviewers we should state openly that we do not unanimously agree with all of the details of the vision and its implementation. However, having started down that path, we do agree that to change direction, or even to change the name of the Office of AED, would mean losing more than is gained. This conclusion is to a great extent based upon the student reaction. Firstly, the retrenchment would send a message to the student body that McGill medical school has its set of values, until it doesn't. Secondly, the present student body is made up of the future alumni and donors to McGill. Instilling pride in their alma mater is much more easily maintained than it is regained once lost. Thirdly, of all stakeholder groups, ultimately the medical student body is the primary one.

But if the vision and the name of the Office of AED is maintained, then what remains is the challenge of contrasting values of significant numbers of faculty, alumni and donors. We would suggest that the core of that problem lies less with the vision and more with the coping mechanisms brought to bear to deal with contrasting values.

A VARNISHED MESSAGE

Messaging the changing face of admissions, equity and diversity could be seen as inadequate; however, that view is readily apparent using a jaundiced eye in retrospect, and not seen so easily in advance. No-one felt, in retrospect, that they controlled the message. Much has been learned in retrospect.

Separations between different endeavours have not been sufficiently demarcated for public consumption. The Office of AED lives in near proximity with the Office of Donor and Alumni Relations (DAR). The Chair of the Admissions Committee is also the Assistant Dean of the Office of Admissions, Equity and Diversity, despite the commendable approach of dividing admissions based upon individual meritocracy from inclusivity based upon recruitment (outreach and mentorship programs). A survey researching diversity is conducted by AFMC and is not intended to impact upon selection in any way, but is nevertheless identified with the Chair of the Admissions Committee.

Messages emanating from external sources cannot be reasonably controlled (e.g. lay press, weblogs, Quebec Ministries of Education and of Healthcare Services), but the same should not be true of messages emanating from sources internal to the university. For vulnerable groups of stakeholders, those messages can be easily misinterpreted. For example, the Principal's Task Force on Diversity, Excellence and Community Engagement of 2012 makes the following recommendation: "Support efforts to recruit and retain a more diverse qualified student body, for example, by developing pipelines of future students, including **Francophone students** and students from underrepresented groups" [emphasis added]. A vulnerable stakeholder might not understand the underlying intent being recruitment, but not selection criteria, based upon Francophone status. Abolishment of the MCAT can be defended solely upon the imbalance of high cost to prospective applicants and low incremental validity beyond GPA, without resorting to language skills as a factor in the decision. Establishment of the Office of AED is interpreted by some as the brainchild of a few leaders with a vision dissonant with the values of groups traditionally well represented in the medical school, rather than a requirement to

maintain accreditation, and a means by which McGill keeps pace with other schools of excellence, like Harvard medical school.

Due to the size and labyrinthine nature of the Faculty of Medicine, communicating clearly and with one message is a distinctive challenge. The staff representative did not have a clear understanding of the direction Admissions and the Office of AED were taking in terms of maintaining and enhancing excellence; withdrawal of the MCAT seemed to sacrifice an objective measure, and while the MMI seemed to introduce more objectivity, the overall process seemed a bit “luck of the draw”. Anecdotal information supported the feeling that the process admits some unworthy people while rejecting other, better, applicants. While ultimate failure to get a seat was seen as palatable, due to the high level of competition, the failure to even get an interview resonated much more negatively, a viewpoint shared by the student representatives as well. This sense of being in the dark is not limited to student selection. Curricular changes were well advertised amongst inner faculty, but less so throughout the hospitals and larger community of practitioners.

AN EVOLVING PROCESS

A review of the process is divided into issues of resources and committee structure and function.

It is a truism that all Canadian colleges and universities work on a shoestring budget. Compounding that historic reality, the introduction of austerity measures provincially, the dependence on generous donors, and the increasing numbers of applicants have conspired to force ever more imaginative ways of getting the administrative job done, while protecting academic integrity. The Deanery has been very supportive of maintaining or expanding resources, despite the challenges. As one example, the new austerity rules mandate attrition, such that vacated positions would remain unfilled. Much effort was expended in successfully reconstituting Michel Dansereau’s position after his departure. As another example, a new position for a psychometrician has been created.

The ongoing strain on resources is seen most in the multi-step process of identifying interviewees, the roll-out of more aggressive recruitment programs, and the conduct of the MMI.

At present, the process of identifying interviewees requires five steps, each with considerable resources applied. The first step is the identification of those applications eventually judged ineligible. Sometimes ineligibility is easily concluded, but other times may require repeated communications between admissions staff and applicants to obtain missing data which may or may not confirm eligibility. The second step consists of verifying GPA based upon the grades provided by applicants, and adjustments required based on the process of judging “extenuating circumstances”. The third step uses the Academic Context Scoring Guide to adjust the GPA in keeping with the student record’s demonstration of strength, breadth, depth, reputation of the feeder institution, and “other known factors”. The Guide was compiled by Michel Dansereau, based upon his many years of experience assessing applicant files, and informed by other sources of information from the university community. Due to its recent implementation, it is unknown whether adjusting GPA in this fashion changes the applicant rankings significantly, nor whether the presumptive changes of the ranking result in a better student “product”.

Given the relative homogeneity of post-secondary educational institutions in Canada, relative to the United States, the likelihood that implementation of the Guide would lead to a salutary result is open to question. The fourth step is the file review, conducted by Admissions Committee volunteers, mostly faculty members. The fifth step is a random background check on the applicant file, conducted on roughly 7% of files. Very little of these steps are automated, putting an enormous burden on Office of AED staff and on Admissions Committee members. The process is further complicated by the multiple streams, with a Non-Traditional Pathway, an International pathway, a pre-med program, the regular medical school program, an MD PhD stream, an MD MBA stream, different GPA calculations for CEGEP (R-score) and non-CEGEP applicants, a provincially-applied GPA adjustment of 0.5 for applicants from rural regions, and four supernumerary provincial seats funded by the province for First Nation, Inuit and Meti applicants.

At present, in the pursuit of recruitment through the extensive outreach programs, and alignment of undergraduate students in the mentorship program, \$15,000 is allocated annually for part-time support staff. The Office of AED staff members and the Chair of WPC both indicated their belief that far more could be accomplished with more generous resources.

The MMI is conducted for 100 interviewees per day, on 5 weekdays. The McGill Simulation Centre allows for up to 25 interviewees per set, including 2 simultaneous circuits each of 10 active stations and rest stations. Four sets are used over the course of the day, making for an exhaustingly long day. All five interview days are weekdays, largely due to inability to recruit faculty members on the weekend to sufficiently staff 75% of interview stations. The 75% mark is already a reduction from historical levels, and a further reduction would not be well received by faculty, though the present weekday arrangement puts significant strain on the Simulation Centre when trying to meet the demands of all McGill healthcare profession schools. Standardized patients are used as actors; student volunteers would not be seriously considered due to concerns over greater potential for test security breaches, property security within the Simulation Centre, and depth of the roles requiring actors with greater experience, adaptability and perseverance, and sometimes a particular age. The costs of conducting the MMI at the Simulation Centre are paid for within the global budget allocated to it on an annual basis.

In terms of committee structure and function, the Professionalism Standards Committee, the McGill MMI (M³I) Review Committee, the Widening Participation Committee and the Advisory Committee on Admissions Best Practices report to the Admissions Committee, which reports to the Office of AED. The Professionalism Standards Committee addresses questions of applicant malfeasance, the M³I Review Committee creates MMI stations, the Widening Participation Committee function is described above, and the Advisory Committee on Admissions Best Practices addresses queries on student selection as they arise. While in theory these queries can come from any source, they have always originated, or been funneled through, the Assistant Dean or the Director of the Office of AED, both of whom sit as non-voting members on the Advisory Committee. Each of these four committees brings forth recommendations that are brought forward for more limited (due to committee size) discussion and voting at the Admissions Committee meetings, held twice a year, and usually attended by approximately 70 of the 120 members of that committee. There is little need to rotate membership, due to the high number of faculty that willingly contribute their time annually.

In the past, these committees have had psychometric support from Meredith Young, whose duties have now shifted elsewhere. One new position for a psychometrician has been created, though this is for the entire group of healthcare profession schools at McGill.

In response to the resource demands, efforts have been made to consolidate parallel activities with other programs, both internal to McGill (nursing school, dental school, etc) and external to McGill (other medical schools in Quebec). While the resource requirements are often shared in these arrangements, this is not always the case. One example of unequal resource provision is the pipeline programs, resourced entirely by the medical school.

RECOMMENDATIONS

The recommendations provided are described in keeping with the last two themes – messaging and process.

Messaging – Several steps can be considered in hopes of providing a consistent, clear message that should be considered palatable by stakeholder groups, and are listed here in random order.

1. Involve the Public Relations resources of the Faculty of Medicine in helping to frame and disseminate the message.
2. Make clear the separate and independent roles of admissions to select on the basis of individual meritocracy and of WPC to recruit applicants on the basis of traditionally underrepresented groups.
3. Emphasize the requirement of an Office of AED to maintain accreditation, and the preference to have an Office of AED to keep pace with other schools of excellence, like Harvard.
4. Take advantage of the great power that comes with powerlessness – if a potentially unpopular decision must be made, it is far better for it to be seen as being done because there was no other reasonable option, rather than it being the result of feeding personal values. Examples include accreditation standards requirements, provincial adjustment to rural value, and provincial supernumerary positions for First Nations, Inuit and Metis.
5. Proactively seek greater engagement of the wider community of staff at Montreal hospitals and local practitioners. For example, a paired comparison analysis of the most desirable non-academic traits of McGill medical students could be conducted, managed by a working group consisting of a well-regarded traditionally-minded faculty member outside of the Admissions Committee membership, a member of that committee, and a psychometrician, with the intent to blueprint future MMI's. Be explicit in how the survey will be used.

6. Make generally available some data sets, which might serve to defray tension, such as the table of 2003, 2009 and 2012 snapshots in linguistic profile of registered students from Quebec.
7. Acknowledging the commonality of all stakeholder groups that they all feel vulnerable, focus the message around the concept of vulnerability.
8. Start planning now on how future potential changes (e.g. MCAT 2015, emerging literature on situational judgment testing) might impact selection processes, and how the decision-making process might best be communicated.
9. It should be made as clear as possible that the surveys of applicants are conducted by AFMC, and not by McGill, and that the survey data is provided by AFMC to McGill Office of AED to inform recruitment, and that the survey data is not provided to the Admissions Committee, nor used in selection processes.

Process – Several steps can be considered in addressing the pressing demands on resources, and clarifying the roles of different groups. These steps are provided below, in random order.

1. The Assistant Dean of the Office of Admissions, Equity and Diversity should not also serve as Chair of the Admissions Committee or Chair of the MMI Review Committee. The combination makes it easy for outsiders to conflate roles that should be entirely separate.
2. For purposes of clarity regarding the separate roles of recruitment and of selection, the WPC should be parallel to the Admissions Committee with both reporting to the Office of AED. The other committees presently reporting to the Admissions Committee should continue to do so.
3. The Advisory Committee for Best Practices is better managed by accomplishing the same goals with some changes in process.
 - a. Because the queries referred to the Advisory Committee are each uniquely different, its mandate is better served by establishing a new working group for each query.
 - b. The Chair of the group would select the members appropriate to each unique query.
 - c. For virtually all queries, one member of the selected working group should be a psychometrician.
 - d. As they funnel questions to the Committee, the Assistant Dean and the Director of the Office of AED should not be members of the working groups, but should make themselves available as resources for the working groups.
4. The pre-interview admissions process is resource-intensive, with limited data to demonstrate that it is providing a better student “product” than simply using GPA and R-scores. There are a number of adjustments that can be considered.

- a. Continue present efforts to homologize processes with other healthcare professional schools at McGill and with other Quebec medical schools.
 - b. Use formulaic rather than holistic practices wherever possible (e.g. Academic Context Scoring Guide automation) as literature review has shown the formulaic approach is usually more predictive of outcome measures.
 - c. Consider conducting file review after interviews to rule out selected applicants rather than pre-interview to rule in applicants for MMI.
5. As part of engaging wider faculty in blueprinting the MMI, challenge them to volunteer on weekend days as well as weekdays to reduce friction with other programs seeking use of the McGill Simulation Centre during the week.
6. Take fullest advantage of the new psychometric resources early, staking out her time for future medical school admissions issues.
7. The Chair and members of the Widening Participation Committee should not be members of the Admissions Committee, as recruitment and selection must be viewed as completely separate functions.
8. Any resources saved by simplifying or automating or homologizing the pre-interview selection process should be considered for shift towards the following priority items:
 - a. greater support for recruitment of the four defined traditionally under-represented groups
 - b. increased investment in garnering greater faculty-wide involvement in the process of selection
9. Because faculty and students are more understanding of the stiffness of competition when interviewees do not get an offer, and less understanding when applicants do not even get an interview, and assuming a fixed number of 500 interview slots, a decrease of the number of interview slots for out-of-province applicants, to the benefit of in-province applicants should be considered, if possible, while maintaining the same 90:10 split for seats. An even better solution would be to expand the number of interview slots above 500, but given the present limits on the system, this seems a non-starter.
10. A better geographic separation of the offices of AED and DAR should be considered; acknowledging the given space considerations, this is likely not possible.

SUMMARY

James McGill...was born in Glasgow, Scotland on October 6, 1744, the eldest son of an ironsmith... he left university without completing a degree – a fact likely due to his family’s poor fortunes...McGill immigrated to North America and entered the rough-and-tumble world of the fur trade. His hard work and French fluency served him well as he spent much of the following nine years in almost constant danger, navigating the rivers and lakes of the Great Lakes frontier, wintering in unmapped wilderness and living off the land... McGill’s dedication to public service distinguished him from many of his fur-trading contemporaries... Always a visionary, McGill was determined to create a rigorous system of education for Lower Canada... McGill took great care of the welfare of others, including his step-children and the orphan daughter of a friend. This ecumenical and generous spirit manifested itself in his final will, which, after his death in 1813, revealed a bequest to the Royal Institute for the Advancement of Learning (RIAL)[sic] for the founding of a college. Spurred on by the gift, the RIAL became the governing body for McGill College, which was officially established in 1821.

[Excerpted from McGill University website]

The faculty and administrative staff of the Office of AED, the Admissions Committee and its reporting committees are exceptionally committed, hardworking, and visionary, and represent worthy heirs to the historical description of James McGill. They conduct themselves in an environment outside the university and inside the university which presents challenges peculiar to Montreal circa 2013. They have provided a vision and pathway which is eminently reasonable and defensible, but have not optimized access to coping mechanisms that would allow future unfettered progress on that road. With adjustments in messaging and process, we are hopeful that the path charted will provide the institution with great reason for continued pride.