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Canadian Medical Schools

Team Report of the Limited Site Visit of

McGILL UNIVERSITY

FACULTY OF MEDICINE

Montreal, QC

February 5-7, 2017

Prepared by an *ad hoc* site visit team
for the
COMMITTEE ON ACCREDITATION OF CANADIAN MEDICAL SCHOOLS
and the
LIAISON COMMITTEE ON MEDICAL EDUCATION

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MEMORANDUM

TO: Committee on Accreditation of Canadian Medical Schools

FROM: The *ad hoc* Site Visit Team that visited the Faculty of Medicine of McGill University on February 5-7, 2017

RE: Limited Site Visit Team Report

On behalf of the *ad hoc* CACMS Site Visit Team that visited the Faculty of Medicine of McGill University on February 5-7, 2017 the following report of the team's findings is provided.

Respectfully,

Pamela Veale, MD
Team Secretary

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

SITE VISIT TEAM COMPOSITION

Team Chair:	Dr. Trevor Young Dean, Faculty of Medicine University of Toronto Toronto, ON
Team Secretary:	Dr. Pam Veale Assistant Dean, UME Cumming School of Medicine University of Calgary Calgary, AB
Team member CACMS-appointed	Dr. Gary Tithecott Associate Dean, UME Schulich School of Medicine & Dentistry Western University London, ON
Team member LCME appointed	Dr. Donna Waechter LCME Assistant Secretary Senior Director, LCME Surveys and Team Training Association of American Medical Colleges
Faculty Fellow	Dr. Darlene Hammell Faculty of Medicine University of British Columbia Victoria, BC

ACKNOWLEDGEMENT

The team wishes to express its appreciation to Dean David Eidelman, Dr. Beth-Ann Cummings, Associate Dean (UGME), Dr. Douglass Dalton, Faculty Accreditation Lead, Natalie Phillips-Elgar, Accreditation & Cyclical Review Officer, and the administrative staff, faculty and students for their participation and candour during the limited site visit

The focus of this limited visit was to assess progress towards achieving full satisfaction with elements for which the school was found to be satisfactory with a need for monitoring or unsatisfactory in a letter of June 15, 2015 from CACMS and the LCME (**Appendices C2 and C-3**).

DISCLAIMER

The summary findings that follow represent the professional judgment of the *ad hoc* site visit team that visited the McGill University Faculty of Medicine on February 5-7, 2017, based on the information provided by the school and its representatives before and during the accreditation visit. The CACMS may come to differing conclusions when they review the team's report and any related information.

FINAL LIMITED SITE VISIT TEAM ELEMENT RATING SUMMARY TABLE

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

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

ACCREDITATION HISTORY OF THE SCHOOL

The last full visit of the Faculty of Medicine, McGill University was carried out on February 22-25, 2015.

Standard	Element (N/A for 2014-15)	June 2015 Full visit (Feb 2015)	Feb 2015 Action plan	June 2017 Limited visit (Feb 2017)			
IS-1	1.1	NC					
IS-14-A	6.6	CM					
IS-16	3.3	CM					
ED-1	8.2	NC					
ED-2	6.2	NC					
ED-3	6.1	NC					
ED-8	8.7	NC					
ED-10	7.1	CM					
ED-20	7.5	NC					
ED-23	7.7	CM					
ED-24	9.1	NC					
ED-25	9.2	NC					
ED-25-A	9.3	NC					
ED-27	9.4	CM					
ED-30	9.8	NC					
ED-32	9.5	NC					
ED-33	8.1	NC					
ED-37	8.3	NC					
ED-38	8.8	NC					
ED-41	2.6	NC					
ED-44	12.4	NC					
MS-4	10.2	NC					
MS-8	3.3	CM					
MS-18	11.1	NC					
MS-26	12.3	CM					
MS-31-A	3.5	NC					
MS-32	3.6	NC					
FA-4	4.5	NC					
FA-14	1.3	CM					
ER-7	5.6 / 5.11	NC					
ER-9	1.4	NC					
ER-11	5.8	NC					
Follow-up 1		action plan					
Due date		Dec 1, 2015					
Follow-up 2							
Due date							
Accreditation status		probation					
Next full Visit		TBD					

SUMMARY OF FINDINGS OF THE LIMITED VISIT OF FEBRUARY 5-7, 2017.

The following is the Summary of Findings for each element evaluated during the limited site visit. Elements are rated as Satisfactory (S), Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U).

Element Rating S, SM, U	Standard 1 – Mission, planning, organization and integrity
S	Element 1.1 – Strategic planning and continuous quality improvement
	Finding: The school has continued to be engaged in an ongoing process of development and monitoring of its strategic plan. A timetable for implementation is now clear and the outcomes are identified.
S	Element 1.3 – Mechanisms for faculty participation
	Finding: The medical school has effective mechanisms in place for direct faculty participation in decision making in the medical education program. There are many opportunities for faculty to participate in discussion about and the establishment of policies and procedures for the education program. The new Faculty Council has been operational for approximately one year. Interviews conducted at the site visit and review of meeting minutes indicated that this was functioning well.
S	Element 1.4 – Affiliation agreements
	Finding: Existing affiliation agreements with each institution contain the required components and are signed. A new province-wide template is being developed, but is not yet available for review. It is understood by faculty leadership that the required components will be included in this template. Current affiliation agreements will remain in effect until this province-wide agreement is implemented.

Element Rating S, SM, U	Standard # 2 – Leadership and Administration
S	Element 2.6 – Functional integration of the faculty (GDC)
	Finding: The McGill MDCM Program does not have a geographically distributed campus but rather has a longitudinal integrated clerkship for an average of 12 students per year at the Gatineau (Outaouais) site, thus technically this element does not apply. At the previous visit, the Gatineau site was included under the discussion of this standard. There was nonetheless evidence from many sources, especially interviews with leaders, faculty and students, that the Gatineau site is now functionally integrated with its Montreal counterpart.

Element Rating S, SM, U	Standard # 3 – Academic and learning environments
SM	Element 3.3 – Diversity/pipeline programs and partnerships
	<p>Finding: The school has redefined its definition of low socio-economic status. The school has established pipeline programs for identified groups, but outcome data is only available for one of these groups (PNIQ). There are plans for future development of the pipeline program for students from rural backgrounds. There is awareness of the diversity goals and processes in place to achieve the desired diversity outcomes, but the school has not yet achieved its diversity goals for identified groups among faculty, or senior and academic leadership groups. This will be a long-term outcome.</p>
SM	Element 3.5 – Learning environment/Professionalism
	<p>Finding: The school has made significant progress in meeting the requirements of this element. The Associate Dean UGME is now a member of the joint Hospital-University Directors of Professional Services Committee. The Assistant Dean Student Affairs presents data on the learning environment to the MDCM Program Committee twice per year on behalf of the WaLE [Wellness and Learning Environment] Subcommittee. In order to synthesize and integrate all perspectives in the evaluation of the learning environment and in the implementation of initiatives, a new committee has been struck: the Learning Environment Advisory Panel (LEAP), chaired by the Vice Dean Education, with the first meeting held in January 2017. The LEAP will provide a venue for formal discussions about issues affecting the learning environment. Work has begun on improving the culture in hospitals that, as cited in the 2015 survey, previously made a change in the learning environment difficult. There was evidence at the visit of widespread awareness and efforts to resolve these issues.</p>
SM	Element 3.6 – Student mistreatment
	<p>Finding: The school has made significant progress in meeting the requirements of this element. Student mistreatment was "top of mind" for education and clinical leaders. Students are clearly aware of processes and opportunities to report issues. Attention to student anonymity has improved the reporting process. A systematic process to inform students about outcomes of their complaints has recently been implemented and was apparent to students in years 3 and 4. Many of the steps taken to address allegations of student mistreatment have been recently implemented, thus there is insufficient time for this to be reflected in the student reported rates of mistreatment.</p>

Element Rating S, SM, U	Standard # 4 – Faculty preparation, productivity, participation and policies
S	Element 4.5 – Faculty professional development
	<p>Finding The Faculty of Medicine provides many opportunities for professional development to all of its members to enhance teaching and leadership skills. This includes areas such as student assessment, curricular design and instructional methods. There are also opportunities for faculty development in program evaluation and research. At the previous visit it was noted that while these opportunities were available at the Montreal sites they were not available at the Gatineau site. It also bears repeating that the Gatineau site is not a distributed campus but rather a teaching site for the longitudinal clerkship for approximately 12 students. In each of the subcomponents there is evidence to support the improvement of availability of resources for faculty at the Gatineau site.</p>

Element Rating S, SM, U	Standard #5 – Educational resources and infrastructure
U	Element 5.6 – Clinical instructional facilities / Informational resources
	<p>Finding: The school has made progress toward meeting the requirements of this element. A clear process has been implemented to ensure that there are sufficient information resources and instructional facilities for medical student education at each site. Wi-Fi has very recently been made available at all clinical sites, however, students report that they do not yet have passwords for the LaSalle or St. Mary’s sites. Administrative staff indicated that Wi-Fi access for students at these two sites was very recently implemented.</p>
S	Element 5.8 – Library resources
	<p>Finding: The issues identified in the previous visit relate mainly to the internet access issues cited in element 5.6. Library resources appear sufficient and are actively used by students. Students report access to a wide variety of electronic resources. Students reported that leadership is working to increase in-person opening hours for the main library site, however there is 24-hour access in an adjacent library. All clinical sites provide access to local libraries with in-person and/or electronic access after regular opening hours.</p>
S	Element 5.11 – Study/lounge/Storage space / Call rooms
	<p>Finding: A clear process has been implemented to ensure that there are sufficient facilities for medical student education at each site. Students have lockers/secure storage space at all clinical sites. Call rooms are available at all sites that require overnight call. One site has plans to improve the call room over the upcoming year. Revised relaxation space and private room is appreciated by the students. Discussion at the site visit indicated that the lower student satisfaction ratings regarding relaxation space likely did not reflect the current facility.</p>

Element Rating S, SM, U	Standard #6 – Competencies, curricular objectives and curricular design
S	Element 6.1 – Program and learning objectives
	Finding: The school has defined program objectives that are competency based and align with national standards. These are effectively communicated to students, faculty and residents across all sites.
S	Element 6.2 – Required clinical learning experiences
	Finding: The school has defined a list of required clinical learning experiences. Documentation provided to the survey team on site and student report at the site visit confirmed the list includes the clinical setting, level of responsibility, patient type, and numbers of encounters for conditions and skills.
S	Element 6.6 – Service-learning
	Finding: The school has created an effective service-learning experience delivered as a required course in Year 2. The experience has program support, learner assessment and evaluation of outcomes. This experience effectively partners with a variety of local agencies and processes aligned with social accountability.

Element Rating S, SM, U	Standard #7 – Curricular Content
S	Element 7.1 – Biomedical, behavioral, social sciences
	Finding: The content areas listed in DCI tables for this standard are included in the revised curriculum, implemented for the Class of 2017. Internal survey data indicates significant improvement in these areas compared with CGQ and GQ data for Classes of 2014-2016.
S	Element 7.5 – Societal problems
	Finding: The content areas listed in DCI tables for this standard are included in the revised curriculum, implemented for the Class of 2017. Internal survey data indicates significant improvement in these areas compared with CGQ and GQ data for Classes of 2014-2016.
S	Element 7.7 – Medical ethics
	Finding: The content areas listed in DCI tables for this standard are included in the revised curriculum, implemented for the Class of 2017. Internal survey data indicates significant improvement in these areas compared with CGQ and GQ data for Classes of 2014-2016.

Element Rating S, SM, U	Standard #8 – Curricular management, evaluation , and enhancement
S	Element 8.1 – Curricular management
	Finding: The school demonstrates an effective governance committee chaired by the Associate Dean UGME with broad membership to oversee all aspects of the curriculum while leading in the design and ongoing improvement of program required student learning. Interviews conducted at the site visit and review of meeting minutes indicated that this was functioning well.
S	Element 8.2 – Use of medical educational program objectives
	Finding: The school has implemented a curriculum built from outcome objectives that direct program and course development, delivery and support a culture of ongoing academic improvement. There are new quality improvement processes in place to review implementation of objectives with reporting to the program committee.
SM	Element 8.3 – Curricular design, review, revision / Content monitoring
	Finding: The school has developed outcome objectives mapped to curricular courses and sessions. There remain challenges in adopting an effective information technology solution for oversight of curricular content and required learning experiences. This is being addressed by leadership with the implementation of a software program used by other large Canadian faculties of medicine. It is anticipated that implementation will be completed in the next 2 years.
SM	Element 8.7 – Comparability of education/assessment
	Finding: The school has made progress towards delivering comparability in learning across program sites and in provision of administrative support.
SM	Element 8.8 – Monitoring time spent in educational and clinical activities
	Finding: The school has made recent progress to effectively deliver a curriculum that is adherent to the standard of learning hours set for the MDCM Program. Students, residents, faculty, department chairs and other leaders are aware of expectations of student workload and are working to resolve issues. A progressive decrease in breaches of the workload policy has been observed.

Element Rating S, SM, U	Standard #9 – Teaching, supervision, assessment, and student and patient safety
S	Element 9.1 – Preparation of resident and non-faculty instructors
	Finding: All residents are required to complete teaching and assessment skills training. Completion of the training is centrally monitored. As a part of the training, residents receive and review medical student learning objectives for the Clerkship. Residents’ teaching of medical students is evaluated at all instructional sites by medical students, and support is provided to improve residents’ teaching when deficiencies are identified.

S	Element 9.2 – Faculty appointments
	Finding: The school has a formal policy in place that provides a process to have faculty appointments assured for all new recruits to the school’s affiliated institutions. Currently greater than 99% of 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.
SM	Element 9.3 – Clinical supervision of medical students
	Finding: The Undergraduate Medical Education (UGME) and Postgraduate Medical Education (PGME) have developed the Faculty of Medicine Supervision Policy for Undergraduate and Postgraduate Medical Trainees in the Clinical Team. Additionally, clinical log (myMED Portfolio) requirements have been revised to explicitly describe student responsibilities to ensure the appropriate balance of student independence and supervisor involvement. An orientation session is given on the first day of every course to familiarize students with clinical settings and their relevant policies and safety considerations. At the site visit, clerkship students indicated they were appropriately supervised and residents and attending physicians were regularly available.
SM	Element 9.4 – Assessment system
	Finding: The school’s requirement that direct observation of history and physical examination skills occurs in all clerkship courses is not reflected in the percentage of students who report being observed on the internal Medical Education Experience Survey (MEE) and CGQ. In response, the school has recently instituted a process whereby third and fourth year students login to myMED Portfolio to document when they have been observed doing a history and physical, the type of patient seen, and the name of the faculty member or resident who observed them.
S	Element 9.5 – Narrative assessment
	Finding: The school has a formal policy that requires narrative assessment when teacher-student interaction meets defined thresholds for sufficient duration and depth. Compliance with this policy is overseen by the MDCM Program Committee.
SM	Element 9.8 – Fair and timely summative assessment
	Finding: The school has established a clear policy specifying the timeline for provision of final grades for all required learning experiences. Provision of final grades is monitored and steps are taken to meet the expected timeline. Results for the current academic year show a positive trend toward compliance with the grade submission policy. Administrative issues have been addressed.

Element Rating S, SM, U	Standard #10 – Medical student selection, assignment and progress
S	Element 10.2 – Final authority of admission committee
	Finding: The final responsibility for accepting students rests with the Admissions Committee. Details are outlined in faculty policies and the membership has been revised to now include a majority of voting faculty members.

Element Rating S, SM, U	Standard #11 – Medical student academic support, career advising, and educational records
SM	Element 11.1 – Academic advising
	Finding: The school has made progress toward meeting the requirements of this element. There are means by which the medical school identifies students experiencing academic difficulty. An "at-risk" category was recently introduced. The process is clearly outlined and both students and faculty were aware of the process. Gatineau students can access resources on site in a confidential manner. Osler Fellows no longer provide academic counseling to students.

Element Rating S, SM, U	Standard #12 – Medical student health services, personal counseling, and financial aid services
S	Element 12.3 – Personal counseling / Well-being programs
	Finding: The medical school provides programs that support well-being to students at Montreal and Gatineau sites. A full-time Wellness Consultant was hired in the spring of 2016 to support students. Students report sufficient time for basic wellness activities. Well-being components are embedded in the curriculum of the MDCM Program. Data from the CGQ and GQ show that the majority of respondents are now more satisfied/very satisfied with programs that promote effective stress management, a lifestyle balance and overall well-being.
SM	Element 12.4 – Student access to health care services
	Finding: The school has made progress toward meeting the requirement of this element. The Absences and Leaves Policy was updated for the 2016-17 academic year in response to student feedback and has been appropriately communicated to students. Students are more comfortable taking absences for health-related matters and the process of approval has been centralized. Students report appropriate access for students based in both Montreal and Gatineau.

EVALUATION OF THE MINI DCI

The site visit team was provided with the mini-DCI eight weeks prior to the limited site visit. The documents were well organized. Additional information was requested prior to and during the visit. This was provided to the team promptly in both paper and electronic format.

LIMITED SITE TEAM FINDINGS

1.1 STRATEGIC PLANNING AND CONTINUOUS QUALITY IMPROVEMENT (IS-1)

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.

Finding of previous visit (2015):

The strategic plan should include a timetable for achieving the various milestones, and have clear outcome markers. This is a recurrent issue.

Finding of the current limited visit:

The school has continued to be engaged in an ongoing process of development and monitoring of its strategic plan. A timetable for implementation is now clear and the outcomes are identified.

Indicators to guide the evaluation of the above element:

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The Doctor of Medicine and Master of Surgery (MDCM) Program at McGill University has a written statement of mission and vision for the medical education program. For purposes of this report the term medical school is synonymous with the MDCM Program.

The mission of McGill University's Faculty of Medicine is to educate current and future health care professionals and health researchers based on the highest standards of excellence and principles of life-long learning, together with the pursuit of novel research and clinical innovation, to improve the health of individuals and populations worldwide. Their vision is healthier societies through education, discovery, collaboration and clinical care.

Within the overall mission of the Faculty, the undergraduate medical education program, the MDCM Program, has its own specific mission and vision statements. The mission of the MDCM Program is to prepare students for careers as key members of the medical community, whether in clinical practice, in medical education, in research, or as leaders of the health care system. To this end, the curriculum is based on a set of premises and orienting statements. The vision of the MDCM Program is to be recognized as Canada's foremost medical undergraduate program, preparing future generations of graduates to take their place as leading medical practitioners, educators and researchers.

The current strategic plan is the result of a strategic planning process which was undertaken under the previous dean and approved in 2010. It was implemented in 2012 after the appointment of the current dean. The next cycle of strategic planning has now been initiated. This has been called "Project Renaissance". The preliminary results of this process were reported to Faculty Council in December 2016. The MDCM Program has developed a preliminary proposal, "Physicians of Tomorrow" which aligns with the overall faculty wide strategic plan.

The outcomes of the strategic plan are monitored by an annual review by Faculty Council and the Dean. The last review was on June 13, 2016. An extensive list of specific actions and outcomes of the components of the strategic plan were provided in the DCI appendices including specific timelines for completion.

The medical school engages in ongoing planning and continuous quality improvement that establishes short and long-term programmatic goals. The plan entitled "Towards a New Curriculum" is monitored continuously with specific outcomes, actions which are assigned to one of the program committees. Progress is monitored in a "scorecard" fashion with a record of tracking this on an ongoing basis over at least the last five years. In addition, a longer term goal is being developed and articulated in "Physicians of Tomorrow" to replace the last few years under the current plan. The new curriculum itself will be formally evaluated starting July 2017.

The medical school monitors compliance with CACMS accreditation Standards and Elements through a variety of means. This process effectively allows the medical school to take steps to maintain compliance. This was amply illustrated by the outcomes of this limited site visit. Compliance is monitored in an ongoing way with the appointment of the Director for Accreditation for Undergraduate Medical Education and the establishment in April 2015 of the Accreditation Implementation Committee (AIC). The Dean chairs the AIC which will be replaced by a Quality Assurance Committee after this limited site visit. Moreover, the MDCM Program Committee and subcommittees have been developed to incorporate CACMS Standards and Elements in each committee. The AIC monitors multiple data sources from student survey and performance to financial statements. The AIC meets monthly. While the MDCM Program Committee monitors many of the items, a most responsible individual is designated by the AIC to monitor those outside of its domain (for instance this element, affiliation agreements and others).

1.3 MECHANISMS FOR FACULTY PARTICIPATION (FA-14)

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.

Finding of previous visit (2015):

A new faculty council has just been created, as part of governance reform, but its effectiveness remains to be determined.

Finding of current limited visit:

The medical school has effective mechanisms in place for direct faculty participation in decision making in the medical education program. There are many opportunities for faculty to participate in discussion about and the establishment of policies and procedures for the education program. The new Faculty Council has been operational for approximately one year. Interviews conducted at the site visit and review of meeting minutes indicated that this was functioning well.

Indicators to guide the evaluation of the above element:

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

Faculty are voting members in all standing committees for the Faculty of Medicine. This includes the MDCM Program Committee and its subcommittees. The only exceptions are for committees which are advisory (Faculty Leadership Commons and Directors of Professional Services Committee) and where decisions are made by consensus.

The process used to select faculty members for the standing committees includes both appointed and elected faculty members. Membership is often defined by virtue of the specific office held but some are elected to their positions.

The Faculty Council, which was approved in December 2015, met first in February 2016 and has broad representation that is independent of departmental leadership. There is representation of each unit, department, centre, professional program and also includes faculty, staff and students. There is a clear process for communication of available positions and nomination by peers from across the faculty. The minutes of Faculty Council meetings and discussion on site confirm that this is a highly functional committee although it is relatively new.

There are many ways in which faculty are made aware of proposed changes to the MDCM Program, its policies and procedures, and are given an opportunity to provide input. This includes the Faculty Council described above but also Town Hall meetings around specific issues such as change in admission criteria to the program and regular electronic communications. There are also many opportunities for faculty members to give feedback to the MDCM Program Committee, its subcommittees and through committees within specific clinical departments.

There are several general faculty meetings each year on site in the McIntyre Medical Building. There were three meetings in the academic year 2015-16 and two so far in 2016-17. The general faculty meetings include Faculty Council and Town Halls. Agenda and the outcomes of the meetings are distributed electronically. Questions and comments from any faculty member can be brought forward by a number of means such as through Faculty Council members or on the governance website.

The medical school has an effective system to inform faculty of important issues at the medical school. This is through a centralized electronic system with appropriate fan out through departments, centres and educational programs. Updates are electronically published at regular intervals and included in Med e-News.

1.4 AFFILIATION AGREEMENTS (ER-9)

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

- a) the assurance of medical student and faculty access to appropriate resources for medical student education*
- b) the primacy of the medical education program's authority over academic affairs and the education/ assessment of medical students*
- c) the role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching*
- d) specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury*
- e) the shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment that is conducive to learning and to the professional development of medical students*
- f) confirmation of the authority of the department heads of the medical school to ensure faculty and medical student access to appropriate resources for medical student education when those department heads are not also the clinical service chiefs at affiliated institutions*

Finding of previous visit (2015):

Affiliation agreements with some institutions do not contain all of the required components, and some are unsigned.

Finding of current limited visit:

Existing affiliation agreements with each institution contain the required components and are signed. A new province-wide template is being developed, but is not yet available for review. It is understood by faculty leadership that the required components will be included in this template. Current affiliation agreements will remain in effect until this province-wide agreement is implemented.

Indicators to guide the evaluation of the above element:

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The medical school has signed affiliation agreements with all clinical facilities at which medical students complete required learning experiences. These include inpatient experiences and apply to those sites which have longitudinal integrated clerkships. There are regional health authorities across Quebec which include one or more of the teaching sites with possible further consolidation predicted in future years. The hospitals include: Lachine Hospital, Montreal General Hospital, Montreal Children's Hospital, Royal Victoria Hospital, Douglas Mental Health University Institution, St. Mary's Hospital, Lakeshore General Hospital, LaSalle Hospital, Jewish General Hospital, Shriners Hospital, and the CSSS Gatineau.

The DCI appendix included each specific agreement with a table indicating the explicit language for a-e in the element. Moreover, the language for "f" is included in the language for "a" and our on-site meetings with department chairs confirm their authority over ensuring faculty and medical students access to appropriate resources for medical student education even when the department chair is not also the clinical chief at a site.

Our discussions at the site visit with the Dean, leaders from the clinical sites and Department Chairs indicate that the Minister of Health and Social Services is in the final stages of developing a province wide template for all four medical schools and all teaching sites. While the draft is still confidential, our interviews at all levels confirm that the template will be consistent with CACMS Standards and Elements (such as described directly above with the exception of "f", which has been removed in the CACMS Standards and Elements AY 2017-2018). The current affiliation agreements remain in effect, until the new template is signed by all parties and approved by the appropriate governing bodies.

2.6 *FUNCTIONAL INTEGRATION OF THE FACULTY (ED-41)*

At a medical school with one or more geographically distributed campuses, 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).

Finding of previous visit (2015):

Very few chairs/course directors have visited Gatineau in the last year. While the survey team noted substantial heterogeneity in levels of administrative attention and support, teaching time, and clinical exposure across all teaching sites, the noted issues at the Gatineau site were particularly acute. The program will need to undertake a comprehensive review of the program in Gatineau.

Finding of current limited visit:

The McGill MDCM Program does not have a geographically distributed campus but rather has a longitudinal integrated clerkship for an average of 12 students per year at the Gatineau (Outaouais) site, thus technically this standard does not apply. At the previous visit, the Gatineau site was included under the discussion of this standard. There was nonetheless evidence from many sources and especially interviews with leaders, faculty and students, that the Gatineau site is now functionally integrated with its Montreal counterpart.

Indicators to guide the evaluation of the above element:

- 2.6 a There are medical school policies or bylaws that assure the participation of faculty based at geographically distributed campuses in medical school governance (e.g., committee membership).
- 2.6 b Over the last two years, the principal academic officer(s) (regional/vice/associate/assistant dean or site director) at each campus or their designate have served as members 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 are minuted meetings (in person or audio/visual conference) or periodic visits to each campus at which the following 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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

Appropriate administrative mechanisms are in place to ensure functional integration. For instance, the Assistant Dean Medical Education Outaouais Region (Gatineau) is on the MDCM Program Committee. The terms of reference of Faculty Council and MDCM subcommittees all include at least one faculty member based on the Gatineau site.

Faculty from clinical departments are integrated at both the Montreal and Gatineau sites. All faculty members have a McGill email address. All Gatineau faculty members have access to McGill electronic resources and libraries. Annual retreats/site visits have been implemented in which course leaders and clinical department chairs visit the site. The retreat in May 2016 was viewed as very successful according to both the Montreal based chairs and the leaders of the Gatineau site. The next retreat is scheduled for May 2017. At the limited site visit, it was clear the faculty members and students were each aware of the complementary resources on each site.

The directors of required learning experiences at both the Gatineau and Montreal sites have been functionally integrated. The Gatineau clerkship directors are on the same Clerkship Component Subcommittee as those from the Montreal teaching sites. Members attend either in person or by videoconferencing.

Although the Gatineau site is not a geographically distributed campus, there are periodic visits (such as the Annual retreat) and a standing committee, the McGill Montreal-Outaouais Committee, to review numerous faculty and student issues. Required patient encounters and procedural skills are assessed in the same fashion at Montreal sites and the Gatineau site. Students rate the Gatineau experience at least as well as Montreal sites. Faculty performance on the Gatineau and Montreal sites are monitored by the academic department head and include student input.

3.3 DIVERSITY/PIPELINE PROGRAMS AND PARTNERSHIPS (IS-16 and MS-8)

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.

Finding of previous visit (2015):

IS-16: The school has a new definition of diversity and has developed interventions to improve the diversity of medical students and faculty. However the school's definition of low- socio-economic status is not in keeping with demographic data for the region. In addition, there remains significant under-representation in the student and faculty body of identified groups, including women in leadership positions, and aboriginal faculty. The commitment to diversity is variable across departments.

MS-8: The school is in the very early developmental phase for a number of pipeline programs and data on their effectiveness are not yet available.

Finding of current limited visit:

The school has redefined its definition of low socio-economic status.

The school has established pipeline programs for identified groups, but outcome data is only available for one of these groups (PNIQ). There are plans for future development of the pipeline program for students from rural backgrounds.

There is awareness of the diversity goals and processes in place to achieve the desired diversity outcomes, but the school has not yet achieved its diversity goals for identified groups among faculty, or senior and academic leadership groups. This will be a long-term outcome.

Indicators to guide the evaluation of the above element:

- 3.3 a The medical school in accordance with its social accountability mission has defined the various categories of diversity it wishes to achieve in its students, faculty and senior academic and educational leadership.
- 3.3 b The medical school engages in ongoing, systematic and focused recruitment activities to achieve mission-appropriate diversity outcomes among its:
 - i. students
 - ii. faculty
 - iii. senior academic and educational leadership
- 3.3 c The medical school engages in ongoing, systematic and focused retention activities to achieve mission-appropriate diversity outcomes among its:
 - i. students
 - ii. faculty
 - iii. senior academic and educational leadership

- 3.3 d The medical school monitors the diversity of enrolled students, employed faculty and senior academic and educational leadership in each of the school-defined diversity categories to measure its progress in achieving the desired diversity in these populations.
- 3.3 e The policies and practices, programs or partnerships used by the medical school aimed at achieving diversity among qualified applicants for medical school admission are appropriate to achieve the expected outcomes.
- 3.3 f The medical school evaluates and monitors the effectiveness of its policies and practices, programs or partnerships in achieving diversity among qualified applicants to the medical school.
- 3.3 g The medical school is moving toward the achievement of mission-appropriate diversity among its students, faculty and senior academic and educational leadership.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The medical school in accordance with its diversity mission has defined the various categories of diversity it wishes to achieve in its students, faculty and senior academic and educational leadership (Core Appendix C-6). The school has redefined its category of low socio-economic status to be in keeping with demographic data.

The medical school engages in ongoing, systematic and focused recruitment activities to achieve mission-appropriate diversity outcomes among its students, faculty and senior and educational leadership. In the fall of 2015, a new Office of Social Accountability and Community Engagement (SACE) was created. SACE is responsible for the development of programs across the continuum of medicine, from student recruitment to Faculty leadership. SACE functions to consolidate equity and diversity activities within the Faculty, including expertise, data collection, and implementation of best practices.

An annual report, generated from data collected on the diversity of incoming MDCM students, is submitted by the SACE to the Widening Participation Committee (WPC). The WPC suggests policy change and pipeline program development. Pipeline programs exist for 3 of the 4 identified groups. There are plans for future development of pipeline programs for students from rural backgrounds.

The school is creating a Faculty Equity Committee to enhance the identified University diversity groups among faculty. There is an appropriate policy to guide Search Committees for Academic Hires.

The Assistant Dean Academic Affairs is mandated with improving diversity in leadership. She is also charged with developing the Faculty's mentoring mandate, in particular, by encouraging qualified mid-career women to take on positions as Chairs and Directors. Search Committees for a new Chair or Director are educated on best practices to assure equity and diversity in hiring. Data on the effectiveness of these measures are not yet available.

The medical school does not appear to engage in ongoing, systematic and focused retention activities to achieve mission-appropriate diversity outcomes among its students, other than for aboriginal students.

However, for faculty, an Assistant Dean Academic Affairs was appointed in March 2016 as part of an approach to develop a working environment that is conducive to faculty retention. For senior academic and educational leadership, a similar approach was taken as for other faculty, as well as targeted mentoring.

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.

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. Further programs need to be developed to enhance recruitment of students from rural backgrounds.

Appropriate medical school entry data are available only for the PNIQ Indigenous students' pipeline program which has operated since 2008. Pipeline programs for the other target groups [students from families with low family income, Black students] were implemented only in 2012. This data should be available in the next few years.

The medical school states that target representation is being met for each of its four school-identified student diversity categories. The SACE interpretation of data from the Entry Survey of Admitted Students to the MDCM Program [up to the incoming class of 2015- Analysis updated July 25, 2016] is that there has been progress in recruiting Black (█████, 4.8%, 3.5% of the incoming classes of 2013, 2014, 2015 respectively) and Indigenous [████████████████████] in the classes of 2013, 2014, 2015 respectively] students but that efforts must be sustained.* For students with lower socio-economic status, some progress has been made in recruitment but more progress is required. The Faculty of Medicine has redefined the category of students coming from a lower socio-economic status as those students who self-identified as coming from a household in which the yearly family earnings are \$0-\$49,999 [the previous definition was yearly family earnings below \$100,000]. Students falling within the newly defined socioeconomic category comprised 19.7%, 15.2% and 21.8% of the incoming classes of 2013, 2014 and 2015 respectively. The WPC [Widening Participation Committee] has identified two significant barriers in rural recruitment that are specific to McGill: 1) The language of instruction at McGill is primarily English and there is a much greater Francophone rural population in Quebec; and 2) More than 90% of MDCM positions are designated for within province candidates therefore recruiting rural candidates from other provinces is not a viable solution. With the planned development of the Gatineau site, McGill sees increasing rural enrollment as a long-term goal. The medical school has not yet moved past the faculty demographics of 2015 toward the achievement of mission-appropriate diversity among its aboriginal faculty and senior academic and educational leadership. Aboriginal faculty represent █████ of all faculty and 0.2% of academic and educational leadership.* Data were not provided for the previous 3 years, only for 2016 [Faculty Diversity Survey 2016]. The Faculty has identified the diversification of leadership with respect to gender as a priority. 23.7% of academic and educational leaders are women [2016 data only provided]. In 2015, the school reported 14% of the department chairs were women (Core Appendix 2015, Appendix L, page 53). However, at the time of the 2017 limited site visit, there was only one female department chair out of 23 chairs. Following the visit, the team was informed that this is unchanged since the 2015 accreditation visit and that there was only one female department chair in February 2015 (direct correspondence from Dean Eidelman following review of the draft report of the limited site visit).

The proportion of women is much higher at the decanal level [71%].

* Please note that percentages and numbers have been redacted for student and faculty groups of 5 individuals or less to protect confidentiality.

See also: Supplemental Appendices

Widening Participation Committee 2015 Report (S1)

Entry survey of admitted students to the MDCM Program – An analysis of the diversity of undergraduate medical students 2016 update (S2)

3.5 **LEARNING ENVIRONMENT/PROFESSIONALISM (MS-31-A)**

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*

Finding of previous visit (2015):

Several of the major teaching hospitals are just starting to implement processes to identify and fix systemic problems in the learning environment. Some Directors of Professional Services identify a culture in the hospitals that makes this challenging. The Dean or one of his delegates is not a member of the joint Hospital-University Directors of Professional Services committee.

Finding of current limited visit:

The school has made significant progress in meeting the requirements of this element.

The Associate Dean UGME is now a member of the joint Hospital-University Directors of Professional Services Committee. The Assistant Dean Student Affairs presents data on the learning environment to the MDCM Program Committee twice per year on behalf of the WaLE [Wellness and Learning Environment] Subcommittee. In order to synthesize and integrate all perspectives in the evaluation of the learning environment and in the implementation of initiatives, a new committee has been struck: the Learning Environment Advisory Panel (LEAP), chaired by the Vice Dean Education, with the first meeting held in January 2017. The LEAP will provide a venue for formal discussions about issues affecting the learning environment.

Work has begun on improving the culture in hospitals that, as cited in the 2015 survey, previously made a change in the learning environment difficult. There was evidence at the visit of widespread awareness and efforts to resolve these issues.

Indicators to guide the evaluation of the above element:

- 3.5 a The medical school has defined the professional attributes (behaviors and attitudes) that medical students are expected to develop.
- 3.5 b These expected professional attributes are effectively communicated to faculty, residents and others in the medical school and clinical learning environments.
- 3.5 c The medical school and its clinical affiliates collaborate in the periodic evaluation of the learning environment using appropriate methods, and share the results of these evaluations to identify positive and negative influences on the development of medical students' professional attributes, especially in the clinical setting.

- 3.5 d The medical school and its clinical affiliates have implemented appropriate strategies to a) enhance the positive influences and b) mitigate the negative influences on medical students' development of the expected professional attributes.
- 3.5 e The medical school and its clinical affiliates identify and promptly correct violations of professional standards in the learning environment.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The medical school has defined the professional attributes that medical students are expected to develop. These attributes are outlined in the Faculty of Medicine's Code of Conduct (<https://www.mcgill.ca/medicine/about/our-vision-mission-values/code-conduct>). The latter applies to faculty and staff as well as learners.

For students, the Code of Conduct is introduced on the first day of medical school and revisited regularly in the Physicianship component of the curriculum which is taught in all four years. The Academic Affairs Office (AAO) ensures that faculty members are aware of expectations for professionalism from the time of hire. The Code of Conduct is sent to new faculty in their letter of offer, and as of 2015, is reinforced annually at the time of the annual Academic Performance Evaluation.

To facilitate collaboration between the medical school and its clinical affiliates, the Associate Dean UGME is now a member of the joint Hospital-University Directors of Professional Services Committee. As well, the Faculty of Medicine has improved collaboration between members of the educational/academic leadership and clinical partners to address problems identified in the learning environment. To change the perception of general tolerance of mistreatment [on which culture is based] in many clinical settings, the Faculty has identified the most responsible person for addressing problems in the specific learning environment. These most responsible persons are members of the educational and academic leadership and clinical partners. They have worked together over the last year to align processes for dealing with breaches of professionalism, investigating and rectifying problems.

Students have the opportunity to evaluate the learning environment in their evaluations of courses and teachers. The evaluations are consolidated within the WELL [Wellness Enhanced Lifelong Learning] Office. The WELL office [previously named the Office of Student Affairs] will thus be able to identify which courses at specific teaching sites are most problematic. The Assistant Dean Student Affairs collates and presents this data on the learning environment to the MDCM Program Committee [which is the new "curriculum committee" overseeing all aspects of the curriculum] twice per year on behalf of the WaLE [Wellness and Learning Environment] Subcommittee. As well, in order to synthesize and integrate all perspectives in the evaluation of the learning environment and in the implementation of initiatives, a new committee has been struck: the Learning Environment Advisory Panel (LEAP), chaired by the Vice Dean Education, with the first meeting held in January 2017. The LEAP (Supplemental Appendix 3) will provide a venue for formal discussions about issues affecting the learning environment.

The faculty has taken a proactive approach to encouraging and teaching professionalism in order to enhance positive elements in the learning environment, as identified in student feedback. Formal training for faculty in professionalism skills is available through two routes: faculty development open to all

faculty and the targeted Faculty Development Program for Osler Fellows. [The Osler Fellows are a group of practicing physicians and faculty members who are recruited to teach a four-year medicine course called Physician Apprenticeship (PA). The program focuses on the dual role of the physician as healer and professional and explores issues like professionalism and the need to promote a patient-centered approach to learning.]

To mitigate negative elements of the learning environment, as identified through student feedback, the Associate Dean UGME takes serious action [as warranted] to address the issues. Disruptive sites or departments are signaled to Faculty leadership. Collaboration between the Academic Affairs Office and the Faculty Development Office has led to tailored and innovative interventions for these departments. Department Chairs have been fully engaged and co-operative. Attendance of departmental faculty at these faculty development sessions has been obligatory.

The medical school and its clinical affiliates have worked together over the last year to align processes for dealing with alleged breaches of professionalism. The Faculty of Medicine Learner Mistreatment Process was most recently revised in August 2016. The companion procedures documenting how the Academic Affairs Office approaches faculty with alleged breaches was approved in September 2016, and how PGME approaches residents with alleged breaches was approved in October 2016. The most recent change to ensure anonymity of reporting by students was completely implemented in January 2017.

The Learning Environment Advisory Panel is using a multi-pronged approach to sensitize students, residents, faculty, academic leaders and hospital staff across university and hospital settings to the reality of a zero-tolerance policy toward mistreatment.

There was evidence at the visit of widespread awareness and efforts to resolve these issues.

See also: Supplemental Appendix
LEAP Terms of Reference (S3)

3.6 STUDENT MISTREATMENT (MS-32)

A medical school defines and publicizes its code of conduct for faculty-student relationship in its medical education program, develops effective written policies that address violations of the code, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing inappropriate behaviors. Mechanisms for reporting violations of the code of conduct (e.g., incidents of harassment or abuse) are understood by students and ensure that any violations can be registered and investigated without fear of retaliation.

Finding of previous visit (2015):

The school has engaged in a comprehensive plan to address mistreatment of students and progress is being made. Nevertheless, students continue to report a lack of confidence to report mistreatment due to fear of reprisals and fear of lack of anonymity/confidentiality. Students cite examples of breaches of anonymity. Students are not informed systematically about outcomes of their complaints.

Finding of current limited visit:

The school has made significant progress in meeting the requirements of this element.

Student mistreatment was “top of mind” for education and clinical leaders. Students are clearly aware of processes and opportunities to report issues. Attention to student anonymity has improved the reporting process. A systematic process to inform students about outcomes of their complaints has recently been implemented and was apparent to students in years 3 and 4. Many of the steps taken to address allegations of student mistreatment have been recently implemented, thus there is insufficient time for this to be reflected in the student reported rates of mistreatment.

Indicators to guide the evaluation of the above element:

- 3.6 a There is a defined and published code of conduct addressing the faculty-student relationship and student mistreatment.
- 3.6 b There are formal policies or procedures for responding to allegations of medical student mistreatment including the venues for reporting and mechanisms for investigating reported incidents.
- 3.6 c Medical students, residents, faculty responsible for required learning experiences and those who teach or assess medical students and other individuals who interact with students in the medical school or clinical environment are informed about the medical school’s standard of conduct in the faculty-student relationship and about medical student mistreatment policies.
- 3.6 d Mechanisms for reporting and investigating incidents of mistreatment protect students from retaliation.
- 3.6 e Medical students are informed of the procedures for reporting mistreatment and investigating reported incidents in a way that protects them from retaliation.
- 3.6 f Data from the AAMC CGQ, and the AFMC GQ or internal data collected by the medical school show that the majority of respondents agree/strongly agree that they are aware of the school’s policies regarding student mistreatment.

- 3.6 g Data from the AAMC CGQ, the AFMC GQ or internal data collected by the medical school show that the majority of respondents agree/strongly agree that they know the procedures for reporting student mistreatment.
- 3.6 h Allegations of student mistreatment are investigated and resolved in a timely manner.
- 3.6 i AAMC CGQ, and AFMC GQ data student mistreatment data and other reports of mistreatment collected by the school are reviewed by individuals/committee(s) in the medical school and clinical learning environments with the authority to take steps to reduce the level of mistreatment.
- 3.6 j The medical school monitors the reasons why students do not report mistreatment and has taken steps to reduce barriers to reporting.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The medical school has a well-developed Code of Conduct that is communicated to faculty, staff, and learners, and is available on the Faculty of Medicine website. Students were clearly aware of the Faculty of Medicine Learner Mistreatment Process. It is disseminated to faculty, residents and other individuals who interact with students. There is a clear algorithm and an online mechanism for students to follow. Course and preceptor evaluation forms include a question regarding mistreatment. Students are directed to a secure website should they wish to report an incident of alleged mistreatment. Students from all 4 years answered the survey team’s questions openly and candidly during the site visit. They stated that attention to anonymity has given them increased confidence in reporting such incidents. Students also expressed to the survey team that they felt confident that the reporting procedures protect them from retaliation.

A systematic process to inform students about outcomes of their complaints [in aggregate form] has been implemented [Our UGME sessions, “You said we did…” e-bulletin] and was apparent to students in years 3 and 4. It was very clear at the visit that decreasing student mistreatment is a top priority for education and clinical leaders.

AAMC CGQ, and AFMC GQ student mistreatment data and other reports of mistreatment collected by the school are reviewed by the Assistant Dean Student Affairs who is also the Chair of the WaLE [Wellness and Learning Environment] Subcommittee. The Assistant Dean refers her findings to the WaLE Subcommittee. This subcommittee’s recommendations then go to the MDCM Program Committee and from there, on to the Learning Environment Advisory Panel.

Many of the steps taken to address allegations of student mistreatment have been recently implemented, thus there has been insufficient time for this to be reflected in the student reported rates of mistreatment. However, during the visit, students expressed confidence that, if a complaint of alleged mistreatment is made, there is a process acceptable to them that will be followed.

See also: Supplemental Appendices

Learner Mistreatment Process Flowchart (S4)

WELL Office summary data of internal tracking of mistreatment rates and sources (January-December 2016) (S5)

4.5 FACULTY PROFESSIONAL DEVELOPMENT (FA-4)

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.

Finding of previous visit (2015):

The Gatineau campus does not have comparable faculty development opportunities for preceptors to the central (Montreal) campus offerings.

Finding of current limited visit:

The Faculty of Medicine provides many opportunities for professional development to all of its members to enhance teaching and leadership skills. This includes areas such as student assessment, curricular design and instructional methods. There are also opportunities for faculty development in program evaluation and research. At the previous visit it was noted that while these opportunities were available at the Montreal sites they were not available at the Gatineau site. It also bears repeating that the Gatineau site is not a distributed campus but rather a teaching site for the longitudinal clerkship for approximately 12 students. In each of the subcomponents there is evidence to support the improvement of availability of resources for faculty at the Gatineau site which is described below.

Indicators to guide the evaluation of the above element:

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

There are individuals with requisite expertise and dedicated time to assist faculty to develop and improve teaching and student assessment skills. At the Faculty level, there is an Associate Dean Faculty Development who oversees faculty development for all the educational programs within the Faculty of Medicine.

At the UGME level there are two academic leads who oversee it for the MDCM Program. This includes the Director of Faculty Development (0.2 FTE) and the Director of the Osler Fellowship Program (0.2 FTE). A number of the departments have experts in faculty development. For instance, in the Department of Family Medicine, there is a Director of Faculty Development and a lead for each of the six academic sites including one at Gatineau.

The school identifies faculty development needs at a variety of levels. A needs assessment survey was sent to all faculty members in 2015 although the response was low (7%). Student feedback from One45 is used to determine faculty development needs. The Associate Dean Faculty Development also conducted semi-structured interviews with all department chairs in 2015 to assess needs and then to plan specific outreach to individual departments.

Faculty at all teaching sites and specifically at the Gatineau site are aware of faculty development activities. There is an annual Faculty Development Series for New Faculty Members and faculty are aware of it from their offer letters. There is also a biannual Orientation Workshop and the last one was held in October 2016. The Academic Affairs Office and Communications Office inform all faculty members about upcoming events and available resources. This includes faculty members at the Gatineau site.

In addition, there were specific workshops held at the Gatineau site after a needs assessment was performed. The last workshop was held in November 2016 with another one scheduled for March 2017.

Through continuous feedback from student evaluation, faculty members are made aware of their teaching and assessment strengths and weaknesses. Any problems are discussed at the Annual Performance Evaluation between the faculty member and Department Chair. The Chair decides on what remediation needs to be done and uses resources at the Faculty Development Office. A successful example was a half day workshop held at the Steinberg Centre for Simulation and Interactive Learning to address concerns in the Department of OB/GYN. There were 42 participants. Other workshops offered to faculty members to address problems include: Giving Effective Feedback, Teamwork, an Optimal Learning Environment, and Teaching in an Ambulatory Context. The programs are validated for effectiveness through the Assessment and Evaluation Unit at McGill which has three members with expertise in curriculum development and program evaluation.

The Centre for Medical Education has expertise and formal programs offered to faculty members in the MDCM Program to enhance research skills. These include seminars on grant applications, manuscript and grant peer review and research methodology.

There are a number of specific programs to assist faculty members to prepare for promotion. This includes an Orientation Workshop for all new faculty hires. The McGill Association of University

Teachers also offers an annual workshop on promotion and tenure. McGill Teaching and Learning Services holds a biannual workshop for promotion of non-tenured faculty. The last one was held at the end of January. A formal session “Preparing Your CV for Promotion” was also give in July 2016 by the Vice Dean Academic Affairs.

As noted above there were a wide variety of faculty development programs in a number of formats: online, seminars, workshops with good attendance. As noted a number of these were tailor made and held at the Gatineau site.

5.6 CLINICAL INSTRUCTIONAL FACILITIES/INFORMATION RESOURCES (ER-7)

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.

Finding of previous visit (2015):

Some of the hospitals affiliated with the medical school have inadequate infrastructure resources such as locker facilities, general Wi-Fi access and call rooms.

Finding of current limited visit:

The school has made progress toward meeting the requirements of this element.

A clear process has been implemented to ensure that there are sufficient information resources and instructional facilities for medical student education at each site. Wi-Fi has very recently been made available at all clinical sites, however, students report that they do not yet have passwords for LaSalle or St. Mary's sites. Administrative staff indicated that Wi-Fi access for students at these two sites was very recently implemented.

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The school has developed and implemented the UGME Clinical Facilities and Resources Policy and its companion Clinical Facilities Checklist. This checklist was implemented for the first time in May 2016 and a report presented to the MDCM Program Committee in September 2016. Site visits have started in October 2016 with reports reviewed in January 2017. Minutes from this meeting and site visit reports were provided and indicated detailed notation of resources including action plans to resolve identified issues. At the time of the site visit, administrative staff told the review team that Wi-Fi access had very recently been made available at the LaSalle and St. Mary's sites; however, students reported that they did not yet have passwords for this access.

Internal data provided indicates that the majority of year 3 students (67-100%) indicate adequate space is available in ambulatory clinics and that the majority (50-86%) considers education/teaching space to be adequate at each site. Internal data provided indicates that 50% or fewer of year 3 students were satisfied with access to information resources at 3 sites.

See also: Supplemental Appendices:

Screen Shot DCI 5.6-1 MEE Amb Space (S6)

Screen Shot DCI 5.6-1.1 MEE Ed&Teaching Space (S7)

Screen Shot DCI 5.6-1.2 MEE IR (S8)

Additional info Minutes – UGME Operations Committee January 16 2017 (S9)

Additional info Site visit report CIUSS Ouest Ile LaSalle (S10)

Additional info Site visit report CIUSS Ouest Ile SMH (S11)

Additional info Site visit report JGH (S12)

Additional info Site visit report MUHC Glen (S13)

5.8 LIBRARY RESOURCES / STAFF (ER-11)

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.

Finding of previous visit (2015):

Access to libraries at some of the affiliated hospitals is problematic (limited hours) and Wi-Fi is not available.

Finding of current limited visit:

The issues identified in the previous visit relate mainly to the internet access issues cited in element 5.6. Library resources appear sufficient and are actively used by students. Students report access to a wide variety of electronic resources. Students reported that leadership is working to increase in-person opening hours for the main library site, however, there is 24-hour access in an adjacent library. All clinical sites provide access to local libraries with in-person and/or electronic access after regular opening hours.

Indicators to guide the evaluation of the above element:

- 5.8 a Data from the AAMC CGQ and the AFMC GQ show that the majority of students at each campus are satisfied/very satisfied with the library.
- 5.8 b School-reported data shows that the majority of students at each campus are satisfied/very satisfied with ease of access to the library resources and holdings (includes virtual access both on and off campus).
- 5.8 c Medical students and faculty have access to electronic and other library resources across all instructional sites both on and off campus, including geographically distributed campuses.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

Data provided shows 68.3-90.6% of students were satisfied/very satisfied with the library. A drop was observed for the Class of 2016, however, at the site visit, students indicated there had been no specific decrease in services available, but rather expressed high satisfaction with current services.

Data provided shows that the majority (50-100%) of students at each site are satisfied/very satisfied with their access to library resources. Sites with lower ratings likely reflected the Wi-Fi issue discussed in element 5.6. All clinical sites provide access to local libraries with in-person and/or electronic access after regular opening hours. During the visit, students indicated that communication regarding access to these resources has improved. Medical students and faculty have access to electronic and other library resources using their McGill credentials regardless of physical location.

5.11 STUDY / LOUNGE / STORAGE SPACE / CALL ROOMS (ER-7)

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.

Finding of previous visit (2015):

Some of the hospitals affiliated with the medical school have inadequate infrastructure resources such as locker facilities, general Wi-Fi access and call rooms.

Finding of current limited visit:

A clear process has been implemented to ensure that there are sufficient facilities for medical student education at each site. Students have lockers/secure storage space at all clinical sites. Call rooms are available at all sites that require overnight call. One site has plans to improve the call room over the upcoming year. Revised relaxation space and private room is appreciated by the students. Discussion at the site visit indicates that the lower ratings for satisfaction with relaxation space likely did not reflect the current facility.

Indicators to guide the evaluation of the above element:

- 5.11 a Data from the AAMC CGQ, the AFMC GQ and school-reported data show that the majority of respondents at each campus are satisfied/very satisfied with the adequacy/availability of relaxation space at the medical school.
- 5.11 b School-reported data show that the majority of respondents at each campus are satisfied/very satisfied with storage space at clinical facilities used for required learning experiences.
- 5.11 c 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 d School-reported data show that the majority of respondents at each campus are satisfied/very satisfied with on-call rooms for required clinical learning experience.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The school has developed and implemented the UGME Clinical Facilities and Resources Policy and its companion Clinical Facilities Checklist. This checklist was implemented for the first time in May 2016 and a report presented to the MDCM Program Committee in September 2016. Site visits have started in October 2016 with reports reviewed in January 2017. Minutes from this meeting and site visit reports were provided and indicated detailed notation of resources including action plans to resolve identified issues.

Data provided shows 60-75.6% of students from Classes of 2014-2017 were satisfied/very satisfied with

relaxation space. However, discussion with students at the site visit indicated these data were collected prior to completion of recent renovations. Students expressed appreciation for the improvements made to their current facilities.

Data provided shows 50-88% of students from Class of 2017 were satisfied/very satisfied with storage space at clinical sites. Improvements in this area were confirmed by students during the site visit and were specified in 3 of the 4 reports from the recent visits to clinical sites (Jewish General, Glen, and St. Mary's Hospitals).

The DCI narrative indicates that data provided in the DCI (DCI table 5.11-4) regarding student satisfaction with call rooms is difficult to interpret due to low response rate and sites are included in the table that do not require overnight call. Thus this information was not used by the survey team, but rather further information was requested (see supplemental appendix) and at the site visit, it was confirmed that call rooms are available for students at all sites that require overnight call. One site (St. Mary's Hospital) has plans to improve the call room over the upcoming year.

See also: Supplemental Appendices

- Additional info Minutes – UGME Operations Committee January 16 2017 (S9)

- Additional info Site visit report CIUSS Ouest Ile LaSalle (S10)

- Additional info Site visit report CIUSS Ouest Ile SMH (S11)

- Additional info Site visit report JGH (S12)

- Additional info Site visit report MUHC Glen (S13)

- Screen Shot additional info call rooms (S14)

6.1 PROGRAM AND LEARNING OBJECTIVES (ED-3)

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.

Finding of previous visit (2015):

At the site visit, the majority of medical students interviewed were not aware of the overall education program objectives.

Finding of current limited visit:

The school has defined program objectives that are competency based and align with national standards. These are effectively communicated to students, faculty and residents across all sites.

Indicators to guide the evaluation of the above element:

- 6.1 a The medical education program objectives are made know to all medical students and faculty members with leadership roles in the medical education program and others with substantial responsibility for medical student education and assessment.
- 6.1 b The learning objectives of each required learning experience are made known to all medical students and those faculty, residents and others with teaching and assessment responsibilities in those required learning experiences.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The program has enacted a multifaceted process to ensure learners, residents and faculty receive and are prompted to review outcome objectives in advance of a learning session. Program objectives are based on Canadian standards of medical education that are competency and evidence based. All sessional objectives are mapped to these outcomes and are outlined to learners in advance of individual learning sessions. The objectives have been reviewed by the MDCM Program Committee in the past year.

Documents reviewed and interviews undertaken confirm learners are aware of overall program objectives from verbal and electronic strategies of communication starting on Day 1 of the program and continuing in all courses in Years 1, 2, 3 and 4. Learners are prompted, when opening a session in the curriculum electronic management program, to review sessional objectives prior to accessing sessional materials. There is a prompting screen at the start of material for each session. At the site visit, student interviews confirmed this to be extremely useful for student learning and communicating the objectives. Lecture

material and some faculty presenters provide secondary reinforcement with prompting in slides and verbal messaging of session objectives.

A consistent and robust multi-faceted approach to distribute sessional objectives to faculty and resident educators is in place, the viability confirmed with sessional disclosures and submitted materials. This system is mostly electronic using a communication strategy of some face-to-face, mostly e-mail and the school electronic learning database. This practice is consistent across courses and years of the curriculum.

During the site visit, there was strong support by the faculty leadership and educators, residents and students (all years) of the program objectives, their origin and the utility on guiding student learning and assessment.

See also: Supplemental Appendix
MDCM Program Objectives (S15)

6.2 **REQUIRED CLINICAL LEARNING EXPERIENCES (ED-2)**

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.

Finding of previous visit (2015):

The school has established specific criteria for the types of patients that students must encounter and the appropriate clinical settings needed for students to meet the learning objectives for clinical education. However, the level of student responsibility is unclear for the majority of patient encounters. This is a recurrent issue.

Finding of current limited visit:

The school has defined a list of required clinical learning experiences. Documentation provided to the survey team on site and student report at the site visit confirmed the list includes the clinical setting, level of responsibility, patient type, and numbers of encounters for conditions and skills.

Indicators to guide the evaluation of the above element:

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The Program has created a list of required patient encounters and clinical skills, classified by courses in Clerkship and the Transition to Clinical Practice (TCP) course with levels of performance and location of completion. The documents in the DCI did not clearly document the type of patient for each entered encounter, however there was clear documentation of the clinical setting, conditions, skills, procedure and level of responsibility. On request for clarification, the program provided supplemental documents that outlined the patient type for each condition or skill/procedure in Year 2, 3, and 4 required clinical learning. There is strong documentation that the required clinical learning experiences were reviewed and approved by the MDCM Program Committee and its relevant course and governance committees in the past academic year. This list directs the student and faculty to the clinical location, level of involvement for the required experience, and mapping of skill/condition to program and Medical Council of Canada objectives.

The program provided in the site visit documents that are complete and clear on the required clinical learning experiences in TCP and Clerkship. These meet the requirements of the element. (Supplemental Appendices S-16 and S-17) The required clinical learning experiences list has five levels of responsibility starting with “Know “and ending in “Does Independently.” There is broad awareness of responsibility for each level.

The table submitted for this element in the DCI was clarified at the site visit. There was strong verbal support from learners and faculty of awareness and understanding of all aspects of required experiences. To validate the actual tool, a member of the CACMS Accreditation site visit team took time to independently review the actual electronic version of the table (submitted in the DCI) with a senior program student. The electronic format uses software from the school and is clear, easy to navigate, and simple to complete with prompting on the numbers of encounters left to complete in future sessions. There is no confusion on tasks to complete and the details of each category.

There was discussion in the site visit sessions on clarifying the Levels of student responsibility in decanal, faculty and student interviews. While the program table “Levels 1-3” are clear and relevant, the title of “Level 4” cites: “Does Independently.’ There are a few hints of confusion of that in submitted documents. On-site interviews confirm consistency by faculty and learners in the content and process of completion for a “Level 4” task. While it is clear to all that “Level 4” means completion under indirect supervision and requires review before completion, the terminology is nonetheless potentially misleading. Unlike the other levels, “Level 4” is mentioned in student and faculty groups as not requiring faculty to be with the student through the early parts of the interview/intervention. All encounters in this category fit with being reasonable for students to see initially under indirect supervision and then reviewed with direct supervision with the patient. It would be helpful to reword “Level 4” to avoid future learner and faculty confusion.

Students cite strong faculty support early in required clinical learning experiences to plan for and complete tasks. While most are planned for completion with actual patient care, the program has created a strategy of a variety of simulation processes to accommodate completion challenges, which are cited as mostly due to climactic or seasonal variability of patient exposure.

Data reviewed support completion rates of 100 % in all Year 2 and 4 courses this academic year. In the Clerkship courses, there were totals of 1-4 encounter logs not completed on time at course conclusion in Surgery, Paediatrics, Obstetrics & Gynecology, Psychiatry and Family Medicine across all sites. All were documented as complete after Program follow-up. Those students who have challenges with completion, completed an encounter in a supplemental session in clinical care or using simulation. There were various reasons provided for the course outlier data citing non-completion as arising from faculty and learner causes. This is improving with program intervention.

See also: Supplemental Appendices

Clinical learning experiences TCP (S16)

Clinical learning experiences Clerkship (S17)

6.6 SERVICE-LEARNING (IS-14-A)

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.

Finding of previous visit (2015):

The new curriculum has just recently instituted a mandatory service-learning component for students, and made sufficient opportunities available. Effectiveness data are not yet available.

Finding of current limited visit:

The school has created an effective service learning experience delivered as a required course in Year 2. The experience has program support, learner assessment and evaluation of outcomes. This experience effectively partners with a variety of local agencies and processes aligned with social accountability.

Indicators to guide the evaluation of the above element:

- 6.6 a There are opportunities for medical students to participate in service-learning activity during their tenure as a student.
- 6.6 b School-reported data show that the 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 activities.
- 6.6 d The medical school supports student participation in a service learning activity (e.g., coordination of student placements, development of opportunities in conjunction with community partnerships or provision of financial support).

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

Since the past site visit, the school and program has implemented a mandatory service-learning requirement in Year 2 – Community Health Alliance Program (CHAP) that is integrated with other curricular learning on diversity and the social determinants of health. The creation of this course arose by innovating from a past well established and highly valued student-led service learning experience to a full year longitudinal course. The CHAP course offers objectives mapped to program objectives, a variety of robust assessments, faculty mentoring, preparation sessions, staff support, effective learning evaluation and a mix of learning – mostly in small group – project based learning. The course content and outcome data have been reviewed, approved and monitored by the MDCM Program Committee.

Documents and interview data confirm the service learning requirement by the CHAP course is supported adequately with a faculty leader and program staff support. While the staff support is adequate, there is a suggestion the faculty leader time demands exceed that outlined in the job description. This may improve

as the course matures and could mirror a phenomenon seen in other new mandatory curricular experiences. The program is monitoring this.

The CHAP student groups are centrally reviewed and reflect working with a broad variety of partner organizations or groups in the city of Montreal. These are described in data provided as diverse in culture, language, population and interpreted as offering a scope that is broad and inclusive. Evaluation data support 62% of students agreeing this course meets objectives, with 21% neutral. The community placement was cited as providing flexibility for learning by 71%; 63% stating adequate pre-departure training was provided; and by 60% of the class as providing population experience. Student concerns expressed in surveys (44% indicating this was an “excellent course”) were probed in site interviews and appear to be anchored in a group of students not seeing the relevance to their careers. Some students state they have done this type of process prior to program matriculation. In the experience of the team, this is a common barrier seen in other schools and is being addressed by the program. This is not a large voice, as over 88% of students were satisfied with the community placement, 64% state the time spent was adequate, and 60-70% agreed with five quality outcome measures of course content and delivery. The need for additional course support is being assessed by the program as a course improvement issue.

The program has further supported the service learning experience with a choice of pre-arranged choices, the option of learners arranging their own partnership, a prize for the top projects and course material to guide student success and address risk.

The CHAP course has been in place for less than 2 years and the outcome data on integration with other courses, small group delivery and partner involvement is at an early stage. Annual review and improvement of the course to date, has shown meaningful adoption. The outcome data from this Year 2 cohort was not available to analyze.

7.1 BIOMEDICAL, BEHAVIORAL, SOCIAL SCIENCES (ED-10)

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

Finding of previous visit (2015):

Over the past 5 years, on the CGQ, students have reported inadequate instruction in pain management (42.7% in 2014), health care system and policy (50.0 and 47.1% respectively in 2014), behavioral sciences (35.5% in 2014), human sexuality (47.4% in 2014) and complementary medicine (39.5% in 2014).

Finding of current limited visit:

The content areas listed in DCI tables for this standard are included in the revised curriculum, implemented for the Class of 2017. Internal survey data indicates significant improvement in these areas compared with CGQ and GQ data for Classes of 2014-2016.

Indicators to guide the evaluation of the above element:

- 7.1 a The topics listed in Table 7.1-2 of the DCI are taught and assessed in the curriculum either as an independent required learning experience, or integrated in a required learning experience(s).
- 7.1 b Data from the AAMC CGQ and the AFMC GQ in Table 7.1-1 of the DCI show that the majority of respondents believe that their instruction in each of the listed issues in social sciences of medicine was appropriate or excessive.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The topics listed in the DCI are taught and assessed in the pre-clerkship and clerkship years. At the site visit, the team was provided with evidence of specific curriculum mapping of various topics including health care systems, health policy and complementary and alternative medicine.

CGQ and GQ data for classes of 2014-2016 provided in the mini-DCI table 7.1-1 does not reflect the revised curriculum (implemented for the Class of 2017). Internal data presented in mini-DCI table 7.1-2 shows that the majority of students in Classes of 2017 (63-93%) and 2018 (53-87%) believe their instruction in pain management, health policy, behavioral sciences, human sexuality and complementary medicine was now appropriate or excessive. This represents a marked improvement, particularly considering the timing of the survey (students in years 2 and 3 of the revised curriculum at the time of survey). Additional instruction of these topics, and most instruction in complementary and alternative medicine is offered in year 4. Note was made that the low response rate (33%) for the Class of 2018 limits the interpretation of data for this year.

See also: Supplemental Appendices

Screen Shot DCI 7.1-1 Soc Sci 2014-2016 (S18)

Screen Shot DCI 7.1-1.1 Soc Sci 2017-2018 (S19)

7.5 SOCIETAL PROBLEMS (ED-20)

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.

Finding of previous visit (2015):

Over the past 5 years, on the CGQ, students have reported inadequate instruction in women's health (range 23.9% to 24.5%) and family and domestic violence (range 51.5% to 59.1%). There has been no discussion on this particular topic at the new curriculum executive level.

Finding of current limited visit:

The content areas listed in DCI tables for this standard are included in the revised curriculum, implemented for the Class of 2017. Internal survey data indicates significant improvement in these areas compared with CGQ and GQ data for Classes of 2014-2016.

Indicators to guide the evaluation of the above element:

- 7.5 a The curriculum includes instruction and has relevant learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of domestic violence/abuse.
- 7.5 b The curriculum includes instruction and has relevant learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting (if relevant), and treatment of the medical consequences of women's health.
- 7.5 c Data from the AAMC CGQ, the AFMC GQ and school-reported data in the DCI show that the majority of respondents believe that their instruction in domestic violence/abuse and women's health was appropriate or excessive.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The topics of domestic violence/abuse and women's health are taught and assessed in the pre-clerkship and clerkship years. At the site visit, the team was provided with evidence of specific curriculum mapping of various areas including domestic violence.

CGQ and GQ data for classes of 2014-2016 provided in the mini-DCI Table 7.5-1 does not reflect the revised curriculum (implemented for the Class of 2017). Internal data presented in mini-DCI Table 7.5-2 show that the majority of students in the Class of 2017 (77-82%) believe their instruction in family/domestic violence and women's health was now appropriate or excessive. This represents a marked improvement. Note was made that the low response rate (33%) for the Class of 2018 limits the interpretation of data for this year.

See also: Supplemental Appendices

Screen Shot DCI 7.5-1 Soc Probs 2014-2016 (S20)

Screen Shot DCI 7.5-1.1 Women's Health 2017-2018 (S21)

7.7 MEDICAL ETHICS (ED-23)

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.

Finding of previous visit (2015):

Over the past 5 years, on the CGQ, students have reported inadequate instruction in ethics (range 15.7% to 29.9%), and law and medicine (range 69.3% to 82.1%). The school has responded with the development of a new course in law and ethics, but effectiveness/evaluation data for this course are not yet available.

Finding of current limited visit:

The content areas listed in DCI tables for this standard are included in the revised curriculum, implemented for the Class of 2017. Internal survey data indicates significant improvement in these areas compared with CGQ and GQ data for Classes of 2014-2016.

Indicators to guide the evaluation of the above element:

- 7.7 a The medical curriculum includes instruction and assessment of the following topics in an independent required learning experience, and/or integrated into a required learning experience(s):
- i. biomedical ethics
 - ii. ethical decision-making
 - iii. law and medicine
- 7.7 b Data from the AAMC CGQ and the AFMC GQ in Table 7.7-2 of the DCI show that the majority of respondents believe that their instruction in each of the listed topics was appropriate or excessive.
- 7.7 c The topics listed in Table 7.7-1 of the DCI are taught and assessed in the curriculum either as an independent required learning experience, or integrated in a required learning experience(s).

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

The topics listed in the DCI are taught and assessed in the pre-clerkship and clerkship years. At the site visit, the team was provided with evidence of specific curriculum mapping of these areas.

CGQ and GQ data for classes of 2014-2016 provided in the mini-DCI Table 7.7-2 does not reflect the revised curriculum (implemented for the Class of 2017). Internal data presented in Table mini-DCI 7.7-2.1 show that the majority of students in Classes of 2017 (87-91%) and 2018 (82-92%) believe their instruction in ethics/humanism and health law was now appropriate or excessive. This represents a

marked improvement, particularly considering the timing of the survey (students in years 2 and 3 of the revised curriculum at the time of survey). Additional instruction of these topics is offered in year 4. Note was made that the low response rate (33%) for the Class of 2018 limits the interpretation of data for this year.

See also: Supplemental Appendices

Screen Shot DCI 7.7-2 Health Law 2014-2016 (S22)

Screen Shot DCI 7.7-2.1 Ethics Law 2017-2018 (S23)

8.1 CURRICULAR MANAGEMENT (ED-33)

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.

Finding of previous visit (2015):

The Curriculum Committee has not managed the curriculum effectively with respect to implementation of workload policy, and ensuring comparability of student experience across sites. There continue to be significant delays in finalizing clinical grades. The committee has also not effectively addressed multiple curricular topics which McGill students have persistently reported are inadequately covered in the curriculum.

Finding of current limited visit:

The school demonstrates an effective governance committee chaired by the Associate Dean UGME with broad membership to oversee all aspects of the curriculum while leading in the design and ongoing improvement of program required student learning. Interviews conducted at the site visit and review of meeting minutes indicated that this was functioning well.

Indicators to guide the evaluation of the above element:

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The program and school leadership has implemented operational and leadership changes since the past review. There is a new Associate Dean for the MDCM Program who was a previous Clerkship director and supported with adequate time for program leadership. This new leader has communicated broadly the new operational and strategic vision of the MDCM Program Committee and invoked a culture of progress and optimism in implementing a new curriculum arising from previous strategic processes.

There was strong support in interviews by students and faculty for the role of the MDCM Program Committee as the overall decision-making body for all aspects of the MDCM program curriculum (planning, implementation, evaluation and ongoing improvement). The program has put in place new program leaders and committees in the MDCM Program Committee as a new leadership team who supports campuses of learning in Montreal and the regional site. Membership of the MDCM Program Committee is inclusive of all aspects and sites of the program including students, foundational sciences, faculty, students and leadership.

There is a strong program governance structure in place with operational committees having oversight of all aspects of the program reporting directly to the MDCM Program Committee. The governance structure covers admissions, quality management, assessment, and promotions. Each committee has acceptable standardized terms of reference with a clear mandate, guidelines and reporting processes. Membership includes an appropriate mix and membership of faculty and students.

The minutes of MDCM Program Committee meetings were reviewed in advance submissions and on the provided library of documents at the site visit. These documents support an outcome driven agenda structure, good member attendance, and regular monthly to semimonthly meetings. The records show open/full discussion, oversight of significant operational issues for the program, and meaningful student, staff, faculty and leadership participation. There is communication of the MDCM Program Committee outcomes to faculty through the operational and course committees and town halls. The Program Committee when interviewed had strong signs of acting as an effective team. Decisions made reflect strong central governance using evidence.

There were decisions reviewed in documents that support decisions reached by this committee to correct deficiencies in student learning for topics such as pain management, workhours, student supervised clinical experiences, mistreatment, curricular design and student assessment.

It is clear in interviews and program documents (including meeting minutes of the MDCM Program Committee) that oversight for the new curriculum and evaluation for ongoing improvement and oversight is under the mandate and reportable to the MDCM Program Committee.

8.2 USE OF MEDICAL EDUCATIONAL PROGRAM OBJECTIVES (ED-1)

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.

Finding of previous visit (2015):

A set of educational program objectives and outcomes is in place for each competency. However, many of the objectives are not explicitly mapped to specific courses or to outcome measures. Existing clerkship rotation objectives are not fully mapped to program objectives or outcomes. The school indicates it is planning to link their new curriculum clerkship rotation objectives to the overall objectives, but this is not yet complete.

Finding of current limited visit:

The school has implemented a curriculum built from outcome objectives that direct program and course development, delivery and support a culture of ongoing academic improvement. There are new quality improvement processes in place to review implementation of objectives with reporting to the program committee.

Indicators to guide the evaluation of the above element:

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The MDCM Program has implemented a new curriculum across all years of study that was designed from newly created program objectives, with cases extracted from the Medical Council of Canada objectives and created to deliver mandated curricular objectives in a progressively laddered process of learning. The oversight for this process is by the MDCM Program Committee and its governance committees.

Decisions are communicated to faculty course leadership and from there to educators to create learning modules. Changes in curriculum must adhere to program and course/ session objectives. Exceptions must be approved by a process of approval by courses and program leadership and committees. Examples were provided of courses and required learning experiences created or revised that support the program and MDCM Program Committee having mapped course material and assessment to program objectives and being actively monitored.

The program and its courses/required clinical learning experiences have clear communication to learners and faculty on where objectives are delivered and assessed. Review of the MDCM Program Committee minutes and discussion with faculty support central oversight for curricular design using program objectives. Examples were provided in documents of sessional and course objectives for Year 1, 2 courses and required clinical experiences in Year 3, 4 to program objectives. Program assessments have been mapped to program objectives for central monitoring of learner progression and program quality.

There is effective communication of curricular objectives in curricular design and evaluation in meetings and electronic communication. There were examples in text and discussion cited on how objectives serve to not only guide the creation of new courses, but also revision of existing clinical learning experiences. Learners are aware, from discussion at the site visit, of what program objectives are guiding each session and linkage with sessional objectives.

The program has implemented a process of central oversight by the MDCM Program Committee for student progress in achieving the program objectives through its governance committees and program leadership. The program provided examples on how this process improved clinical performance in patient care after examples of student challenges in clinical assessment led to a review using objectives that revised curriculum to strengthen student competency prior to the Medicine required learning experience. Many of these processes are only in place for their first full academic year.

There is evidence that all existing course sessions and assessments are mapped to session and program objectives. The creation of new learning arises from using existing mapping to clarify if there is indeed a gap and how/where best to implement effective student learning.

The program adoption, evaluation and use for ongoing improvement using program objectives is consistent across all years of study.

8.3 CURRICULAR DESIGN, REVIEW, REVISION/CONTENT MONITORING (ED-37)

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.

Finding of previous visit (2015):

The school lacks a well-functioning curriculum mapping system. A new internet based mapping system has just been purchased, but its effectiveness and utility remain to be determined. This is a recurrent issue.

Finding of current limited visit:

The school has developed outcome objectives mapped to curricular courses and sessions. There remain challenges in adopting an effective information technology solution for oversight of curricular content and required learning experiences. This is being addressed by leadership with the implementation of a software program used by other large Canadian faculties of medicine. It is anticipated that implementation will be completed in the next 2 years.

Indicators to guide the evaluation of the above element:

- 8.3 a 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 b The system used for curricular mapping is effective in identifying where in the curriculum, and to what extent, topics are addressed.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The Program has mapped using a variety of strategies and systems, all program and sessional objectives centrally. This process involves manual processes and is complete with the present software approach. This process involves using two software programs to search for a topic throughout the curriculum. There were examples provided. The searches provided showed student learning for both topics across all years of curriculum. The software uses a learning management system – myCourses, specific to McGill.

The Program delivers objectives to faculty using a variety of electronic means that involve internal communication (email and program management system) and by posting on the program web site.

The faculty and students have the option of undertaking a curricular search for topics, evaluation of student learning or creation/improvement of curricular content. This system does not seem simple, easily undertaken and accessible by learners. There are faculty who can undertake the search if needed.

The Program has elected in 2016 to move to adopt *Entrada*TM - a new learning management system presently implemented by three other large Canadian medical schools. This will replace the previous approach of using 2 software systems and present a software program with cited ease in use. While the present system is functional for searches if run by certain staff, it is cited as not being easy to use by students or faculty who may want to monitor or review content. Mapping of curricular and sessional objectives is underway in *Entrada* and 25% of the assessments are presently mapped.

It is anticipated that this electronic system will create a more robust and user friendly process for student and faculty search and oversight of program learning. It is anticipated that full implementation will be completed in the next two years.

8.7 COMPARABILITY OF EDUCATION/ASSESSMENT (ED-8)

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.

Finding of previous visit (2015):

There is significant heterogeneity across multiple teaching sites and hospitals in levels of administrative support provided to the program, amount of dedicated teaching time and content, clinical exposure, and overall student satisfaction with clerkship rotations. This is a recurrent issue.

Finding of current limited visit:

The school has made progress towards delivering comparability in learning across program sites and in provision of administrative support.

Indicators to guide the evaluation of the above element:

- 8.7 a 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 b 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 c 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 d The 'curriculum committee' (or its subcommittee) reviews the data described in 8.7.c and takes steps when needed to address lack of comparability in the educational experience identified in the data.
- 8.7 e The strategies used by the medical school to address inconsistencies across instructional sites that were identified in student satisfaction data and/or student performance data are appropriate and likely to address identified problems.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The Program required clinical learning experiences occur across sites in Montreal and Gatineau. The program has implemented a process of distributing program and course objectives electronically and by inclusion in the outlines of the required clinical learning sessions. These are provided in face to face

sessions delivered at least once yearly to faculty in clinical learning experiences through presentations or within department meetings; in one to one meetings; in committees and through electronic format. The results support an effective process of informing all educators and students.

The program has enacted a process that promotes communication within courses and required clinical learning experiences between sites using email and voice communication by phone and video communication (Skype). This is reported as being effective in disclosures during sessions at the site visit. The program has formal course committees that have a minimal expectation of meeting with minutes taken and reporting to oversight committees including the PECO Subcommittee (see below) who reports to the MDCM Program Committee.

The program has created two oversight committees that report in sequence for decision making to the MDCM Program Committee. These are the Program Evaluation and Curricular Outcomes Subcommittee (PECO) and the Student Assessment Subcommittee (SAC). These committees have a mandate through their terms of reference to review and make recommendations from program evaluations and assessments. The data used comes from outcome results, questionnaires and focus groups. These have led to curricular changes by the MDCM Program Committee, however this process has been implemented for only one calendar year.

The DCI appendices and supplemental data provided as S24 support equivalency between sites with small outliers remaining in required clinical learning experiences. Student assessment data reviewed showed no statistical significance of student outcomes between clinical learning sites. Student interviews in the site visit support this. In fact, students cite the 1:1 model in Gatineau and some affiliated Montreal hospitals as being a very effective preferred learning model compared to the larger academic center.

Minutes reviewed from the MDCM Committee support central oversight and recommendations for improvement in student learning from data from program evaluations.

While program processes have been in place for a short time and decisions from the MDCM Program Committee based on assessment and evaluation data have supported improvements, there remain issues identified in data from Appendix N and supplemental material provided. These support a small number of remaining learning experiences in Medicine, Geriatrics, and Pediatrics that were cited as 3.3 to 3.6 on a scale of 5 in comparison with the majority of evaluations of 4.2 or higher across a variety of learning sites. While we see the program and school making great progress in this area, it is early in the timeline and there remains a need for further oversight to support continued success.

See also: Supplemental Appendix
Table of quantitative student evaluations (S24)
DCI Appendix N (S25)

8.8 MONITORING TIME SPENT IN EDUCATIONAL AND CLINICAL ACTIVITIES (ED-38)

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.

Finding of previous visit (2015):

Although the school has a well-developed workload policy, there are frequent violations of the policy in all rotations except psychiatry and family medicine, coupled with reluctance by students to report violations. This is a recurrent issue.

Finding of current limited visit:

The school has made recent progress to effectively deliver a curriculum that is adherent to the standard of learning hours set for the MDCM Program. Students, residents, faculty, department chairs and other leaders are aware of expectations of student workload and are working to resolve issues. A progressive decrease in breaches of the workload policy has been observed.

Indicators to guide the evaluation of the above element:

- 8.8 a 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 b The policy described in 8.8.a. 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 c The 'curriculum committee' (or its subcommittee) monitors the effective application of the policies for required clinical learning experiences on a regular basis.
- 8.8 d There are effective mechanisms for students to report violations of the policy described in 8.8.a., and steps are taken to rectify identified problems.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The school has a policy in place to clearly delineate work hours for all required clinical experiences and in non-clinical learning. This policy is aligned with similar processes for residents and all medical students in Quebec medical education programs. There was confirmation of broad awareness of this policy with faculty, residents and students across all learning sites. This policy is communicated to students, residents and faculty through a variety of means including face to face and large lecture (grand rounds) sessions; email and program electronic management systems tools; and electronic formats such as the school/program web site and course outlines. This policy was approved by the MDCM Program Committee and compliance is monitored by this committee. The time allowed for students to attend while on call is clearly outlined in this policy and there seems, from interviews, broad awareness of it across

program sites.

This policy was developed by faculty leaders in collaboration with students, approved by the MDCM Program Committee and communicated to the relevant subcommittees (TCP and Clerkship). The communication methods used that were reviewed are felt to be effective (see above). Awareness by faculty leaders, department chairs, faculty, learner and resident was confirmed with data at the site visit.

To comply with the policy, the program has implemented changes in curricular design (shift-work and daily schedule changes) and assessment reviews. The school has brought in supplemental learning and awareness sessions for departments cited as recurrently breaching this policy (Medicine, Surgery and Paediatrics) to address challenges in adoption. There is a process where the UGME Associate Dean meets with the Department Chair and at times a department, if there is a pattern of infraction and non-compliance with the policy. The Associate Dean works with leadership to address the issue and seek compliance with the policy. This has proven very effective and is supported by chair and faculty leadership discussion in the site visit. Students are encouraged to discuss infractions that week with their Clerkship faculty lead and this was disclosed as being valuable to students.

In evaluating this process, the program has created a process aligned with their quality improvement strategy that gathers ongoing data and monitors through the PECO Subcommittee and other program course committees. Students are monitored weekly (since January 2016), a change that has improved compliance with the policy. This data is forwarded after analysis to the course, department (if infractions) and MDCM Program Committee. Actions are taken as outlined above. This has proven effective in driving awareness and compliance.

The data reviewed by the team supported broad improvement in departmental support for the policy and process with rates documented across the Year 3 Clerkship courses in 2015-2016 as 2.1% overall infraction rate (with individual Clerkship courses recorded as having infraction rates of 4.3% in Paediatrics; 3.3% in Surgery and less than 2% in the other rotations). When adding in the Year 4 courses, this rate drops to 1.5%. This data shows progress from the work of the Program leadership as supported by the decline in infractions from 3.9% in the 2014-2015 year. There remain infractions across sites and departments aside from Family Medicine in required Clerkship clinical learning. With this intervention, the number of infractions has shown a decrease over the past calendar year to a rate cited as previously 4% to below 2%. (DCI Appendix O2) While this occurs in Clerkship, the Year 2 and 4 require clinical learning experiences have a rate in evaluation data of close to or equal 0% after intervention.

See also: Supplemental Appendix
DCI Appendix O2 (S26)

9.1 PREPARATION OF RESIDENT AND NON-FACULTY INSTRUCTORS (ED-24)

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.

Finding of previous visit (2015):

Teaching skills training is not mandatory for residents or graduate students, and they are not uniformly aware of program objectives. Residents do not consistently receive feedback about their teaching.

Finding of current limited visit:

All residents are required to complete teaching and assessment skills training. Completion of the training is centrally monitored. As a part of the training, residents receive and review medical student learning objectives for the Clerkship. Residents' teaching of medical students is evaluated at all instructional sites by medical students, and support is provided to improve residents' teaching when deficiencies are identified.

Indicators to guide the evaluation of the above element:

- 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.a. are mandatory for residents who supervise, teach or assess medical students and attendance is centrally monitored.
- 9.1 d Residents' teaching of medical students is evaluated at all instructional sites by medical students or faculty members, and support is provided to improve residents' teaching when deficiencies are identified.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The PGME Educational Enhancement Committee developed an online course called *Teaching Residents to Teach* that is mandatory for all McGill residents. The course was launched in September 2016 and includes interactive multi-media presentations, reflective learning activities and quizzes. The course includes modules on teaching and assessing medical students. Central monitoring to ensure that residents complete the course is accomplished by the E-curriculum administrator and the PGME Educational Enhancement Committee. Data regarding completion rates for each program are extracted and reported on

regular basis (detailing program specific resident progress) to Program Directors. The PGME Office can ascertain at any given time the progress of all residents throughout the course (e.g., number of modules completed) and the completion rate of the course. Successful completion of this course is a requirement for resident promotion. As of December 2016, the vast majority of the 1249 residents at McGill had completed Part 1 of the course.

Part 1 of the online course provides an orientation to the MDCM Program with the requirement that residents review the curriculum schema, the generic schedule for the Transition to Clinical Practice curriculum, and the learning objectives for the Clerkship courses. In addition, Program Directors for all specialty programs orient the residents to the learning objectives by providing them with electronic and/or hard copies for the required learning experiences in which they participate. Part 1 also includes an orientation to methods of assessment. Part 2 of the course contains five core modules: Interactive Lecturing, Clinical Teaching, Feedback, Technical Skills and Role Modeling.

Residents' teaching of medical students is evaluated at all instructional sites by medical students using a standard evaluation of residents form. During the site visit, medical students confirmed that they evaluate resident teaching and noted that they are very satisfied with the quality of resident teaching. Residents also confirmed to the team that they are evaluated by medical students and that student feedback regarding their teaching is reviewed during formal evaluation sessions with their supervisor.

9.2 FACULTY APPOINTMENTS (ED-25)

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

Finding of previous visit (2015):

Efforts are being made in Gatineau to provide faculty appointments, but 29% of supervisors remain without McGill faculty appointments.

Finding of current limited visit:

The school has a formal policy in place that provides a process to have faculty appointments assured for all new recruits to the school's affiliated institutions. Currently greater than 99% of 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.

Indicators to guide the evaluation of the above element:

- 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 (physicians) who do not hold a faculty appointment, the teaching activities provided by these individuals are overseen by physicians who hold a faculty appointment. The faculty member ensures that the teaching is aligned with the learning objectives, is of good quality, and the learning environment is appropriate.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The Policy on Clinical Faculty Appointments was approved by the Deanery Executive Committee on October 28, 2016. The policy provides a process to have faculty appointments assured for all new recruits to the school's affiliated institutions.

The faculty appointments policy is newly in place, and it appears that greater than 99% of 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 (only one exception, representing an in-process renewal).

There is only one instance in which teaching and assessment of students in a required clinical learning experience is carried out by non-faculty members. In the Family Medicine Clerkship, students have the option to do a rural Special rotation (commonly referred to as a "Special"). A Special is primarily in

ambulatory care and completed at a non-McGill site that is located 50 km or more from a university with a population of less than 100,000. Students submit a proposal of their Special to the Department of Family Medicine at least three months prior to the beginning of their Family Medicine Clerkship rotation. The proposal is reviewed and, if appropriate, approved by the Family Medicine Clerkship Director.

A Special rotation must be supervised by a certified family physician who is affiliated with a university's faculty of medicine/department of family medicine, or a community physician at an accredited family medicine teaching site. The supervisor must communicate in writing his/her acceptance of the student, as well as the learning objectives, required clinical encounters and procedures, and assessment criteria. The supervisor must also provide a weekly schedule of study. The Family Medicine Clerkship Course Director thus maintains oversight and responsibility for the quality of teaching and assessment. Once the rotation has concluded, students are required to provide site-specific feedback on the quality of supervision and education they received, which is then entered into a database for future students' reference.

9.3 CLINICAL SUPERVISION OF MEDICAL STUDENTS (ED-25-A)

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.

Finding of previous visit (2015):

At times in the surgery clerkship, supervision of clinical clerks is not adequate. Despite 79.3% of students in the ISA indicating they were well supported while on call, at the site visit, multiple students reported an inability to reach residents or staff when needed for a variety of acute patient care issues in the surgery clerkship.

Finding of current limited visit:

The Undergraduate Medical Education (UGME) and Postgraduate Medical Education (PGME) have developed the Faculty of Medicine Supervision Policy for Undergraduate and Postgraduate Medical Trainees in the Clinical Team. Additionally, clinical log (myMED Portfolio) requirements have been revised to explicitly describe student responsibilities to ensure the appropriate balance of student independence and supervisor involvement. An orientation session is given on the first day of every course to familiarize students with clinical settings and their relevant policies and safety considerations. At the site visit, clerkship students indicated they were appropriately supervised and residents and attending physicians were regularly available.

Indicators to guide the evaluation of the above element:

- 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 AAMC CGQ data show that the majority of respondents at each campus agree/strongly agree that they were appropriately supervised and were given an appropriate level of responsibility.
- 9.3 f AFMC GQ data show that the majority of respondents at each campus agree/strongly agree that 1) the level of supervision a) ensured their safety, and b) ensured the safety of the patients for whom they provided care and 2) that they were given appropriate responsibility for patient care.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

Since the last accreditation survey, Undergraduate Medical Education (UGME) and Postgraduate Medical Education (PGME) developed the Faculty of Medicine Supervision Policy for Undergraduate and Postgraduate Medical Trainees in the Clinical Team. The Deanery Executive Committee and Faculty Leadership Council approved the Policy in October 2015. Additionally, clinical log (myMED Portfolio) requirements were revised to explicitly describe student responsibilities to ensure the appropriate balance of student independence and supervisor involvement. An orientation session is given on the first day of every course to familiarize students with clinical settings and their relevant policies and safety considerations. The Faculty of Medicine's Code of Conduct defines the rights and responsibilities of all who supervise students and participate in teaching within the hospital environment. The Code is widely distributed and all new faculty are required to sign that they have read it. It is also posted on the Faculty's website.

The MDCM Program Committee received a report from the PECO Subcommittee on September 19, 2016. The report summarized key findings from the Medical Education Experience Survey (MEE) as well as the 2015 AFMC GQ. The MDCM Program Committee determined that the MEE Survey data suggested unacceptable supervision in the Surgery clerkship course and tasked the Associate Dean UGME to bring the matter to the attention of the Dean of Medicine in order to meet with the Chair of the Department of Surgery. The Dean of Medicine, Associate Dean of UGME, Clerkship Component Director, Chair of the Department of Surgery, and Surgery Clerkship Course Director met in October 2016 and agreed to a number of remedial measures: (1) discuss trainee supervision with surgical division chiefs, (2) review potential factors impacting the supervision of trainees, and (3) develop a multifaceted action plan involving the Chair of the Department of Surgery, clinical chiefs, and the Course Director. The Dean of Medicine held a follow-up meeting with the Surgical Executive Committee at the end of November to reinforce with the division chiefs the importance of supervision.

The school has developed guidelines for students on how to escalate clinical questions or concerns in a timely fashion and these were included in the orientation package of students at all sites. On December 14, 2015, the Clerkship Surgery Course Director informed the Site Directors, Administrators, and Vice-Chair Education for the Department of Surgery about these guidelines as well as the McGill Supervision Policy for Trainees in the Clinical Team and asked them to disseminate the information to the division chiefs, clinical teachers, attending and residents. Site Directors were made responsible for informing medical students of these guidelines during their in-person orientation.

Medical students can report concerns regarding adequacy and availability of supervision during a course directly to Site Directors. Students can reach Site Directors by email, through the Course Administrators, and in face-to-face meetings in midway feedback sessions. If a student is not satisfied with the response from the Site Director, or cannot reach out due to a conflict (e.g., the Site Director is the source of concern), then students can contact the Course Director or Clerkship Component Director. The Course Director and his/her departmental undergraduate education committee are positioned to address students' concerns directly given their knowledge of the clinical environments and faculty members. The Clerkship Component Director, PGME Program Director, and Department Chair provide support when needed. If there is a persistent concern regarding adequacy and availability of supervision, the Associate Dean UGME and Dean are called to assist the Course Director and Department Chair resolve the issue.

Medical students are required to evaluate their clinical preceptors' availability and approachability. Aggregate data from preceptor evaluations are used in the faculty member's annual performance review and the resident's six-month review. Concerns about attending physicians are handled first by the Department Chair who may escalate the matter to the Academic Affairs Office if necessary. Concerns related to residents are handled first by the Program Director and, if unresolved, escalated to the Associate Dean PGME.

The learning objectives for each course are approved by the MDCM Program Committee as stage-appropriate. The TCP Component Subcommittee developed a description of the level of the TCP student and outlined appropriate tasks for students in this component of the curriculum. These descriptions and tasks were implemented in the 2016-17 academic year.

Clerkship courses give medical students clear learning objectives and require students to log specific patient encounters and procedures that are linked to the MDCM Program Objectives and Medical Council of Canada (MCC) clinical presentations. These patient encounters and procedures are also assigned a level of student responsibility that is listed in the myMED Portfolio requirements for the course in myCourses and relates to specific encounters in the myMED Portfolio tool. The level of responsibility progresses from assisting in a simulation activity, participating in part of a procedure, completing a procedure under direct observation, to completing the required encounter or procedure under supervision with no direct observation.

Medical students always have direct or indirect supervision in the clinical setting. Their performance is assessed dynamically and the student is assigned additional clinical responsibilities as appropriate. For example, at the outset of a clinical learning experience, a student is initially assigned less complicated patients and/or few patients. As the clinical learning experience progresses and the student demonstrates successful evolution in clinical acumen and skills, the level of complexity and/or number of patients assigned to the student increases. In an operating room setting, the student has to first demonstrate successful performance of simple tasks, such as skin closure, before more complex tasks such as fascial closure. This progressive approach is used in each clinical experience throughout the clerkship component.

Clerkship Clinical Assessment Criteria are available on the UGME website to all attending physicians and surgeons as well as residents and fellows involved in teaching, supervising and assessing medical students. There is a link to these assessment criteria on each clinical assessment form (CAF) so that descriptions of clerkship-level performance can be reviewed at the time of assessment. Supervising faculty, residents, and fellows also receive the medical students' learning objectives for their related course once a year by email and/or through one45.

At the site visit, clerkship students indicated they were appropriately supervised and residents and attending physicians were regularly available. The survey data provided for the Classes of 2014, 2015 and 2016 indicated that the majority of students felt they were appropriately supervised and had an appropriate level of responsibility. There is some variability in this data, suggesting ongoing monitoring is necessary (DCI tables 9.3-1, 9.3-2, 9.3-2.1).

See also: Supplemental Appendix

DCI Table 9.3-1 CGQ Data Class 2014 (S27)

DCI Table 9.3-2 GQ Data Class 2015, 2016 (S28)

DCI Table 9.3-2.1 MEE Survey Class 2016 (S29)

9.4 ASSESSMENT SYSTEM (ED-27)

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.

Finding of previous visit (2015):

Direct observation of history and physical examinations has not been consistent across all core clerkship rotations. The CGQ identified significant deficiencies in Emergency Medicine, Surgery, and Obstetrics and Gynaecology. However, the school has recently mandated observation, and data tracked this academic year for the class of 2016 suggests improvement.

Finding of current limited visit:

The school's requirement that direct observation of history and physical examination skills occurs in all clerkship courses is not reflected in the percentage of students who report being observed on the internal Medical Education Experience Survey (MEE) and CGQ. In response, the school has recently instituted a process whereby third and fourth year students login to myMED Portfolio to document when they have been observed doing a history and physical, the type of patient seen, and the name of the faculty member or resident who observed them.

Indicators to guide the evaluation of the above element:

- 9.4 a AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus agree/strongly agree that they were observed by a faculty member or resident taking a history in each required clinical learning experience, OR medical school administrative data show that medical students at each campus were observed taking a history in each required clinical learning experience by a faculty member or resident.
- 9.4 b AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus agree/strongly agree that they were observed by a faculty member or resident performing a physical examination, OR medical school administrative data show that medical students at each campus were observed performing a physical examination in each required clinical learning experience.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

There are discrepancies in the data regarding direct observation during required clinical experiences in Clerkships. Directly observed encounters are mandatory in all required clinical courses in Clerkships, and 100% of students complete their requirements in myMED Portfolio. Course evaluation surveys indicate that approximately 95% students are observed at least once taking a history and performing a physical

examination. However, across sites and disciplines, 83%-100% of respondents to the McGill Medical Experience survey report having been observed (see Appendix R1). The MDCM Program Committee has not been successful in determining whether this is due to students entering inaccurate information in their myMED Portfolio logs or, for example, to students answering the AFMC GQ based on their perception of the frequency of direct observation in a specific course. However, focus groups with residents from the Class of 2015, and Clerkship students during 2015-16 and 2016-17 have suggested that both of these factors may contribute to the discrepancy. During the site visit medical students stated to the site visit team that many students may interpret the GQ question as pertaining to a full history and physical, whereas the clerkship curriculum involves observation of focused histories and physicals.

On September 19, 2016, the MDCM Program Committee tasked the Clerkship Component Subcommittee with reviewing the issue and returning to the MDCM Program Committee with a recommendation for how to clearly demonstrate that direct observation is occurring in all Clerkship courses. Subsequently the school has recently instituted a process whereby third and fourth year medical students login to myMED to document when they have been observed doing a history and physical, the type of patient seen, and faculty member or resident who observed them.

See also: Supplemental Appendix

DCI Table 9.4-1 data classes 2014-2016 (S30)

DCI Appendix R1 internal data 2015-2016 (S31)

9.5 NARRATIVE ASSESSMENT (ED-32)

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.

Finding of previous visit (2015):

The school uses narrative feedback in most course and clerkship settings, however a significant number of blocks that include small group learning (permitting narrative assessment), in the new Fundamentals of Medicine and Dentistry (FMD) 18-month course Component do not include a narrative assessment.

Finding of current limited visit:

The school has a formal policy that requires narrative assessment when teacher-student interaction meets defined thresholds for sufficient duration and depth. Compliance with this policy is overseen by the MDCM Program Committee.

Indicators to guide the evaluation of the above element:

- 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 of four weeks duration or greater with small group, or 1:1 learning activities for which there is a summative performance assessment by the tutor/preceptor.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The UGME Student Assessment Policy outlines the MDCM Program requirements for narrative assessment. Per the Policy: "Where supervisor-student interaction permits, assessment must include a narrative description of student performance, including non-cognitive achievement." The MDCM Program Committee considers narrative assessment to be feasible when: 1) the same teacher meets the same student for a minimum of 4 sessions within the same course, and 2) the teacher: student ratio is no greater than 1:20.

During Year 1 of the MDCM Curriculum, two courses include narrative comments as a formative assessment (FMD Human Behavior and FMD Movement) and two include narrative comments as part of the final summative assessment for the course (Longitudinal Family Medicine Experience and Physician Apprenticeship 1). During Year 2 of the curriculum, 11 courses include narrative comments as part of the final summative assessment for the course. The site visit team considered the school's approach to providing narrative assessment sufficient to meet the requirements of Element 9.5.

9.8 FAIR AND TIMELY SUMMATIVE ASSESSMENT (ED-30)

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.

Finding of previous visit (2015):

Provision of final grades in the family medicine, pediatrics, obstetrics and gynaecology, general surgery, and surgical subspecialty clerkship rotations at one or both campuses (Montreal and Gatineau) is beyond six weeks. This is a recurrent issue.

Finding of current limited visit:

The school has established a clear policy specifying the timeline for provision of final grades for all required learning experiences. Provision of final grades is monitored and steps are taken to meet the expected timeline. Results for the current academic year show a positive trend toward compliance with the grade submission policy. Administrative issues have been addressed.

Indicators to guide the evaluation of the above element:

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

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

For 2016-17, timeliness of grade reporting is being tracked at the end of each Block by course and site for clinical courses. A data analyst was hired by UGME on October 31, 2016 to help resolve the technical challenges associated with extracting data by site on a weekly basis for contributor forms (i.e., the forms completed by direct supervisors that feed into the final clinical assessment for the course).

The MDCM Program and the UGME Office made several changes during the 2015-16 academic year in order to address the timeliness of grade submissions program-wide. This included the establishment of the UGME Student Assessment Policy, active follow-up and tracking by Student Records, and re-centralizing some tasks in the UGME Office rather than leaving these at the course level. Some examples of centralized tasks include the release of grades to students and the ability to modify previously submitted assessment forms. In courses where these measures were insufficient to ensure timely provision of grades in accordance with the Student Assessment Policy, the Dean of Medicine was notified. The Dean then contacted the appropriate Department Chair to enlist cooperation in ensuring that grades were submitted.

The MDCM Program has also supported the development of course-specific strategies to address delays

in grade reporting. As a result of program-wide and course-specific interventions, improvements are evident thus far in the current academic year in both TCP and Clerkship courses. The average time for availability of final grades for most of these learning experiences is less than 6 weeks. (Appendices S32-S34).

The timing of the provision of grades is monitored by the Student Records Officer, who provides a report to the Associate Director Medical Education Services on a weekly basis. Some technical issues with One45 have made it difficult to interpret these data, but a new data analyst is developing ways to resolve these issues and the school expects these technical issues will be obviated once Entrada is fully implemented for student assessment (anticipated 2017-18).

As outlined in the UGME Student Assessment Policy, the Student Records Officer follows up directly with outstanding contributors four weeks after the end of a course to ensure that the grades are available to students within six weeks. The Student Records Officer notifies the Associate Dean UGME when contributors have not submitted grades at the four-week mark. The Associate Dean UGME then notifies the Dean, who contacts the contributor's Department Chair who takes up the matter up with the involved faculty member.

See also: Supplemental Appendix
DCI Appendix S2 (S32)
Updates provided at site visit (S33,S34)

10.2 FINAL AUTHORITY OF ADMISSION COMMITTEE (MS-4)

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

Finding of previous visit (2015):

The admissions committee does not have a majority of voting faculty members.

Finding of current limited visit:

The final responsibility for accepting students rests with the Admissions Committee. Details are outlined in faculty policies and the membership has been revised to now include a majority of voting faculty members.

Indicators to guide the evaluation of the above element:

- 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 Faculty members constitute a majority of voting members at all meetings.

RATING

- Satisfactory
 Satisfactory with a need for monitoring
 Unsatisfactory

Evidence to support the above rating

The final responsibility for accepting students to the MDCM Program at McGill rests with the MDCM Admissions Committee. The authority and composition and also the rules for its operations are specified in the policies of the Faculty of Medicine. The voting privileges and the definition of quorum are specified in these same policies. The majority of voting members are faculty members and quorum is defined as 50% plus 1 of voting members. Since there are only two non-faculty voting members (a student and community member) there is a majority (three) of voting faculty members at all times that the committee meets with quorum.

There are several subcommittees of the MDCM Admissions Committee: Admissions Best Practices Subcommittee, MDCM Multiple Mini-Interview Subcommittee, MDCM Qualifying Year Subcommittee, and the Admissions Professionalism\ Standards Subcommittee. All of these subcommittees are described in approved policies of the Faculty of Medicine. Each has a majority of voting faculty members whenever quorum is met.

The selection of individual medical students for admission is not influenced by any political or financial factors. This was not an issue at the last accreditation visit nor at this one.

11.1 ACADEMIC ADVISING (MS-18)

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

Finding of previous visit (2015):

Osler fellows provide both academic advising and student assessment concurrently. In addition, students at the Gatineau campus do not have comparable access to academic counselling.

Finding of current limited visit:

The school has made progress toward meeting the requirements of this element.

There are means by which the medical school identifies students experiencing academic difficulty. An “at risk” category was recently introduced. The process is clearly outlined and both students and faculty were aware of the process. Gatineau students can access resources on site in a confidential manner. Osler Fellows no longer provide academic counseling to students.

Indicators to guide the evaluation of the above element:

- 11.1 a The medical school has a system of academic advising in place for medical students (identified as needing assistance based on performance or through self-referral) that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff.
- 11.1 b There are means by which the medical school identifies students experiencing academic difficulty.
- 11.1 c 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 d 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 e AAMC CGQ and AFMC GQ data over the last three academic years show that the majority of respondents at each campus were satisfied/very satisfied with academic advising/counseling.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The medical school has a system of academic advising in place for medical students. This advising/counseling is available to students in Gatineau for the Longitudinal Integrated Clerkship as well as for students in Montreal. Resources can be accessed on site in a confidential manner.

There are means by which the medical school identifies students experiencing academic difficulty. An "at-risk" category was recently introduced. Students in this category will be referred to the McGill Faculty of Medicine Academic Advising Flowchart (Supplemental Appendix S35). They are followed up by the WELL Office. The process is clearly outlined and both students and faculty are aware of it.

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. Osler Fellows no longer provide academic counseling to students.

The school has provided data from the GQ and CGQ for the years 2014, 2015 and 2016 regarding the percentages of respondents that were *satisfied/very satisfied* with academic advising/counseling: 72.9% [2014], 90.2% [2015] and 78.1% [2016]. However, as the new academic advising protocol was implemented in 2016, there has been insufficient time to show the current degree of satisfaction with academic advising/counseling. This data should become available in the next few years.

See also: Supplemental Appendix
Academic Advising Flowchart (S35)

12.3 PERSONAL COUNSELING / WELL-BEING PROGRAMS (MS-26)

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.

Finding of previous visit (2015):

The school is beginning to integrate health and wellness into the curriculum, but most students remain uncomfortable taking absences for health related matters and note insufficient time for basic wellness activities. The school has recently instituted a flex day policy that permits five (5) flex days per year to deal with these concerns, but this has been poorly communicated to students.

Finding of current limited visit:

The medical school provides programs that support well-being to students at Montreal and Gatineau sites. A full-time Wellness Consultant was hired in the spring of 2016 to support students. Students report sufficient time for basic wellness activities. Well-being components are embedded in the curriculum of the MDCM Program. Data from the CGQ and GQ show that the majority of respondents are now more satisfied/very satisfied with programs that promote effective stress management, a lifestyle balance and overall well-being.

Indicators to guide the evaluation of the above element:

- 12.3 a The medical school provides programs that support well-being (DCI Table 12.3-2) 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 well-being programs provided by the medical school at each campus.
- 12.3 c Data from the AAMC CGQ and AFMC GQ show that the majority of respondents at each campus are satisfied/very satisfied with programs that promote effective stress management, a lifestyle balance and overall well-being.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

The Longitudinal Wellness and Resilience Curriculum is embedded in the curriculum of the MDCM Program. It aims to equip students with tools to reduce stress and increase resilience. Wellness and Resilience sessions are delivered by the WELL Office and use a combination of didactic teaching, small groups, interactive mindfulness medical practice, online modules and simulation as its teaching methods. Programs supporting wellbeing are provided to students at both the Gatineau and Montreal sites. A full-time Wellness Consultant was hired in the spring of 2016 to support students. She visits the Gatineau site every 12 weeks to offer group wellness activities and individual counseling She is available in between visits for telephone and Skype interviews. The Francophone students particularly appreciate that they are

able to speak with her in French. The Wellness Consultant is also available for evening appointments which the year 3 and 4 students find especially convenient.

Based on student feedback, the Absences and Leaves Policy was updated for the 2016-17 academic year to include 10 Flex Days for students' academic or personal purposes. Subsequently, students report sufficient time for basic wellness activities. They are comfortable requesting a Flex Day.

Data from the CGQ and GQ show that the majority of respondents are now more satisfied/very satisfied with programs that promote effective stress management, a lifestyle balance and overall wellbeing. Percentages of respondents that were *satisfied/very satisfied* with these programs were 58.1% [2014], 69.4% [2015] and 79.7% [2016].

12.4 STUDENT ACCESS TO HEALTH CARE SERVICES (ED-44)

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.

Finding of previous visit (2015):

Students at the Gatineau campus reported not having comparable access to health and other preventative and therapeutic health services, including mental health services, despite having a dedicated family physician and psychologist.

Finding of current limited visit:

The school has made progress toward meeting the requirement of this element.

The Absences and Leaves Policy was updated for the 2016-17 academic year in response to student feedback and has been appropriately communicated to students. Students are more comfortable taking absences for health-related matters and the process of approval has been centralized. Students report appropriate access for students based in both Montreal and Gatineau.

Indicators to guide the evaluation of the above element:

- 12.4 a The medical school at each campus facilitates medical students' timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of required learning experiences.
- 12.4 b Medical students at all instructional sites and campuses are informed about availability and access to health services.
- 12.4 c The medical school at each campus has policies and procedures in place that permit students to be excused from required learning experiences including required clinical learning experiences to seek needed care.
- 12.4 d The policies and procedures described in 12.4c are disseminated to medical students, faculty, and residents.
- 12.4 e The AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with student health services and mental health services.

RATING

- Satisfactory
- Satisfactory with a need for monitoring
- Unsatisfactory

Evidence to support the above rating

Since most health services operate during regular business hours, the Absences and Leaves Policy allows students to use Flex Days to access services. The Absences and Leaves Policy was updated for the 2016-17 academic year in response to student feedback and has been appropriately communicated to students
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and faculty. Students are more comfortable taking absences for health-related matters and the process of approval has been centralized. Students in both the Gatineau and Montreal sites report timely access to medical and mental health services locally.

The WELL Office facilitates health and mental health appointments for Clerkship students. Monthly email notices are sent to remind students that appointments with McGill Student Health Services and/or McGill Mental Health Services can be made through the WELL Office. LIC students have preferential access to appointments during Recall Days, but also have access to health care in Gatineau through local resources. A physician who is based in Gatineau and not involved in the student assessment is available to provide students with health care services.

All resident, faculty and education/clinical leaders at the visit were aware of the Absences and Leaves Policy. They were fully supportive of students asking to be excused from required learning experiences for needed care.

Student satisfaction with health and mental health services, as illustrated in the GQ and the CGQ data for the graduating years 2014-2016 were not consistent with the general satisfaction that was expressed by students in all 4 years that were interviewed at the current site visit. The GQ and CGQ percentages of respondents that were *satisfied/very satisfied* with Student Health Services were 69.1% [2014], 81.1% [2015] and 64.4% [2016]. For students *satisfied/very satisfied* with Mental Health Services, the percentages were 55.9% [2014], 72.5% [2015] and 57% [2016]. However, as the Absences and Leaves Policy (<https://www.mcgill.ca/ugme/academic-policies/absences-and-leaves>) was implemented only in the 2016-17 year, there has been insufficient time for this to be reflected in the current student reported rates of satisfaction. Nonetheless, students during the visit consistently confirmed their satisfaction with access to student health and mental health services. These students represented all four years of the program as well as both the Montreal and Gatineau sites. The affirmations at the 2017 visit are in contrast to the 2015 accreditation visit when students at the Gatineau site reported not having comparable access to health and mental health services, despite having a dedicated family physician and psychologist. This issue has been resolved.