TEAM REPORT
OF THE
SITE VISIT OF

DALHOUSIE UNIVERSITY
FACULTY OF MEDICINE

Halifax, Nova Scotia

February 26 – March 1, 2017

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

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MEMORANDUM

TO: Committee on the Accreditation of Canadian Medical Schools

FROM: The Secretary of the *ad hoc* Site Visit Team That Visited the Dalhousie University Faculty of Medicine on February 26 – March 1, 2017

RE: Report of the Site Visit Team

On behalf of the *ad hoc* CACMS Site Visit Team that visited the Dalhousie University Faculty of Medicine on February 26 – March 1, 2017, the following report of the team's findings is provided.

Respectfully,

_____

Susan E. Andrew, PhD
Secretary

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

SITE VISIT TEAM COMPOSITION

Team Chair:	Richard Reznick, MD Dean, Faculty of Health Sciences Queen's University Kingston, ON	Surgery
Team Secretary:	Susan Andrew, PhD Assistant Dean, Education Quality and Accreditation Faculty of Medicine and Dentistry University of Alberta Edmonton, AB	Medical Genetics
Team Member:	Karl Stobbe, MD Regional Assistant Dean Niagara Regional Campus Michael G. DeGroote School of Medicine McMaster University St-Catharines, ON	Family Medicine
LCME Team Member:	Veronica M. Catanese, MD, MBA Senior Director, Accreditation Services Co-Secretary, Liaison Committee on Medical Education Washington, DC	Medicine
Student member:	Doulia Hamad McGill University Montreal, QC	Medical Student
Faculty Fellow:	Athena McConnell, MD College of Medicine University of Saskatchewan Saskatoon, SK	Paediatrics

ACKNOWLEDGEMENT

The team expresses its sincere appreciation to Dean Anderson and the staff, faculty, and students of Dalhousie University Faculty of Medicine for their many courtesies and accommodations during the visit. Anne Weeden, Darrell White, Evelyn Sutton and Jennifer Hall merit special recognition and commendation for their thoughtful visit preparations and generous support during the conduct of the visit.

DISCLAIMER: This report summarizes the findings and professional judgments of the *ad hoc* site visit team that visited the Dalhousie University Faculty of Medicine on February 26 – March 1, 2017, based on the information provided by the school and its representatives before and during the accreditation visit, and by the CACMS. The CACMS may come to differing conclusions when they review the team's report and any related information.

FINAL SITE VISIT TEAM ELEMENT RATING SUMMARY TABLE

Site Visit Team CACMS Element Rating Summary Table
Dalhousie University Faculty of Medicine

Standard	1	2	3	4	5	6	7	8	9	10	11	12
Element	1.1	2.1	3.1	4.1	5.1	6.1	7.1	8.1	9.1	10.1	11.1	12.1
	1.1.1	2.2	3.2	4.2	5.2	6.2	7.2	8.2	9.2	10.2	11.2	12.2
	1.2	2.3	3.3	4.3	5.3	6.3	7.3	8.3	9.3	10.3	11.3	12.3
	1.3	2.4	3.4	4.4	5.4	6.4	7.4	8.4	9.4	10.4	11.4	12.4
	1.4	2.5	3.5	4.5	5.5	6.5	7.5	8.5	9.5	10.5	11.5	12.5
	1.5	2.6	3.6	4.6	5.6	6.6	7.6	8.6	9.6	10.6	11.6	12.6
	1.6				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 monitoring	
Unsatisfactory	

SUMMARY OF SITE VISIT TEAM FINDINGS

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

Element Rating SM, U	**Standard**
	Standard 3
SM	3.3 Diversity
	Finding: The school has achieved diversity with respect to the student population and has recognized a need for stronger initiatives to increase diversity at the faculty and leadership level. Measures to address diversity at this level were implemented very recently.
SM	3.6 Student Mistreatment
	Finding: It was recognized that there is a significant focus and commitment on dealing with student mistreatment. There are revised mistreatment policies, and those appear to be effective although relatively recently put in place.
	Standard 9
SM	Element 9.3 Clinical Supervision of Medical Students
	Finding: Although the majority of student responses are satisfied with the level of clinical supervision, less than half of students were satisfied with Psychiatry at DMNB. The school has responded with additional resources that have been recently implemented.
SM	Element 9.4 Assessment System
	Finding: The GQ data demonstrate a decrease from 2015 to 2016 in the percentage of students being observed with History Taking and Physical Examination in Psychiatry at DMNB. Less than half of the students were observed at this clerkship at this site. The school has responded with additional resources in Psychiatry that have been recently implemented.
	Standard 11
SM	Element 11.2 Career advising
	Finding: Student satisfaction on career advising has been suboptimal. A newly developed 4-year career advising program is in the process of being rolled out and will need to be evaluated.
	Standard 12
SM	Element 12.3 Personal Counseling/Well-being Programs
	Finding: Overall there is a varying level of satisfaction with personal counseling and services to promote well-being. A series of new wellness programs has been implemented and will require ongoing monitoring.

HISTORY OF THE SCHOOL

Since 1868, Dalhousie Medical School has played a leadership role in advancing health and quality of health care in the Maritimes, Canada, and around the world. It provides MD, residency, and continuing medical education programs, conducts original and relevant research, translates evidence into new practices and policies, and works in partnership with the broader community on health-related issues.

Today, Dalhousie Medical School has grown into the largest health research faculty in Atlantic Canada, attracting significant research funding to the region. Two campuses, located in Halifax, Nova Scotia and Saint John, New Brunswick, house 22 clinical and basic science departments. Over 2000 faculty members mentor trainees across a network of more than 100 community-based teaching sites and nine teaching hospitals throughout the Maritime Provinces. In the current year, 460 medical students and 559 residents and fellows are enrolled in the medical school's education programs.

In 2010, the medical school established Dalhousie Medicine New Brunswick (DMNB), in partnership with the Government of New Brunswick and the University of New Brunswick. The addition of a second campus increased the overall number of seats available for first-year medical students by 10, for a total of 109 medical students per year across the two campuses. Twenty first-year seats formerly reserved in Halifax for New Brunswick students have been shifted to DMNB, so that 30 students now enter this program each year. These students complete the first two years of their undergraduate medical education in Saint John, while their first clinical year is distributed throughout the province. The creation of DMNB has substantially expanded the school's distributed undergraduate education programming. Faculty development, state-of-the-art videoconferencing technology, and web-based technologies are but a few of the means used to provide all trainees with the same high-quality teaching.

The medical school embarked on a major renewal and restructuring of its undergraduate medical curriculum in 2010, rolling out to full implementation in 2014. Over the past five years, the school has made ongoing additions and improvements, with significant student involvement in every stage of the process. For example, all medical students now complete a one-week rotation in a rural community in the Maritimes at the end of first year. "Rural Week" has proven popular, with many students reporting the experience inspired a new interest in pursuing rural family practice upon completion of their training. Another notable initiative is the Longitudinal Integrated Clerkship Dalhousie (LICD), which places the student in one location for an entire year, so they can follow patients over time, forming stronger doctor-patient relationships and gaining deeper insights into the complexities of patient care. The school launched the LICD in Miramichi, New Brunswick, in 2012, later expanding to include two other communities in the province, Upper River Valley and Moncton, so that now a total of 12 senior medical students participate in longitudinal integrated clerkships in three New Brunswick communities. A fourth site, in Fredericton, is scheduled to begin training students in 2017. Plans are underway to continue to grow the program expanding into communities in Nova Scotia.

Dalhousie's medical students also take part in a four-year, longitudinal research program called Research in Medicine (RIM), now into its fourth year. Through RIM, students conduct a research project from start to finish, gaining the foundational knowledge and skills required to develop, complete, present—and possibly publish—successful peer-reviewed research. At the same time, students gain an appreciation and understanding of research that prepares them to critically appraise the scientific literature so they can more skillfully practice evidence-based medicine in their future careers.

Since its founding, the medical school has graduated more than 6,600 physicians. Dalhousie-trained physicians have gone on to practice in the Maritime Provinces, across Canada and in many of the world's top medical institutions.

ACCREDITATION HISTORY OF THE SCHOOL

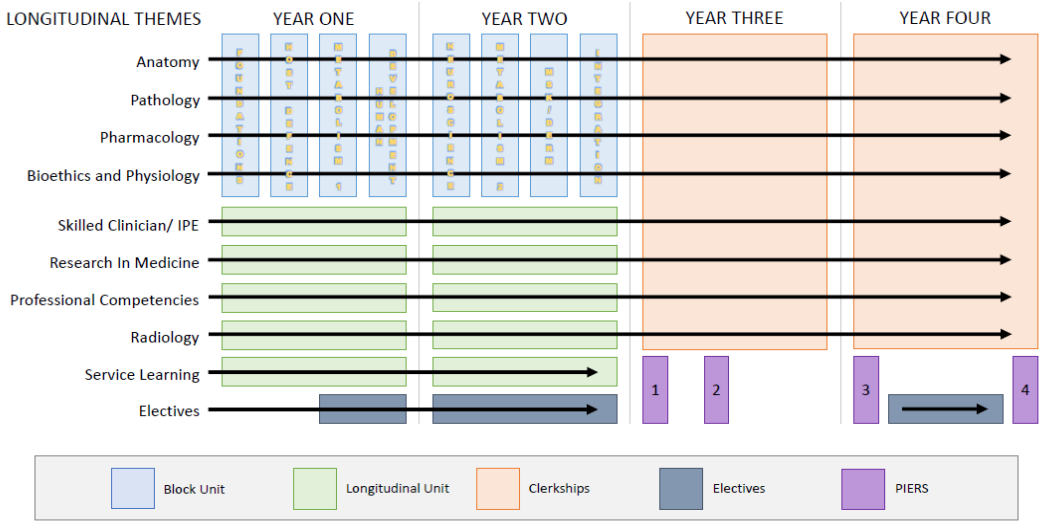
Dalhousie University Faculty of Medicine			**Last full survey: February 15-19, 2009**					**UPDATED: 3 August 2017**		
Standard	15-16 Element	Full survey June 2009	Branch Campus June 2009	Reconside-ration October 2009	Action plan Feb 2010	Limited June 2011	Limited Oct 2012	Status Report Oct 2014	Status Report Feb 2015	Status Report May 2015
ED-1	8.2	NC		NC		NC	CM	C		
ED-1-A	6.1	NC		NC		NC	CM	C		
ED-2	6.2/8.6	NC		NC		NC	C			
ED-3	6.1	NC		C						
ED-8	8.7	NC		NC		NC	C			
ED-24	9.1	NC		C						
ED-30	4.5/9.8	NC		NC		NC	C			
ED-33	8.1	NC		NC		NC	CM	CM	C	
ED-35	8.3	NC		NC		C	CM	C		
ED-36	5.2	NC		C						
ED-37	8.3	NC		NC		NC	CM	CM	CM	C
ED-47	8.5	NC		C						
MS-4	10.2						CM	CM	C	
MS-6	10.4						CM	C		
MS-19	11.2	NC		NC		NC	C			
MS-30	12.8	NC		C		NC	C			
MS-31-A	3.5	NC		C						
MS-32	3.6	NC		C						
MS-37	5.11	NC		NC		NC	C			
ER-2	5.1						CM	NC	C	
ER-9	1.4/5.12	NC		NC		NC	C			
Leadership		T								
Br campus plan		T				C				
Finances		T				T	ER-2		C	
Admissions		T				C				
Health IT		T				C				
Follow-up 1		Sec. Cons.		Sec. Cons.	Limited	Limited	Status Rpt	Status Rpt	Status Rpt	
Due date		TBD		Nov 2009	April 2011	12 months	Aug 15 /14	Dec 1 / 14	Mar 13/15	
Follow-up 2		Action Plan		Action plan						
Due date		TBD		TBD						
Action			Defer	Affirm	Approved	Rescind				
Accreditation status		Probation	Probation	Probation		Accredit	Accredit	Accredit	Accredit	Accredit
Next full survey		Not det.		Not det.		2016-2017	2016-2017	2016-2017	2016-2017	2016-2017

CURRICULUM DESCRIPTION

DCI Appendix DD (schematic or diagram that illustrates the structure of the curriculum and Appendix FF (structure of the longitudinal integrated clerkship) follow.

Appendix DD

Dal Med Curriculum At-A-Glance



Clerkship Schedule 2015-16

Note: Dates are Subject to Change

Class of 2017

Med 3

Track #	August 24 - September 18, 2015	Unit 1	Saturday, Dec 12, 2015	Dec 13 - Dec 19, 2015	Dec 21, 2015 - Jan 3, 2016	Unit 2	Saturday, March 26, 2016	March 28 - April 3, 2016	Unit 3	Saturday, June 25, 2016	Unit 4	Friday Sept 16, 2016	Saturday, Sept 17, 2016	Thurs-Fri, Oct 13-14, 2016	Thurs-Fri, 27-28, 2016
		Sept 21 - Dec 13, 2015 (12 weeks)				Jan 4 - March 27, 2016 (12 weeks)			April 4 - June 26, 2016 (12 weeks)		June 27 - Sept 18, 2016 (12 weeks)				
1	PIER 1 / RIM (4 weeks)	12 wks Internal Medicine	MCQ Exam	PIER 2 (7 days)	Holiday Break (2 week)	6 wks Family Med & 6 wks Psychiatry	MCQ Exam	Vacation (1 week)	9 weeks of Surgery + 3 weeks of EM	Official CaRMS Presentation	6 wks Pediatrics +6 wks ObsGyn	Skilled Clinician Phase 3 OSCE	End-of-Unit Exams	MCQ Exam Deferral	MCQ Exam Supplemental
2-a		6 wks Family Med & 6 wks Psychiatry				12 wks Internal Medicine			6 wks Pediatrics +6 wks ObsGyn		9 weeks of Surgery + 3 weeks of EM				
2-b		LICD				LICD			LICD		LICD				
3		9 weeks of Surgery + 3 weeks of EM				6 wks Pediatrics +6 wks ObsGyn			12 wks Internal Medicine		6 wks Family Med & 6 wks Psychiatry				
4		6 wks Pediatrics +6 wks ObsGyn				9 weeks of Surgery + 3 weeks of EM			6 wks Family Med & 6 wks Psychiatry		12 wks Internal Medicine				

Deferral or supplemental exam dates are provided in the table above. The specific day for your deferral exam(s) can only be determined after the Unit 4 exam date. Shortly after this date, you will be contacted with a specific day, time and location of your deferral exam(s). The specific day for supplemental exam(s) can only be determined after the Progress Committee meeting for Unit 4. Shortly after this date you will be contacted with a specific day, time and location of your exam(s).

R:\UME\Common\AD Administration\Schedules\Clerkship

Updated: October 17, 2014

Med 4 Clerkship Schedule
2015/2016

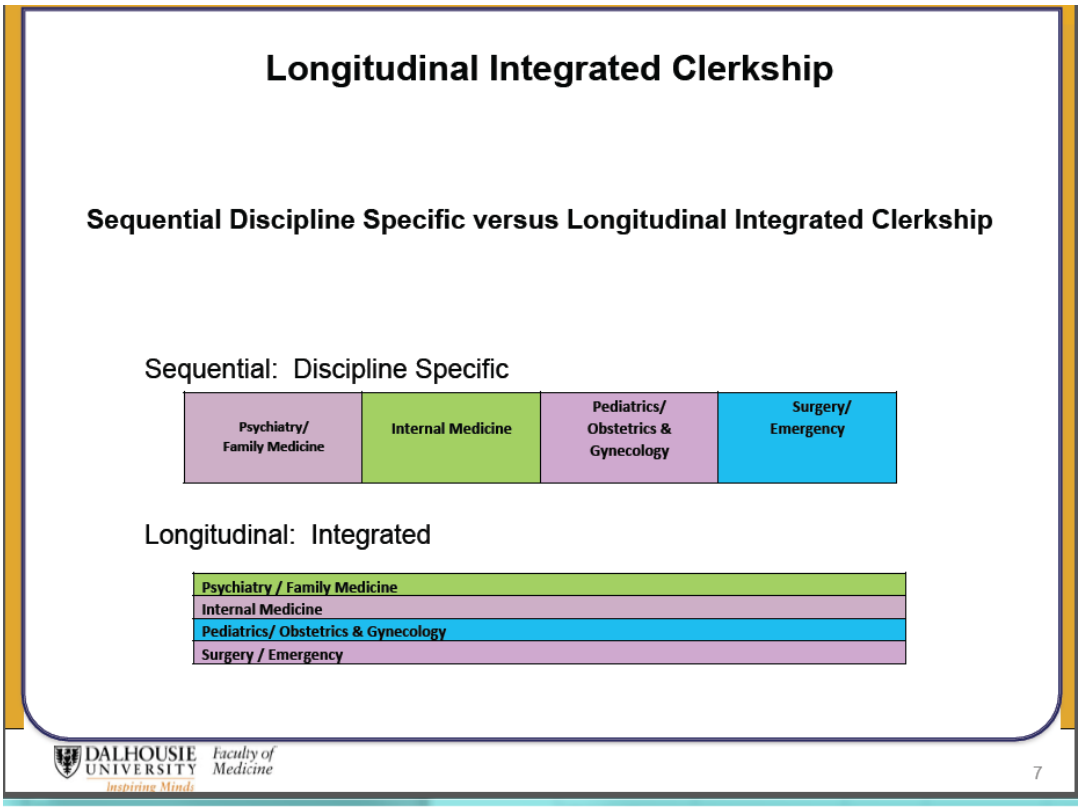
Class of 2016

Note: Dates are subject to change.

September 21 to 26, 2015	Thurs - Fri Oct 15 - 16, 2015	Thurs - Fri Oct 29 - 30, 2015	September 28, 2015 to January 15, 2016	January 16 to February 7, 2016	February 8 to March 19, 2016	March 21 to April 29, 2016
6 days			16 weeks	3 weeks	6 weeks	6 weeks
PIER III	MCQ Exam Deferral	MCQ Supplemental	Elective, Non-Tertiary/Community, Interdisciplinary, or Vacation	CaRMS Interviews	Elective, Non-Tertiary/Community, Interdisciplinary, or Vacation	PIER IV

Electives (12 weeks) - must complete electives in three (3) different disciplines; may be completed between September 28, 2015 and March 19, 20
Interdisciplinary (3 consecutive weeks) - may complete this rotation between September 28, 2015 and March 19, 2016.
Non-Tertiary/Community (3 consecutive weeks) - may complete this rotation between September 28, 2015 and March 19, 2016.

Appendix FF



Dalhousie Medical School's distributed Undergraduate Medical Education Program (the MD program) is an integrated four-year program delivered at campuses in Halifax and Saint John and sites throughout the Maritimes. All students are required to meet the same objectives. The curriculum is patient-centred and supports lifelong learning and integrated learning experiences.

The first two pre-clerkship years support the development of foundational knowledge, skills and professional behaviours with a mixture of classroom work, clinical skills and electives. Learning activities emphasize building a knowledge base through conceptual lectures, case-based learning in tutorials, self-directed learning, and elective experiences integrated with clinical skills-building exercises. Case-based learning enables students to take a patient-centred, clinically contextualized approach to learning. Through this, they begin to apply the first steps of a clinical reasoning process that will be refined and further developed over their four years of undergraduate medical education.

The curriculum introduces important elements of biomedical and clinical sciences in a staged manner over the first two years. The curriculum is composed of discrete units, which often contain multiple complementary components. An example would be the Host Defense Unit, which runs from October to December in the first year. It is composed of three complementary components: immunology, microbiology and hematology. These discrete units are overlaid with longitudinal units (Clinical Skills, Professional Competencies, Bioethics, Biochemistry and Physiology) and longitudinal themes (anatomy, pharmacology, pathology) that span the full length of the curriculum. Considerable effort has gone into the integration of the longitudinal themes and units with the discrete units, such that the subject matter in the longitudinal aspects of the curriculum is appropriate to the content of each of the discrete units as they progress through time. This provides the foundation upon which to build the more complex knowledge and skills required for diagnosis and treatment, which are introduced in the first two years but expanded upon in years 3 & 4.

The Research in Medicine (RIM) unit is mandatory for all students enrolled in the MD program. It is designed to develop creativity and critical thinking skills through a mentored research project conducted longitudinally across the four-year curriculum. In addition to didactic courses students develop a research question, gather and analyze data, and write up the findings which are to be presented at a conference or research day.

The Professional Competencies and Skilled Clinician longitudinal units lay the groundwork for clinical practice—both the hands-on practical aspects and the psychosocial, legal and ethical aspects of practice. Students also develop strong communication and critical thinking skills through these units. Med 3 is the core clerkship year, which rolls out over a 12-month time frame in a variety of clinical settings and across a variety of medical specialties. A growing number of students are able to experience this clerkship year via Longitudinal Integrated Clerkship (LIC), which are currently offered at three sites in New Brunswick and will continue to expand over time. Med 4, the final year, supports students' electives and preparation for career decisions.

During the two years of clerkship, students return to their home campuses on four occasions for PIERs (Positioning Integration Evaluation Review)—transition phases positioned at crucial junctures in their training to prepare them for subsequent experiences, such as introduction to clinical medicine, preparation for electives, strategies for successful residency matching and preparation for entering residency training. Content is largely delivered via small-group learning sessions, interactive workshops and hands-on experiences (including simulations).

OVERVIEW DATA

Table 6.0-1 | Academic Year 1 - Instructional Formats

Source: School-Reported

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

Campus	Required learning experience	Weeks	Number of formal instructional hours per required learning experience					
			Lecture	Lab	Small group	Patient contact	Other (describe)	Total
Halifax & Saint John	Foundations	6	28	20.5	13			61.5
Both	Host Defense	9	48	24	28			100
Both	Metabolism & Homeostasis	10	52	23	36			111
Both	Human Development	8	36	25.25	32			93.25
Both	Rural Week	1	1				25-40 shadowing a preceptor so amount of time depends on the preceptor	26-41
Both	Electives	12	1				48 Developed mentor relationship with clinicians and other health professionals. This usually involves patient contact but could be a clinical or basic research electives	49
Both	Professional Competencies 1 (longitudinal)	33	32		60		Up to 8 Shadow a physician day	100
Both	Skilled Clinician 1 (longitudinal)	33	9	9			114.5 small group/patient contact	132.5
Both	Research in	33	5		8		8	21

	Medicine (RIM)*						Exposed to research panels	
Both	Health Mentors (longitudinal)	25	1-1.5		4-4.5	2-4		7-10
TOTAL		170	213-213.5	101.75	181-181.5	2-4	203.5-218.5	701.25-719.25

Table 6.0-2 | Academic Year 2 - Instructional Formats Source: School-Reported

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

Campus	Required learning experience	Weeks	Number of formal instructional hours per required learning experience							
			Lecture	Lab	Small group (Tutorials)	Sessions	Patient contact	Exam Review	Elective Time	Total
Both	Neuroscience	12	48.0	21.0	22.0	-	-	1.0	48	92.0
	Metabolism II	14	56.0	25.0	64.0	-	-	-	56	145.0
	Musculoskeletal & Dermatology	5	19.0	6.5	20.0	-	-	-	20	45.5
	Integration	4	14.0	8.75	14.0	-	-	-	16	36.75
	Professional Competencies 2 (longitudinal)	35	33	-	64	-	-	-	-	97.0
	Electives	27	-	-	-		-	-	94	94.5
	Skilled Clinician 2 (longitudinal)	35	17.5	-	-	-	56.25 (Neuro) 13.5 (Integ.) 76.5 (Met II) **90 hrs.**	-	-	107.5
TOTAL		132	187.5	61.25	184		90	1.0	234	618.25

Source: School-Reported

Table 6.0-3 | Academic Years 3 and 4 - Weeks/Formal Instructional Hours

Provide data from the most recently-completed academic year on the total number of weeks and formal instructional hours per week (includes lectures, conferences, teaching rounds, clinical and procedural skills teaching/workshops) for each required learning experience in years three-four of the curriculum. Provide a range of hours if there is significant variation across weeks. Note that hours devoted to patient care activities should NOT be included. Add rows as needed for each instructional site if there are differences between sites.

Instructional site	Required learning experience	Total weeks	Typical hours per week of formal instruction*
Halifax & Saint John	Medicine	12	3
Both	Obstetrics & Gynaecology	6	5
Both	Family Medicine	6	2.5
Both	Psychiatry	6	8
Both	Surgery	9	6

Both	Emergency Medicine	3	6
Both	Pediatrics	6	4.5
Both (linked in according to Track 2)	Longitudinal Integrated Clerkship	48	**5
Both	PIER 1	3	35-40
Both	PIER 2	2	35-40
Both	PIER 3	2	35-40
Both	PIER 4	3	35-40
Both	Critical Review & Mastery (CRAM) & Advanced Cardiovascular Life Support (ACLS) Course	3	35-40

* Minimum number of designated hours of clinical clerk teaching in each block. In addition there are additional rotation specific teaching sessions.

** LIC students follow teaching sessions for Track 2 so they attend whatever sessions that the Track 2 block students are attending throughout the year

KEY PARAMETERS OVERVIEW SUMMARY TABLE

In 2010, the medical school established Dalhousie Medicine New Brunswick (DMNB), in partnership with the Government of New Brunswick and the University of New Brunswick. The addition of a second campus increased the overall number of seats available for first-year medical students by 10, for a total of 109 medical students per year across the two campuses. Twenty first-year seats formerly reserved in Halifax for New Brunswick students have been shifted to DMNB, so that 30 students now enter this program each year. These students complete the first two years of their undergraduate medical education in Saint John, while their first clinical year is distributed throughout the province. The creation of DMNB has substantially expanded the school's distributed undergraduate education programming. Faculty development, state-of-the-art videoconferencing technology, and web-based technologies are but a few of the means used to provide all trainees with the same high-quality teaching. The number of faculty is approximately the same, if slightly lower in numbers than the previous visit. The financial resources show a school in a strong position.

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

	Data from the last full Site Visit Report	**AY 2014-2015**
Entering class size	94	109
Total medical school enrollment	385	460
Number of residents & fellows	473	559
Number of full-time basic science faculty	99	91
Number of full-time clinical faculty	184	180
($ in Millions)		
Visa student and trainee fees	1.1	5.8
University (excluding allied health and other program)	29.6	35.4
Federal government	0.0	0.0
Provincial government	5.1	13.5
Practice plan/Alternate Funding Plan/Billing Group	12.3	11.5
Hospital Health Authority	1.0	0.1
Research awards, grants and contracts	50.0	37.1
Research grant overhead funds	0.5	0.0
Gifts, donations and interest earned on endowments/investments	3.9	5.7
Other	2.1	8.6
Total revenues	105.7	117.7

EVALUATION OF THE DCI

The DCI was very thorough with excellent attention to detail. Data was consistent and complete. The school is to be commended for adhering to the deadlines suggested by CACMS for delivery of the DCI, MSS, and appendices. The school provided additional material requested by the team in a timely manner both prior to the visit and during the visit itself.

EVALUATION OF THE MSS

The Medical School Self-study committee was composed of a mix of faculty with leadership positions, university representation, affiliated faculty members, student representation and representation from affiliated health institutions (Core Appendix C-3).

The MSS was complete and the evaluations were for the most part accurate. The taskforce summary statement provided an accurate summary of findings for the school at the time of completion. The MSS identified and recognized most of the same concerns that the students had in the ISA (for example, student mistreatment, career advising, financial aid). The MSS accurately reflected the status of the school at the time of the visit - the school identified 12 elements as "satisfactory with monitoring", in line with the fact that the school was fully compliant in May 2015. Our discussions with students and faculty as well as supplemental information received prior (Supplemental Appendix S1) and during the site visit, led us to determine that many of these elements were now satisfactory (elements 1.1.1, 5.5, 6.6, 7.1, 7.9, 8.3, 9.1, 10.5, 11.1 and 12.1).

We found elements 3.3 (diversity), 3.6 (student mistreatment) and 11.2 (career advising) still "satisfactory with monitoring. We also added elements 9.3 and 9.4 as "satisfactory with monitoring". The school had previously recognized the issue with these standards and had felt they had been resolved by additional resources however the site visit team felt that continued monitoring was still important.

We agreed with the school that elements 11.2 (career advising) and 12.3 (personal counseling/well-being programs) also required continued monitoring.

The team felt that the school was very thorough in identifying their deficiencies and very responsive in addressing any issues. The dean and his leadership team are very committed to excellence in medical education and dedicated to processes of continuous quality improvement.

EVALUATION OF THE ISA

The students at Dalhousie set up a task force to lead the student survey. Incentives were provided to encourage student participation. The overall response rate was 70%. This varied by year (year 1 = 75%, year 2 = 85%, year 3 = 62% and year 4 = 57%). Programmatic strengths identified by the students are in the core curriculum of pre-clerkship and clerkship. Curriculum units overall scored very highly, with most queries clearing the threshold for 'no concern'. The learning environment and facilities are also seen as an area of strength of Dalhousie medical school, including the technology linking Halifax with all the distributed sites. The students noted their interprofessional educational experiences (IPE) as an area for improvement, but noted that the school has made recent efforts to improve the unit by partnering with other health professional schools to develop new IPE opportunities. The students also noted that Dalhousie has also made efforts with regard to improved awareness of mistreatment and how to report it. The student recommendations included detailed quality improvement efforts such as refining scheduling of the PIER units and continuing to work with students to modify the RIM program.

The ISA provided some useful information to the site team. Overall, the responses in the ISA revealed a high degree of student satisfaction with their educational experience. However, the students and the faculty acknowledge that in many instances, the data from the ISA differed from the data provided in the GQ. Talking to students during the site visit was a third source of student feedback and the team did its best to triangulate all student data, determine which data was most appropriate for the element (for example GQ data may be more relevant for questions about required clinical experiences than the ISA which included all students) when reaching its conclusions.

The students felt that the survey questions were not always clear to the students, leading to the potential for misinterpretations of the data. This was especially true for some questions where students chose the middle category of a 5 point Likert scale, especially when the mid-point of that scale was "neither agree nor disagree". For example, on the DMNB ISA Addendum (Appendix S2) it was noted on page 14 that students who were in good academic standing are not likely to have accessed academic counseling and when asked a question as to their satisfaction with counseling, might well have chosen 3 (neither agree nor disagree), simply because they never tried to access the service. In addition, focus groups to investigate the concerns with career advising and academic advising showed that some students were not perfectly clear with respect to the distinction of the two terms. The student understanding of IPE also may not have been clear to all students (as discussed on page 35 of the ISA). In the ISA, many students did not feel there were opportunities to participate in service learning. However, at the site visit, it was obvious that there are more opportunities than there are interested students.

An ISA Addendum was carried out on the DMNB campus (Supplemental Appendix S2), as it was important for students at DMNB to have campus-specific results to analyze. This involved a second survey with 3 questions, 2 being DMNB specific, and an interpretation from the DMNB perspective.

From the student perspective at the time of the site visit, and GQ results, 98.5% of respondents rated the quality of their medical education as good, very good or excellent (81.8% ranked it as very good or excellent). The students were generally happy with the leadership, particularly the dean and the associate deans UGME at DMNB and at the Halifax site; so much so that the survey site visit team included leadership as a strength at the school. The team was impressed with how seamlessly the medical school integrated the two sites, Saint John and Halifax, using videoconferencing. All committees have good representation from both sites, and student involvement on all committees is high. Students are pleased with their representation in key decision making committees and value that their voice is heard, through the accessibility of the associate deans and the dean (through lunches with the medical students as one example). Students at the site visit commented on how the administration has listened to student concerns and made positive changes, for example changes made to the RIM program. It is of note that historically the UGME office was not always viewed in such a positive light, and that the appointments of Associate Deans Sutton and Hall have resulted in marked improvement in communications between the UGME office and students as well as the students' perceptions of open communication lines with that office.

Please note that the ISA is found in Appendix C-4 of the Core Appendix.

EVALUATION OF CGQ and AFMC GQ DATA

The response rate for the GQ was 55.9%. The GQ provided some perspective for the team to assess the school. As mentioned previously, there were often discrepancies between the ISA and the GQ that may reflect the different populations who completed each survey and the relevance of the questions to the group completing the survey, and/or different understanding of the questions being asked (for example career counseling vs academic counseling). Overall, in analyzing the 2016 GQ, one observes a high level of student satisfaction ($3.94 \pm .60$). All pre-clinical courses showed a satisfaction score of 3.5 or greater. All clinical rotations showed a satisfaction of 3.5 or greater, except Ob-Gyn (3.11)

EVALUATION OF ELEMENTS BY STANDARD

Please see the following pages for the element rating tables and evaluation forms for each standard.

Site Visit Team
Standard 1 Element Rating Table

School's Self-Rating

Standard 1	Mission, Planning, Organization and Integrity
Element	
1.1	Strategic Planning and Continuous Quality Improvement
1.1.1	Social Accountability
1.2	Conflict of Interest Policies
1.3	Mechanisms for Faculty Participation
1.4	Affiliation Agreements
1.5	Bylaws
1.6	Eligibility Requirements

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 1.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 1 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 1 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 1 Mission, Planning, Organization and Integrity

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

1.1 STRATEGIC PLANNING AND CONTINUOUS QUALITY IMPROVEMENT

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

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 strategic plan is a comprehensive document: http://medicine.dal.ca/about/strategicplan.html. This 28 page document articulates 7 focus areas for the school. The executive summary of the strategic plan can be found in Core Appendix C-6.

The school has a strategic planning steering committee that is charged with oversight of the strategic plan and its renewal. There are three subcommittees, one for each theme of the plan: research, education, serving and engaging society. The plan is reviewed every five years. During the on-site visit we found that there was wide-spread understanding of the pillars of the plan, especially the pillar that speaks to serving and engaging society.

The strategic plan committee has created an evaluation plan with project charters aimed at an ongoing monitoring of the outcomes and milestones of the plan.

In addition to the strategic plan committee's work of ongoing monitoring of the effectiveness of the plan, the dean submits an annual strategic plan progress report to the provost. This reports includes progress on the top 5 strategic priorities and evidence of linkage with the schools plan and priorities and that of Dalhousie University. In addition, each department is charged with the development of its own strategic plan which needs to articulate with the school's plan. This is monitored at the annual department head performance evaluation with the dean.

Accreditation issues have been front and center of the work of Dalhousie for the last 5+ years. They have an appointed Interim Review Coordinator, Dr. Darrell White. In a review of Dalhousie's accreditation history, they have had had either a site visit, a limited site visit or a report due in virtually every year in the last six years. This has culminated in CACMS decisions on compliance with all standards as of this

visit. There is ample evidence that Dalhousie has been taking its accreditation decisions most seriously and has focused time, energy and substantial resources to quality improvement. The process is well integrated with their overall program evaluation initiatives. During the on-site visit we found ample evidence that Dr. White is respected in his role, that he has taken the role very seriously, and that he has the cooperation of the entire faculty and the ear of the dean. We also found strong commitment to the process from Dean Anderson, a commitment that was palpable throughout the visit.

1.1.1 SOCIAL ACCOUNTABILITY

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

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

1.1.1 a The medical school has identified the priority health concerns of the populations it has a responsibility to serve.

1.1.1 b The medical school's social accountability is:

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

RATING

☒ Satisfactory
☐ Satisfactory with a need for monitoring
☐ Unsatisfactory

Evidence to support the above rating

The school has identified the following outcome measures that are rooted in their social accountability mission and reflect attention to the needs of the population: a) attracting and retaining African Nova Scotian and Aboriginal students, b) Implementing Truth and Reconciliation Commission recommendation #24, c) integrating social accountability evaluation and enhancement framework into its governance structure, d) making students aware of careers relevant to the social priorities of the region, e) aspiring to diversity within faculty, staff and senior leadership.

There is evidence that the school has imbedded priority health concerns of the populations it serves into its strategic planning. One of three major elements of the plan is "serving and engaging" that are manifest in two major themes; catalyzing system change to improve health outcomes and partnering with communities to improve health outcomes.

During the 2010 curriculum renewal process there was engagement of the community. In part, this led to the creation of Rural Week and the Professional Competencies Unit. Attention to this thematic element is evidenced in their admission policies, their curricular content, and their proactivity with respect to diversity, such as the Summer Research Program for Non-Medical Students which focus on Aboriginal and African Nova Scotian students. For example, in the last 3 years they have had 79 attendees to summer camps in a program called PLANS: Promoting Leaders in health for African Nova Scotians. They have a robust Aboriginal Health Science Initiative (AHSI). The school provides evidence that they have reached 4082 students through outreach programs in the last 6 years. The school has articulated catalyzing system change to improve health outcomes and partnering with communities to improve health outcomes in their last strategic plan. The school has identified a comprehensive suite of initiatives emanating from the above-mentioned themes.

1.2 CONFLICT OF INTEREST POLICIES

A medical school has in place and follows effective policies and procedures applicable to board members, faculty members, and any individuals with responsibility for the medical education program to avoid the impact of conflicts of interest in the operation of the medical education program, its associated clinical facilities, and any related enterprises.

1.2 a There are conflict of interest policies and procedures that apply to the individuals noted in the element.

1.2 b The medical school informs the relevant individuals about these policies and procedures.

1.2 c These policies and procedures address conflict of interest in each of the following areas:

i. research
ii. faculty with academic and teaching responsibilities
iii. commercial support for continuing professional development

1.2 d There are strategies for managing actual or perceived conflicts of interest in the operation of the medical education program, its associated clinical facilities, and any related enterprises.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Dalhousie, like most Canadian universities operates under a bicameral governance structure. This is well articulated in the DCI, with references to appropriate documents describing its structures. There are well-documented COI policies at the university and medical school level. Specifically, there are policies in place at the medical school level regarding a) procurement, b) relationships with industry, c) creating a professional environment and d) research conduct.

Policies are communicated through appropriate websites, new leader orientation training, and through dissemination through appropriate committees.

Evidence suggests policies cover all areas of potential concern including research, faculty and commercial support.

Dalhousie policies provide specific information on disclosing conflicts and managing conflicts.

All relevant policies are referenced in the DCI.

1.3 MECHANISMS FOR FACULTY PARTICIPATION

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

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

The DCI reports on the constitution of 15 standing committees. All committees have both appointed and elected members with the exception of the tenure committees, which are strictly elected. (Core Appendix C-7). On-site we found strong evidence that faculty and students are engaged in ongoing committee work. There was a high level degree of knowledge from interviewees about current initiatives emanating from committees in the medical school.

The self-study reports on the nomination mechanisms which include solicitation for membership to committees from all faculty members. The nomination committee is charged with the task of ensuring appropriate representation and all appointments are ratified at Faculty Council.

The school deploys several vehicles for notifying faculty of proposed changes; including, announcements on websites, town halls, departmental meetings, electronic surveys, annual faculty meetings, the deans blog, and at Faculty Council. Specific examples of each are provided in the DCI.

An annual meeting occurs each June and notification with agenda and materials are circulated to all faculty members.

The DCI and the self-study provide examples of the multi-pronged communication vehicles the school uses to communicate on issues. These include: email, newsletters, blogs, social media (Facebook, Twitter and Instagram), website communication, Dalhousie vehicles, a Research Quarterly, “lunch with the dean”, visits to DME sites, and a Faculty Council Chair blog. The “lunch with the dean” events are active, and we heard about them in a very positive light, especially from the new faculty.

1.4 AFFILIATION AGREEMENTS

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

- ***a) 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***

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

Table 1.4-1 in the DCI provides the dates of the last signing of relevant affiliation agreements of the medical school with its teaching sites. During our on-site meetings with hospital executives we found ample evidence of strong communications between the medical school and its hospital partners, and moreover, a strong sense of mutual collaboration in a shared mission.

A review of a sample affiliation agreement, between Health PEI and Dalhousie, reveals that the six relevant conditions needed in an affiliation, as outlined by CACMS/LCME are present. Very specifically, in the Health PEI affiliation agreement:

- *the assurance of medical student and faculty access to appropriate resources for medical student education* is found in article 8.1
- *the primacy of the medical education program's authority over academic affairs and the education/ assessment of medical students* is found in article 4.2
- *the role of the medical school in the appointment and assignment of faculty members with*

responsibility for medical student teaching is found in article 3.4

- *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* is found in article 9.4
- *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* is found in article 9.1
- *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* is found in article 6.2

This was an area of noncompliance in 2009.

1.5 BYLAWS

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

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

1.5 b The bylaws or similar policy documents support an effective governance structure for the medical school.

RATING

☒ Satisfactory
☐ Unsatisfactory

Evidence to support the above rating

A description of the terms of reference for the dean are provided in the DCI. The 4 page document outlines the dean's responsibilities and authorities with reference to: a) academic and administrative leadership, b) promoting faculty and staff development, c) participation in institution policy-making and management, d) promoting good student relations, e) promoting external relations, and f) revenue generation.

The DCI provides a link to the faculty's governance document. In review of that document, entitled faculty governance: procedural framework and terms of reference for faculty, faculty council, and standing committees of faculty. This document was approved in 2011, received Senate approval for the terms of reference in 2013 and had minor revisions approved by the faculty both in 2015 And 2016. This 38-page document outlines an effective governance structure for the faculty.

1.6 ELIGIBILITY REQUIREMENTS

A medical school ensures that its medical education program meets all eligibility requirements of the CACMS for initial and continuing accreditation and is either part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine.

1.6 a The medical school and its geographically distributed campuses are located in Canada.

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

1.6 c The medical school is part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Dalhousie Faculty of Medicine is part of Dalhousie University. Established in 1818, it is situated in Halifax, Nova Scotia, Canada.

Students complete all of their training in Halifax, Saint John or one of the affiliated distributed sites in the Maritimes.

Dalhousie University has the legal authority to grant the M.D. degree. Dalhousie is a member of Canada's U15, the group of Canada's research-intensive universities.

STANDARD 2
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 2: LEADERSHIP AND ADMINISTRATION

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

Site Visit Team
Standard 2 Element Rating Table

School's Self-Ratings

Standard 2	Leadership and Administration
Element	
2.1	Senior Leadership, Senior Administrative Staff and Faculty Appointments
2.2	Dean's Qualifications
2.3	Access and Authority of the Dean
2.4	Sufficiency of the Dean's Administrative Staff
2.5	Responsibility of and to the Dean
2.6	Functional Integration of Faculty

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 2.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 2 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 2 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard - Leadership and Administration

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

2.1 SENIOR LEADERSHIP, SENIOR ADMINISTRATIVE STAFF AND FACULTY APPOINTMENTS

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

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

RATING

- ☒ Satisfactory
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school is part of Dalhousie University, founded in 1818. The university has a bi-cameral governance structure with a board of Governors and a Senate. The Board of Governors is responsible for the appointment of academic administrators, including the dean. Offers of employment for the dean, associate deans and other senior administrators come from the President of the University.

2.2 DEAN'S QUALIFICATIONS

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

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

2.2 b The dean's performance in providing effective leadership in the missions of the medical school is evaluated on a regular basis to enhance performance in those areas.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The dean, Dr. David Anderson, is a haematologist. He went to medical school at Dalhousie and did his internal medicine training at Dalhousie as well. He did both clinical and research fellowships in haematology at McMaster University. He is board certified in internal medicine and haematology.

He has been licensed as a medical practitioner since 1992. He has served Dalhousie as a faculty member, as Assistant Dean of Clinical Research, as Head of the Department of Medicine, and was appointed dean, after an internal/external search process in 2015.

An accomplished research scientist, he is funded by CIHR, and currently is the PI on a CIHR grant looking at aspirin vs rivaroxaban in the prevention of venous thromboembolism. He is co-investigator on two other CIHR grants. He has published over 150 articles in peer-reviewed journals. He is the co-founder of the VECTOR research group. He is a well-respected member of the Board of Directors of AFMC (Core Appendix C-8).

The dean's performance is evaluated annually by the Provost and Vice President (Academic). He is measured on the following: a) alignment with strategic directions, b) top 3 contributions in the last academic year, c) biggest challenges faced over the last year, d) updates to the faculty's strategic plan, and e) an overview of the faculty's workload policy and actual workload.

2.3 ACCESS AND AUTHORITY OF THE DEAN

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

2.3 a The dean has appropriate access to the university president or other university official charged with final responsibility for the medical education program in order to fulfill his or her responsibility for the medical education program.

2.3 b The dean has appropriate access to other university officials in order to fulfill his or her responsibilities for the medical education program.

2.3 c The dean has appropriate access to officials in the hospitals or health authorities in order to fulfill his or her responsibilities for the medical education program.

2.3 d The position description of the dean clearly identifies his or her authority and responsibility for the medical education program.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The dean has regularly scheduled meetings with the Provost and Vice President (Academic) to whom he directly reports, and he also has meetings with the President. The dean sits on the Dean's Council which meets every two weeks. He is a functional member of the senior administrative team of the university. In a brief meeting with the President and the Provost, it is obvious that the dean has a strong and warm relationship with the university's senior administration.

The dean has both scheduled meetings with the President and CEO and VPs of health authorities in Nova Scotia, New Brunswick, and PEI. The dean is an ex officio member of the board of the IWK Health Centre and Horizon Health Care network. He attends monthly meetings with Academic Health Science Network, which includes VPs of medicine from Nova Scotia Health Authority (NSHA) and IWK and VP of Research, is a member of the Provincial Medical Advisory Committee of the Nova Scotia Health Authority, regularly serves on advisory committees and *ad hoc* meetings as required and has access to senior department administrators through department heads. As examples of the dean's engagement with the hospital community, we were able to corroborate the close working relationship that Dean Anderson has with the leader of the Nova Scotia Health Authority, the CEO of IWK, and the VP of Horizon Health in NB. The dean and his relationship to leadership of the university, other schools and colleges and administrators of the health science center and affiliated teaching hospitals is outlined in Core Appendix C-9.

The dean has authority for the medical school as outlined in the position description (Core Appendix C-10) and confirmed during the site visit.

2.4 SUFFICIENCY OF ADMINISTRATIVE STAFF

A medical school has in place a sufficient number of associate or assistant deans, leaders of organizational units, and senior administrative staff who are able to commit the time necessary to accomplish the missions of the medical school.

2.4 a There are a sufficient number of vice, associate or assistant deans; senior administrative staff (e.g. CFO), and leaders of other organizational units who have the time necessary to fulfill their responsibility for the mission(s) of the medical school for which they are responsible.

2.4 b Vacant positions are filled in a timely manner that ensures appropriate leadership in these areas.

2.4 c AAMC CGQ/AFMC GQ and ISA data show that the majority of respondents are satisfied/very satisfied with the accessibility and responsiveness of the office of the vice/associate/assistant dean or director of the medical education program (academic) to address their concerns and include them on key medical school committees and working groups.

2.4 d AAMC CGQ/AFMC GQ and ISA data show that the majority of respondents are satisfied/very satisfied with the accessibility and responsiveness of the office of the vice/associate/assistant dean or director of student affairs to address their concerns and include them on key medical school committees and working groups.

2.4 e The performance of the each of the individuals noted in 2.4a and the department chairs is evaluated on a regular basis to enhance performance in the area for which they are responsible.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Table 4.41 of the DCI indicates that there are currently 20 associate deans or assistant deans traversing all major portfolios. Protected time for these administrative roles range from 20% to 100%. In addition, there are 22 department heads (Core Appendix C-11).

Of the 44 members of the senior leadership team, only 2 currently are interim. In 2014/15 and 2015/16 there were no department head vacancies. In 2016/17 there is one interim department head vacancy. Recruitment is underway for this position. The process for survey/search is quite formal and initiates two years before a term end. Discussion with department heads confirmed that any leadership vacancies are filled in a timely manner.

Data from the DCI (2.4-2) indicates a high degree of accessibility for the offices of the associate dean in both Halifax and New Brunswick (84.6% and 90.9% respectively – 2016 data). The ISA reports accessibility of the UGME office ranging from 74% to 92% across the four years of medical school for Halifax and 62%-78% for the medical school in New Brunswick. During the on-site visit we saw repeated evidence of strong engagement of both Associate Deans Sutton and Hall with their respective leadership communities, and conversely, with the senior associate dean and dean.

We heard repeatedly from students during the on-site visit that the offices of the two associate deans UGME were very responsive to student concerns. There has been a noticeable increase in that

responsiveness in both the Halifax and DMNB campus in the last two years, coincident with the arrivals of Associate Deans Sutton and Hall respectively.

With respect to awareness to student problems, 72% of students (2016 data) in Halifax were satisfied or very satisfied and 72% in New Brunswick were satisfied or very satisfied. With respect to responsiveness, 70% of students (2016 data) were satisfied or very satisfied in Halifax, 72% were satisfied or very satisfied in New Brunswick. There has been marked improvement in all of these indices in 2016 compared to data provided for 2014 and 2015. Data from the ISA with respect to accessibility, awareness to student concerns and responsiveness to student concerns ranges from 50% satisfied or very satisfied to 92% satisfied or very satisfied depending on student year and location. In general, percentage satisfied or very satisfied is in the 70 - 80% range in Halifax to 50-60% range in New Brunswick.

The majority of students responding to the GQ were satisfied or very satisfied with the office of the Associate Dean UGME with respect to inclusion of students on key medical school committees; 81.8% in 2016.

With respect to responsiveness, accessibility and awareness to student concerns for the office of the Assistant Dean of Student Affairs there is strong satisfaction reported from both the GQ and ISA (table 2.4-4). This was corroborated through interviews with students who showed strong confidence in the function and responsiveness of the two student affairs teams.

The majority of students responding to the GQ were satisfied or very satisfied with the office of the Assistant Dean Student Affairs with respect to inclusion of students on key medical school committees; 78.6%-87.5% (respondents from years 1-4).

There is evidence of a stable senior leadership team, in that there are only 2 of 44 members who are currently interim. Formal surveys of departments occur every five years, survey reports are reviewed by Faculty Council and by the executive of the relevant health authority for clinical departments and by Faculty Council and the Faculty of Graduate Studies for basic science departments. The dean meets with departments heads and associate deans annually for the purpose of performance evaluation.

2.5 RESPONSIBILITY OF AND TO THE DEAN

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

2.5 a The dean himself /herself or through a delegated chief academic officer (vice/associate/assistant dean), is administratively responsible at each geographically distributed campus for the:

i. conduct and quality of the medical education program
ii. adequacy of faculty

2.5 b The principal academic officer (regional/vice/associate/assistant dean or site director) at each geographically distributed campus reports (organizational charts/position descriptions) to the chief academic officer of the medical school.

2.5 c The faculty and administrative staff who participate or oversee the medical education program at each geographically distributed campus report to the principal academic officer at that campus.

2.5 d The adequacy of faculty at each campus is monitored and the chief academic officer works with the principal academic officer to remedy any deficiencies.

2.5 e The conduct and the quality of the medical education program are monitored at each campus and the chief academic officer works with the principal academic officer to remedy any deficiencies.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

An excerpt from the Tripartite Agreement between Dalhousie University and DMNB was provided in the DCI. In it there is a clear delineation that the Associate Dean DMNB reports directly to the dean. Further, it is clear that the Associate Dean DMNB and the Associate Dean UGME together are accountable to the Dean for the UGME program at both campuses. Moreover, during our on-site review we found a very close and collegial working relationship between the two associate deans UGME. We were very impressed that the two campuses functioned "as one", and there was no sense, whatsoever, that the distributed site was subsidiary to the Halifax site.

The organizational chart for the New Brunswick campus is shown in Supplemental Appendices S8. It was last updated April 2016. The chart clearly shows that the Associate Dean DMNB reports to the Dean.

The organizational chart for the DMNB campus (Supplemental Appendices S8) reveals the organization framework for 36 individuals all of whom report to the Associate Dean DMNB. These 36 individuals consist of assistant deans, directors, managers, coordinators, and other administrative personnel.

It was clear from our meetings with DNMB faculty and from our interview with students, that there is adequate faculty at the DMNB campus. This was further corroborated during the on-site visit to New

Brunswick. In fact, the engagement from the Saint John medical community has been impressive, and there appears to be a "waiting list" of practitioners who want more involvement with the teaching mission at DMNB.

The Associate Dean DMNB has responsibility for the conduct and quality of the educational programs at the campus and reports to the Dean on conduct and quality. There is language in the Tripartite agreement indicating the medical school is responsible for, and monitors, all aspect of the curriculum content, design, delivery and evaluation of program both at DMNB and Halifax sites. This was confirmed during the site visit.

2.6 FUNCTIONAL INTEGRATION OF THE FACULTY

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).

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 three 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

The faculty governance document, last updated June 7 2016, was provided in the DCI. This document states that faculty representation from both campuses is mandatory on all standing administrative committees. Membership requirements in this document specifically state the requirement minimum number of faculty based at the geographically distributed campus, which must participate. Further, we noted that the two campuses functioned together in a seamless fashion. This was true at all levels, for committee work, cooperation at the leadership level, and for student-student engagement. This was so clear, that we noted this aspect of the Dalhousie program as a specific strength.

The DCI provides a table listing 21 committees or programs; all of these committees or programs have terms of reference that ensures representation of faculty from both campuses. This includes the standing committees such as curriculum committee, admissions committee and executive committee of the medical school.

Faculty at the departmental level at each campus are very functionally integrated into the medical school by appropriate administrative mechanisms as outlined in the paragraphs above.

The Clerkship directors at the Halifax campus are responsible for delivery, assessment and comparability at the sites working with DMNB clerkship discipline/site directors. Common objectives and grading systems are used for all students at both campuses. All committees include directors and faculty from both sites and operate seamlessly.

Video conferencing is used extensively to ensure comparability in the delivery of the curriculum. The Associate Dean UGME, Assistant Dean Clerkships and Clerkship directors at the Halifax campus carry out bi-annual site tours of the 5 sites located in New Brunswick. This provides an opportunity for face-to-face meetings with medical education leaders from both campuses. Multiple modalities are used for communication between campuses including video conferencing, web-based conferencing and webinars. Lectures can emanate from either campus. We felt the communication system was so good that this aspect deserved special commendation, both in terms of the human resources and IT infrastructure.

There are minuted meetings from the Undergraduate Medical Education Curriculum Committee (UMECC) and its subcommittees, in which data with respect to patient encounters, student performance data, student evaluation data, and faculty performance are discussed. Minutes of the October 2016 meeting were provided in a supplemental submission and indicate discussion regarding student logs and strategies to optimize student-patient encounters (Supplemental Appendix S1. Information Request Follow Up, page 1).

STANDARD 3
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 3: ACADEMIC AND LEARNING ENVIRONMENTS

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

Site Visit Team
Standard 3 Element Rating Table

Standard 3	Academic and Learning Environments
Element	
3.1	Resident Participation in Medical Student Education
3.2	Community of Scholars/Research Opportunities
3.3	Diversity/Pipeline Programs and Partnerships
3.4	Anti-Discrimination
3.5	Learning Environment/Professionalism
3.6	Student Mistreatment

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 3.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 3 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 3 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 3 – Academic and Learning Environments
SM	3.3 Diversity / Pipeline Programs and Partnerships
	Finding: The school has achieved diversity with respect to the student population and has recognized a stronger need for initiatives to increase diversity at the faculty and leadership level. Measures to address diversity at this level were implemented very recently.
SM	3.6 Student Mistreatment
	Finding: It was recognized that there is a significant focus and commitment on dealing with student mistreatment. There are revised mistreatment policies, and those appear to be effective although relatively recently put in place.

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

3.1 RESIDENT PARTICIPATION IN MEDICAL STUDENT EDUCATION

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

3.1 a Every medical student at each campus in the last three graduating classes worked with a resident in a healthcare setting in a required clinical learning experience of at least a four-week duration.

3.1 b The residents who worked with medical students as described above are, or were enrolled in accredited programs of postgraduate medical education.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Most of Dalhousie's core clerkship sites have Dalhousie specialty residents on-site and clinical instruction takes place in a team environment. The exceptions include the smaller rural and longitudinal integrated clerkship sites. In these sites, Family Medicine residents have an ongoing presence. All rotations have been developed specifically to ensure that all students have the opportunity to work with residents regardless of location. Data from the last 3 years indicates compliance with this standard as shown below in DCI Table 3.1-1.

Table 3.1-1 | Resident Participation in Medical Student Education — Source: School-Reported

Provide the number and percentage of medical students in the last three graduating classes who did not work with a resident in a health care setting in a required clinical learning experience of at least four-week duration by the end of the medical education program. Add rows as needed for each campus.

Campus	AY 2014-15		AY 2015-16		AY 2016-17	
	Number of students	Percentage of students	Number of students	Percentage of students	Number of students	Percentage of students
Halifax	0	0	0	0	0	0
DMNB	0	0	0	0	0	0

3.2 COMMUNITY OF SCHOLARS/RESEARCH OPPORTUNITIES

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

3.2 a The medical school informs medical students about, and encourages them to participate in research and other scholarly activities of the faculty.

3.2 b The medical school supports medical student participation in research and other scholarly activities of the faculty (e.g. coordination of student placements, development of opportunities, or provision of financial support).

3.2 c AAMC CGQ and AFMC GQ data show that respondents who wanted to participate in a research project with a faculty member had the opportunity to do so.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Opportunities and support for students wishing to participate in research are offered. In 2013-2014, the school created the longitudinal Research in Medicine program (http://medicine.dal.ca/research-dal-med/programs/rim/html) that is mandatory - all students must participate in a research project. Data from the 2016 GC confirmed this, with no students lacking an opportunity for research. In the ISA, 6-18% of respondents said they had no opportunity for research, however, the course is mandatory and conversations with faculty and students during the site visit confirmed that there are more research opportunities at both geographic sites than there are students.

The "Research in Medicine" program, according to the ISA, is unpopular among students. The student commentary indicates that this program reduces student interest in research, and frustration with a lack of responsiveness to feedback (ISA 6.8.3). Supplementary information provided by the school (Supplemental Appendix S3. 3.2 ResearchinMedicineProgramEvaluation) demonstrates robust program evaluation involving students, faculty and leaders, with examples of changes made in response to feedback. The program is reviewed each year, however, the governance group of RIM meet every 2 weeks, incorporating student feedback and initiating modifications to the program.

During the site visit, there was consensus among the students that the program has several desirable attributes; multiple disparate ideas for improvement were presented, some of which are in the process of implementation. The students in first and second year felt the program had improved in response to student feedback and their experience was more positive; those in third and fourth year also felt it had improved, and that junior students' experience was improving. Fourth year students admitted to seeing the value of completing such a course when in the process of preparing for CaRMS. When asked, the consensus from the students is that the program should continue, and should continue to be modified in collaboration with student input as continuous quality improvement.

Other opportunities for research include attending Professional and Research Education Program (PREP) sessions throughout the year, participating in The Living Lab projects, Med ED Rounds, Humanities

Research Projects and other opportunities such as research days etc.

3.3 DIVERSITY/PIPELINE PROGRAMS AND PARTNERSHIPS

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

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 has identified indigenous people, African Nova Scotians and women as its diversity targets (Core Appendices C-12 and C-13). It engages in ongoing, systematic and focused recruitment activities to achieve diversity outcomes among its students. In most years, the school's targets are met

(DCI Table 3.3-2) for students. A report on diversity of Dalhousie medical students will be used to track, measure and shape diversity of the future medical students (Supplemental Appendix S4).

For faculty and leaders, there is no target, only a goal to increase (DCI Table 3.3-1). The university has an employment equity policy (DCI Appendix N4), and an Affirmative Action Hiring Policy https://www.dal.ca/content/dam/dalhousie/pdf/dept/university_secretariat/policy-repository/EmploymentEquityPolicy.pdf which identify indigenous people, black Nova Scotians, women, and people with disabilities. It has created the position of Human Rights and Equity Advisor, and a Council on Employment Equity through Affirmative Action. Policies for Senior Administrative Appointments (DCI Appendix N2) and Academic Appointments (DCI Appendix N3) reference the employment equity policy. Dalhousie University has conducted a Diversity Census, showing that the medical school has some diversity among assistant and associate deans, and currently virtually none among department heads (although this has been different in the past). In addition, the medical school approved Diversity, Inclusion and Equity Guidelines (DCI Appendix N1) in December 2016. A "Diversity in Leadership Task Force" began meeting in January 2017; this is tasked with making recommendations to improve diversity in senior leadership roles within the School of Medicine by July 2017 (Supplemental Appendix S1. Information Request Follow Up, page 4).

These measures were instituted very recently (late 2016 and early 2017). Monitoring is required, particularly looking at changes resulting from the work of the "Diversity in Leadership Task Force", and the impact of these changes on hiring policies for senior leadership roles in the medical school.

3.4 ANTI-DISCRIMINATION POLICY

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

3.4 a The medical school and its clinical affiliates have anti-discrimination policies that are made available to faculty, students and other members of the medical school community.

3.4 b The medical school and its clinical affiliates foster an environment in which all individuals are treated with respect and takes steps to prevent discrimination.

3.4 c There is a safe mechanism for reporting incidents of known or apparent breaches of the anti-discrimination policy.

3.4 d Allegations are investigated in a fair and timely manner.

3.4 e There is prompt resolution of documented incidents with a view to preventing their repetition.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Anti-discrimination policies are in place at the medical school and clinical affiliates, and are available on-line (DCI Appendices O1-O5). The clinical affiliates, the dean, and the medical school foster an environment that prevents and does not tolerate discrimination.

Students have 2 options for reporting: to the Dalhousie Office of Human Rights, Equity and Harassment Prevention, or through an online reporting tool. Dalhousie University policy mandates that investigation of allegations be initiated within 5 working days. Other options include reporting directly to a unit head, clerkship director, or Office of Student Affairs. Students on site discussed that they felt comfortable with using any of the options to report breaches.

Student affairs leaders verify investigation and resolution within 2 weeks in most cases. During the site visit, students demonstrated an awareness of safe mechanisms for reporting, and felt the school responds promptly.

3.5 LEARNING ENVIRONMENT/PROFESSIONALISM

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***

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 school has defined the professional attributes that medical students are expected to develop (DCI Appendix AAA1), communicates them effectively, and regularly evaluates students' professional conduct (DCI Appendix P). These attributes include Community Contributor, Lifelong Leaner and Skilled Clinician. Evaluation of the learning environment takes place through rotation evaluation by asking students whether they were made to feel uncomfortable in any way, and whether they were harassed or witnessed harassment (DCI Appendix Q). Site visits to clinical affiliates are conducted annually, including meetings with groups of students, to inquire about the learning environment. Processes are in place for managing instances of student concerns around the learning environment that include the Clerkship director, in consultation with the appropriate leaders, developing an approach to managing the situation and reporting to the Assistant Dean Clerkship to describe the outcome. A report detailing any incidents is provided to the Med3&4 Committee on a quarterly basis. Positive comments are fed back to

department heads so that faculty members can be recognized either informally or formally. There are several awards that recognize excellence.

During the site visit, students affirmed that each rotation evaluation has a section relating to the learning environment, and verified that concerns are followed up promptly and appropriately. Discussions with the clinical affiliates at both DMNB and Halifax (Horizon Health and Nova Scotia Health Authority respectively) confirmed their dedication to ensuring an appropriate learning environment. Discussions with third and fourth year students, residents, and clinical coordinators repeatedly asked about the learning environment responded that the clinical affiliates worked closely with the Faculty of Medicine to implemented appropriate strategies to enhance the positive influences, mitigate the negative influences and to promptly correct violations of professional standards in the learning environment. Each clinical department at the Halifax campus and each hospital site in New Brunswick has a medical education committee. The Associate Dean, UGME is a standing member of each departmental committee. Meetings of these committees provide another avenue for faculty to voice concerns about unprofessional behaviours—either individual incidents or emerging patterns, involving either faculty members, residents, medical students, or staff.

This was an area of noncompliance in 2009.

3.6 STUDENT MISTREATMENT

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.

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, the ISA or more recent 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, the ISA or more recent 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.

3.6 k Since the time of the last full survey, the medical school implemented appropriate educational activities aimed at reducing and preventing student mistreatment at instructional sites where mistreatment has occurred.

3.6 l AAMC CGQ, AFMC GQ and ISA data show that levels of physical and sexual mistreatment of medical students are virtually non-existent.

3.6 m AAMC CGQ, AFMC GQ data, ISA and other data collected by the medical school show that the level of student mistreatment is decreasing.

RATING

- ☐ Satisfactory
- ☒ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

While no formal code of conduct exists, a series of policies appear to have a similar intent and effect. The university has a sexual harassment policy (Supplemental Appendix 10), and the Faculty of Medicine has a personal harassment policy (Supplemental Appendix 11). The university has also created a document for faculty and instructors on instructor-student relationships (Supplemental Appendix 12). During the site visit faculty leaders, hospital leaders and students indicated awareness of these policies. A Professionalism Working Group was struck in 2015 and has completed an environmental scan, and a process to report and address Professionalism concerns and the Learning Environment.

Students have multiple avenues for reporting: in-person, on-line, and anonymously (DCI 3.6a). Measures exist to protect students from retaliation. Dalhousie Faculty of Medicine's personal harassment policy with a statement against retaliation towards students who file mistreatment complaints:

> "There will be no retaliation against any person on account of a complaint or an expressed intention to complain under this Policy or on account of evidence or assistance given with respect to a complaint or a proposed complaint under this Policy. Such retaliation will be grounds for a complaint under this Policy."

Similar retaliation statements are included in the university's sexual harassment, prohibited discrimination and harassment policies. Communication and information gathered is confidential except to the limited extent that it must be disclosed to implement the harassment policies (e.g. information disclosed to Investigation Committee) or for disciplinary or remedial steps (e.g. contact with Human Resources). The complainant is consulted at each step of the process and can bring up any concerns about retaliation. The student may also meet with the Assistant Dean Student Affairs in Halifax, Director of Student Affairs DMNB and/or personnel in Student Affairs (all individuals are available to students at both campuses) to discuss any fears of the process. If a student feels they are being retaliated against they can make another complaint under the policy. If a student would like to file a complaint against an Associate Dean or the Senior Associate Dean, they will be directed to the Senior Associate Dean or the Dean, respectively. If students are not comfortable making a retaliation complaint through the same mechanisms, they can access central university resources. Students at both campuses can access Dalhousie's Office of Human Rights, Equity and Harassment Prevention (http://www.dal.ca/dept/dalrespect.html). DMNB students may also access the Human Rights and Positive Environment Office (http://www.unb.ca/humanrights/) at the UNB Saint John Campus. In discussion with students on site, students were confident that the school protected students effectively from retaliation.

The GQ and ISA provide conflicting evidence about awareness of mistreatment policies. GQ data suggests over 75% awareness of both policies and procedures (Core Appendices C-14 and C-15), while the ISA shows 44% familiarity with the medical school's policy on mistreatment, and 41% know how to report (ISA 6.6.1). On site, it was suggested by students that a reason for these low values in the ISA may be attributed to them having not ever had to look for the policy and a lack of confidence in knowing exactly where to find it, although they were confident they could find it online or on BrightSpace if necessary.

Student mistreatment (Core Appendices C-16 and C-17) occurs with some regularity, according to GQ data (DCI Table 3.6-5): over 10% of students at the Halifax campus reported at least one incident of: threats of physical harm, denied opportunities for training or rewards based on gender, subjected to offensive, sexist remarks/names. At the DMNB campus over 10% of students reported being subjected to offensive, sexist remarks/names. 5-10% of students indicated they were subject to unwanted sexual advances at the Halifax campus, and were denied opportunities for training or rewards based on gender. These rates do not appear to be decreasing however, the school has a strong awareness and focus on addressing this.

During the site visit we found that faculty leaders demonstrated awareness of, and interest in, the conduct and mistreatment policies, and are actively engaged in investigating and resolving reported incidents. The students we met were aware of the policies and the multiple reporting procedures, including confidential and anonymous reporting. Faculty and hospital leaders described prompt investigation and appropriate resolution of reported mistreatment, and students in all years said they are satisfied that investigation and resolution occurs promptly, and that their right to confidentiality is explained to them and is respected. It was clear at the site visit that the focus on mistreatment is new, and at the time of the visit incidents are investigated and managed by the Assistant Dean Student Affairs together with the Senior Associate Dean, with an indication that this may be delegated to other faculty in the future. Monitoring is required to ensure ongoing student satisfaction with both the new processes, and the incidence of mistreatment.

While no formal code of conduct exists, the series of policies outlined appear to have a similar intent and effect. During the site visit faculty leaders, hospital leaders and students indicated awareness of, and use, of these mechanisms to report and deal with mistreatment. It appears that the Professionalism Working Group has been successful in creating awareness for both faculty and students, and in creating effective reporting mechanisms. These changes are recent, implemented after the accreditation documentation was submitted. Data is required to verify that this is both effective and sustained.

This was an area of non-compliance in 2009.

STANDARD 4
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

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

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

Site Visit Team
Standard 4 Element Rating Table

Standard 4	Faculty Preparation, Productivity, Participation, and Policies
Element	
4.1	Sufficiency of Faculty
4.2	Scholarly Productivity
4.3	Faculty Appointment Policies
4.4	Feedback to Faculty
4.5	Faculty Professional Development
4.6	Governance and Policy-Making Procedures

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 4.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 4 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 4 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 4 – Faculty Preparation, Productivity, Participation, and Policies

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

4.1 SUFFICIENCY OF FACULTY

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

4.1 a The medical school has a sufficient number and types of faculty members to deliver the medical education program at each campus.

4.1 b The directors of required learning experiences, hospital site directors, campus site directors (includes longitudinal integrated clerkship site directors) and the chair of the curriculum committee (or equivalent committee) have the appropriate amount of protected time (time with salary support or release from other responsibilities) to fulfill their responsibilities in the medical education program.

4.1 c The medical school anticipates faculty retirements and plans recruitment activities to minimize any negative impact on the delivery of the medical education program at each campus.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The total number of faculty is found in Core Appendices C-18. The medical school has sufficient types of faculty to deliver the medical education program. Data from internal sources (student performance and student satisfaction, as presented in the *DMNB 2015-2016 Supplementary Report*, Supplemental Appendix S1 Information Request Follow Up page 8) and from external sources (e.g., residency program directors' assessment of graduates' performance, analyzed by campus) show a number of small differences between the two campuses. During its meetings with students, faculty and administration at the survey visit, the team determined that insufficiency of faculty at the DMNB campus is not a contributing factor. Although the number of basic science faculty members at the DMNB campus is small (5 basic science faculty), the size of the student cohort at this site is also small (30 students). Students expressed no issue with the number of basic science faculty during discussions in Saint John.

The directors of required learning experiences, hospital and campus site directors and the chair of the curricular curriculum have specifically allocated, appropriate protective time to fulfill their medical education program responsibilities (Core-Appendix C-19).

The school tracks anticipated faculty attrition and states that it anticipates no reductions in faculty complement over the next three years. It also states that "as vacancies are anticipated (across all disciplines), each position will be evaluated individually to ensure the medical school has a sufficient cohort of faculty members with appropriate qualifications and available time to deliver the medical education program" (DCI 4.2b). This assessment depends upon a clear determination of faculty needs, based upon comparability metrics, at both Halifax and DMNB. The school has committed significant effort and resources to ensuring that these needs are continuously monitored.

4.2 SCHOLARLY PRODUCTIVITY

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

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

4.2 b The medical school requires some faculty members to engage in scholarly work for promotion, and if applicable tenure.

4.2 c The medical school fosters and supports faculty members' development as scholars by appropriate means.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The faculty demonstrates scholarly productivity over the past three years, although there is variability in the way in which data are collected at the departmental level (Core Appendix C-20). In 2015, there were over 1300 peer reviewed manuscripts, and over 900 extramural grants held by faculty.

The school clearly delineates expectations for and supports development of faculty scholarship. In 2016 a new Academic Funding Plan (AFP) was negotiated and approved; 12/16 clinical departments are implementing the new AFP in AY 2016-17. There is a continuing professional development unit, a Division of Medical Education unit, a Dalhousie Medical Research Foundation that supports research, a Medical Research Development Office and Research Services provided by Dalhousie. The affiliated health centres also provide supports to faculty for scholarship.

4.3 FACULTY APPOINTMENT POLICIES

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

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

4.3 b If the medical school has different employment (career) tracks, the description of the requirements for each track is clear. The information about career tracks is communicated to faculty as well as the selection or assignment process, and the requirements for advancement within the career tracks.

4.3 c Each faculty member is given written information about his or her term of appointment, responsibilities in teaching, research and where relevant patient care, lines of communication, privileges and benefits, performance evaluation and remediation, terms of dismissal, and if relevant, the policy on practice earnings.

4.3 d Each faculty member is notified regularly of the terms and conditions employment including privileges, benefits, compensation including policies on practice earnings, and responsibilities in teaching, research and where relevant patient care.

4.3 e Each faculty member is notified in timely way when there are changes made to his or her terms of employment including privileges, benefits, compensation including policies on practice earnings, and responsibilities in teaching, research and where relevant patient care.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school has clear policies in place for faculty appointment, appointment renewal, promotion, tenure, remediation, and dismissal. These are the University Regulations Concerning Appointments, Tenure and Promotion (1987) and the University Policy regarding Academic Appointments (2013). Faculty of Medicine Promotion and Tenure Guidelines provide additional information explaining the above policies for faculty. Tenure stream appointments are governed by the Collective Agreement between the Board of Governors and the Dalhousie Faculty Association 2014-2017. All policies can be found at https://medicine.dal.ca/for-faculty-staff/promotion_tenure.html. Each faculty member is provided with terms of his/her appointment at the time of hire. This includes written information about his or her term of appointment, responsibilities, lines of communication, privileges and benefits, performance evaluation and remediation, terms of dismissal, and, if relevant, the policy on practice earnings.

There are three main employment tracks: tenure stream, continuing and limited term. These are clearly outlined in the documents listed above. Faculty members receive clear, regular, and ongoing information regarding their conditions of employment, responsibilities, privileges, compensation, and benefits.

Requirements for advancement are discussed annually with the department chair. Promotion criteria are found at https://medicine.dal.ca/for-faculty-staff/promotion_tenure.html along with worksheets and checklists. Position descriptions are discussed and reviewed annually with the department head. Any changes are discussed at this time.

4.4 FEEDBACK TO FACULTY

A medical school faculty member receives regularly scheduled and timely feedback from departmental and/or other programmatic or institutional leaders on his or her academic performance and progress toward promotion and, when applicable, tenure.

4.4 a Faculty members receive regularly scheduled and timely feedback from departmental and/or medical education program or university leaders on his or her academic performance and progress toward promotion and, when applicable, tenure (there is documentation to support this statement) at each campus.

4.4 b The provision of regular and timely feedback to faculty members is monitored to ensure it occurs.

4.4 c The medical school or the university has policies that require faculty to receive regular formal feedback on their performance and their progress toward promotion and, if relevant, tenure.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school has policies in place for provision to faculty of regular and timely feedback on performance and progress toward promotion (and, if applicable, tenure). These include Regulations Concerning Appointments, Tenure and Promotion (1987) articles 3, 5 and 6 http://www.dal.ca/content/dam/dalhousie/pdf/university_secretariat/policy-repository/AppointmentTenurePromotionRegulations.pdf; Board/Dalhousie Faculty Association Collective Agreement (2014-17), Article 15, 16, 17 and 20 and Clause 31.08 http://www.dal.ca/content/dam/dalhousie/pdf/hr/Academic-Staff-Relations/DFA-collective-agreement.pdf and Regulations Concerning Continuing Appointment with Annual Academic Career Development (2013) article 2. The Dean holds department heads responsible for this feedback and, according to the DCI, receives annual reports from the department heads on the meetings held with faculty. At the survey visit, the team confirmed in its meetings with department heads and junior faculty that progress is monitored, that the meetings between department heads and faculty occur, and that faculty at DMNB have opportunities for feedback and career development equivalent to those available to faculty at Halifax.

4.5 FACULTY PROFESSIONAL DEVELOPMENT

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

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.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Dalhousie Medical School's Faculty Development Program is located within the Office of Continuing Professional Development (CPD) and Dalhousie Medicine New Brunswick (DMNB), with parallel reporting to the Associate Dean, CPD and the Associate Dean DMNB.

In Halifax, there is a Director of Academic Faculty Development (0.4 FTE) and a Director of Community Faculty Development (0.2 FTE), both of whom report to the Associate Dean, CPD. A Faculty Development Manager (1.0 FTE) reports to the directors of Community and Academic Faculty Development, and a Program Coordinator (0.5 FTE) reports to the CPD Office Manager. In Saint John, a Faculty Development Director (DMNB) (0.2 FTE) reports to the Associate Dean DMNB and a Faculty Development Manager (1.0 FTE) reports to the COO for DMNB. The COO, in turn, reports to the Associate Dean DMNB.

In addition, there are educators (including PhD medical educators, simulated patient educators, and

evaluation specialists) within the Division of Medical Education (DME) and Undergraduate Medical Education (UGME) who collaborate and consult with Faculty Development. Two research associates in the Office of CPD provide research support to the seven directors.

Faculty Development also draws upon the expertise of a large number of AFP and non-AFP faculty, who provide teaching in the medical school's Clinician-as-Teacher (CAT) program, as well as in other CPD programming.

At the university level, the Centre for Learning and Teaching also assists faculty in improving their teaching and assessment skills. The centre offers professional development opportunities, awards, grants and other resources and supports. Thus, there is an appropriate number of individuals with the required expertise and time to assist faculty in developing their teaching and assessment skills.

The medical school identifies faculty development needs through a variety of mechanisms, including environmental scans and surveys.

Sessions are provided both "onsite" and via webinar, and the faculty development team also is available for department- or site-based programming upon request. In person session with experts traveling to various sites, and train the trainer sessions are also offered to develop localized expertise. Communication on faculty development activities include bi-weekly emails to all faculty outlining upcoming sessions , Faculty Development website, notices on the DalMedix calendar, electronic posters sent to medical education coordinators for display, targeted communication to relevant offices, such as PGME, UGME etc, departmental newsletters etc.

Remediation of faculty teaching and assessment issues is dependent upon the problem areas identified. Any issues reported (e.g., through SRI or other means) would first be discussed between the department head and faculty member. Together they would identify and/or consult with the appropriate resources, including:

- The Office of CPD/Faculty Development provides guidance and support as needed. For example, a faculty member may need to attend specific faculty development offering/s on topics such as assessment or having difficult conversations. Faculty Development offers sessions to help anticipate possible needs of faculty, in advance of any problems. Faculty Development is also available to assist in identifying/facilitating targeted remediation on particular topic areas as requested.
- The Division of Medical Education is also often called upon as a resource with support from the Communications Skills Director and the use of the CCCLR (Centre for Collaborative Clinical Learning and Research) to implement learning plans.

Dalhousie's Centre for Learning and Teaching is an additional resource for faculty. They offer workshops, customized support and various resources.

For assistance with curriculum design, instructional methods or program evaluation, the Director of Academic Faculty Development, CPD, Director of Community Faculty Development, CPD, Faculty Development Manager, CPD, Director of Faculty Development, DMNB, Faculty Development Manager, DMNB and Evaluation Specialist DMNB are all able to assist faculty. In UGME, there are two full-time staff (one Assessment Specialist and one Evaluation Specialist) who collaborate with and support faculty in their assessment- and/or evaluation-related needs. Two full-time evaluation specialist in CPD—one in PGME and one in the Dean's Office—are also available to assist and support faculty with program evaluation. Individual departments may also provide sessions for faculty. For example, Family Medicine and Internal Medicine both offer faculty development programming for their members. At the university level, the Centre for Learning and Teaching works in partnership with individuals and groups on course

design and program development. Depending on the need, the CLT team offers workshops and individual consultations to support faculty members in enhancing their skills.

Faculty Development (CPD office) offers relevant one– to two-hour facilitated sessions three to four times per year—as in-person workshops, rounds or online webinars—to assist faculty members in preparing for promotion. Faculty Development also provides resources to support promotion on its website and, in the future, will do so on the online learning platform via eModule.

Research skills and grant procurement have not been prominent faculty development topics, but programs are available at the H**a**lifax campus from the Medical Research Development Office, the Division of Medical Education, the Research Methods Unit and Dalhousie Research Services. Discussions with faculty in DMNB provided evidence of good participation on webinar-based offerings from faculty members based in New Brunswick. Most formal onsite programming is based at Halifax.

The table provided in Supplemental Appendix 9 shows good faculty attendance at faculty development sessions.

This was an area of noncompliance in 2009.

4.6 GOVERNANCE AND POLICY-MAKING PROCEDURES

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

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

4.6 b This executive committee or other similar medical school leadership group meets often enough to fulfill its responsibilities.

4.6 c There is a list of priority areas that the committee addressed during the last academic year.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The Faculty Council is the governing body for academic affairs for the school of medicine. It has elected faculty members as well as ex officio members, including the Dean and members of his administration. The UGME Curriculum Committee is a standing subcommittee of the Faculty Council; it works with the Dean to determine the governance and policy-making procedures of the medical education program. Both committees meet monthly and have addressed appropriate priority areas over the last academic year. Over the past year, Faculty Council focused on such priority areas as approving the renewed clerkship, overseeing implementation of LICD, approving promotions of medical students, and reviewing recommendations from the Progress Committee with regard to student promotions.

STANDARD 5
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 5: EDUCATIONAL RESOURCES AND INFRASTRUCTURE

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

Site Visit Team
Standard 5 Element Rating Table

School's Rating

Standard 5	Educational Resources and Infrastructure
Element	
5.1	Adequacy of Financial Resources
5.2	Dean's Authority/Resources
5.3	Pressures for Self-Financing
5.4	Sufficiency of Buildings and Equipment
5.5	Resources for Clinical Instruction
5.6	Clinical Instructional Facilities/Information Resources
5.7	Security, Student Safety and Disaster Preparedness
5.8	Library Resources/Staff
5.9	Information Resources/Staff
5.10	Resources used by Transfer/Visiting Students
5.11	Study/Lounge/Storage Space/Call Rooms
5.12	Required Notification to the CACMS

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 5.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 5 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 5 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 5 – Educational Resources and Infrastructure

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

5.1 ADEQUACY OF FINANCIAL RESOURCES

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

5.1 a The dean has authority for the budget of the medical school and the governance of the medical school supports the effective management of its financial resources.

5.1 b The trends in past and present financial resources of the medical school indicate that they are stable and adequate to sustain the medical education program and to accomplish other goals of the medical school.

5.1 c The anticipated financial resources of the medical school appear to be adequate to sustain the medical education program and to accomplish other goals of the medical school.

5.1 d If there is an anticipated decrease in the financial resources of the medical school, there is a plan to address the shortfall.

5.1 e If the financial reserves were used over the past three years to balance the operating budget, the financial reserves were restored in a timely manner.

5.1 f The dean engages in effective financial planning that addresses the operating budget, current and projected capital needs and financing deferred maintenance of medical school facilities.

5.1 g The key findings resulting from an external financial audit are consistent with the other financial data provided by the medical school and indicate that the medical school has adequate operating funds.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The dean of the medical school has overall responsibility for the budget of the school. He is assisted in this task by a finance committee, and works during the budgeting process with the Council of Assistant and Associate Deans, and the Joint Departments Heads. The Faculty of Medicine is part of Dalhousie University and the dean submits an annual budget for approval to the University Budget Office.

A review of the financial information summarized in the DCI (Core Appendices C-21 and C-22) reveals three years of revenue statistics that show an overall stable picture. On-site, the dean confirmed that some financial uncertainties from the past have been reconciled through a multi-year governmental commitment to the medical school.

Revenue sources are multi-dimensional and include: a) university operating budget, b) provincial funding, c) Practice Plan (AFP) funding, d) VISA trainee funding and e) other sources. The total operating funding appears to be sufficient for the size of the enterprise.

There is no forecasting of any deficit or changing financial picture in the submitted materials.

The DCI reports that carry-forwards have not been used to balance the budget in the last three years.

The dean participates in the financial planning for the medical school and has overall budget responsibility. The dean reviews quarterly variance reports with the Director of Finance. As reported in the DCI, the dean is involved in capital planning via: 1) making submissions to Dalhousie Alterations & Renovations Fund. ($776,000 allocated to the medical school in the last three years), b) spearheading laboratory renovations, and c) working with Facilities Management on major capital projects, such as a current $12 energy re-fit project in the school's scientific facilities.

The medical school does not have a financial audit, with the exception of the New Brunswick campus. The DMNB audit is provided. For the Dalhousie campus, the university's audit role-up is presented, and reports a balanced budget. This was an area on noncompliance in 2009.

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5.2 DEAN'S AUTHORITY/RESOURCES

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

5.2 a The chief academic officer (CAO) (dean or vice/associate dean) has sufficient protected time (salary support or release from other responsibilities) to fulfill his or her responsibilities for the management and evaluation of the medical curriculum.

5.2 b The CAO participates in medical school-level planning including planning for geographically distributed campuses to ensure that the resource needs of the medical education program (e.g., funding, faculty, educational space, and other educational infrastructure) are considered.

5.2 c There is administrative and academic support for the planning, implementation, evaluation and oversight of the curriculum, and for the development and maintenance of the tools (e.g., curriculum database) to support curriculum monitoring and management. The individuals providing the administrative and academic support are accountable to the CAO.

5.2 d The number and types of individuals who provide administrative or academic support for the planning, implementation, and evaluation of the curriculum and for student assessment are sufficient. These individuals have adequate protected time (salary support or release time from other responsibilities) to fulfill their responsibilities related to the curriculum.

5.2 e The process used to determine the budget for the medical education program and the mechanisms by which funds are distributed to support teaching are appropriate and effective in facilitating delivery of the curriculum.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The CAO for the medical program is the dean, who delegates the management of the program to the UGME Associate Deans. At Dalhousie, there are two such individuals, one for the Dalhousie campus and the entire medical program, and one specifically for the DMNB campus (Associate Dean DMNB). The protected time for the two individuals is 80% and 70%, respectively.

The UGME Associate Deans are part of the budget planning process, part of the senior leadership team, have monthly meetings with the dean, and have quarterly meetings with the Finance Director and Assistant Dean Operations. The two UGME deans meet weekly.

The UGME Associate Dean has as direct reports an evaluation specialist, an assessment specialist, an assistant dean clinical skills, an assistant dean clerkship, and an assistant dean operations. The assistant dean operations has as a direct report a UGME administrator who in turn, interacts with 11 sector leads. For the DNMB site there is, in addition to the Associate Dean DMNB, an assistant dean for clinical education, a COO, and operations manager, a technical operations manager, and nine other administrative positions.

There appears to be sufficient personnel to provide administrative and academic support to the MD program. The names of the individuals are provided in the DCI. These include, UGME leaders, Associate

and Assistant deans, evaluation specialists, curriculum administrators, education coordinators for the pre-clerkship and the clerkship, unit heads for the pre-clerkship courses, departmental leads for the clinical curriculum and electives coordinators.

The DCI provides details of specific budget information for the various elements of the UGME program. There has been significant investment into the UGME administrative sector since 2009. While the faculty has seen a budgetary increase of 26% the UGME budget has grown by approximately 300%. The student affairs budget has grown by 65%. A specific breakdown of approximately $1M of salary commitment to support the UGME program is detailed in the DCI. On site, we found a strongly engaged and considerable team of associate deans, assistant deans, unit leaders, and senior administrators. This was an area of noncompliance in 2009.

5.3 PRESSURES FOR SELF-FINANCING

A medical school admits only as many qualified applicants as its total resources can accommodate and does not permit financial or other influences to compromise the school's educational mission.

5.3 a In setting the size of the medical school entering class, medical school resources, such as space, faculty numbers, and teaching responsibilities are taken in account such that the quality of educational program is not compromised.

5.3 b The pressures to generate revenue from tuition, clinical care, and/or research are managed to ensure the ongoing quality of the medical education program.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school class size has been stable; ranging over the last five years from 100-110. The extra 10 seats were a product of opening the DMNB campus. Prior to the opening of the campus, 20 seats at Dalhousie were reserved for New Brunswick students. With the opening of the campus, 10 new seats were added. The DCI presents data to indicate that in the last three years, 99% of the students were a product of domestic enrolment. Tuition fees are reported to be at the mid-range for Canadian medical schools.

The medical school does not appear to be under any undue pressure to generate additional revenues. The financial situation is monitored and managed by: a) the Finance Committee of the faculty, b) an AFP renewal process, c) an integrated multi-year budget process.

5.4 SUFFICIENCY OF BUILDINGS AND EQUIPMENT

A medical school has, or is assured the use of, buildings and equipment sufficient to achieve its educational, clinical, and research missions.
Note: If the medical school operates one or more geographically distributed campus, provide the data separately for each campus.

5.4 a Data from the ISA show that a majority of respondents are satisfied/very satisfied with the adequacy of lecture halls, large group classroom facilities, small group teaching spaces, and space used for clinical skills teaching at each campus of the medical school.

5.4 b If educational spaces used for required learning experience in years one and two of the curriculum (lecture halls, large and small group rooms, and laboratories) are shared with other schools/programs, there is a mechanism for scheduling these spaces that accommodates the needs of the medical education program such that the delivery of the curriculum is not disrupted.

5.4 c If the facilities used for teaching and assessment of students' clinical and procedural skills are shared with other schools/programs, there is a mechanism for scheduling these facilities that accommodates the needs of the medical school so that teaching and assessment are not disrupted.

5.4 d If there was an increase in class size since the time of the last full survey, teaching space was adjusted to accommodate the increase in class size.

5.4 e If an increase in class size is anticipated over the next three years, there is a plan to adjust teaching space if needed to accommodate this increase.

5.4 f The facilities and resources for basic, clinical and evaluative research are appropriate to support the research mission of the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Data from the ISA shows overwhelming positivity about all three categories of facilities at both the Dal and DMNB campuses. Positive (satisfied or very satisfied) response rates range from 85.7% to 100% across the 4 Years of student respondents.

The DCI outlines that the programs at the Dalhousie Campus run primarily out of 4 facilities: the Sir Charles Tupper Medical Building which underwent a 23M$ renovation in 2009, the Life Sciences Research Institute, the Clinical Research Centre, and a new Collaborative Health Education Building (CHEB) which opened in 2016.

The facilities at DMNB were reviewed by the visiting on-site team, and reported to be excellent, modern and appropriate for the number of students. Specific mention was made of the excellent IT facilities at DMNB, which function seamlessly for communication with the Halifax site on a daily basis. It is also of note that DMNB students and faculty have access to many resources provided by the University of New

Brunswick.

There appear to be appropriate processes for inter-faculty communication with respect to facility utilization. For example, an operations advisory committee at the University ensures that faculties have access to appropriate educational and research space.

The MSS reports no increase in class size since the last survey. (see 5.12)

There are no plans to increase the class size in the near future.

The MSS provides details of the research space, both in Halifax and NB campuses. The epicenter of the research facilities is in Halifax. The DCI reports 240,000 square feet of research space in Halifax, and 7375 square feet of space in NB. There are a suite of core research services provided to faculty, including an animal care facility, a cellular and molecular digital imaging facility, an enhanced gene analysis discovery facility, a flow cytometry facility, a brain tissue bank, a proteomics and mass spectrometry facility, and a zebrafish facility. There are dry lab facilities at hospital sites in Halifax to which clinical faculty have access. In addition, there are research facilities in the hospital settings. A research budget of $63 million in 2015-16 provides evidence of substantial research productivity and opportunities for student learning.

5.5 RESOURCES FOR CLINICAL INSTRUCTION

A medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in ambulatory and inpatient settings and has adequate numbers and types of patients (e.g., acuity, case mix, age, gender).

5.5 a Data provided by the AAMC CGQ and the AFMC GQ show that the majority of respondents at each campus agree/strongly agree that they had sufficient access to the variety of patients and procedures required for the encounter log in the seven core required clinical learning experiences listed in the survey.

5.5 b When selecting inpatient and ambulatory teaching sites for required clinical learning experiences for both rotation-based and longitudinal integrated clerkships, the medical school makes an initial determination and then monitors to ensure there are adequate numbers and types of patients to support the number of students placed at each site.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

A review of the GQ for 2016 reveals a mean response rate ranging from 3.91- 4.36 with respect to sufficient access to the variety of patients and procedures required during clinical clerkship. The response to question 21 on the GQ for DMNB on the sufficiency of variety of patients and procedures in both psychiatry and paediatrics at the New Brunswick campus (with 11 respondents) demonstrated a mean of 3.55 for psychiatry and 3.73 pediatrics. Similar figures were evident for 2015 as well.

Supplemental materials were submitted prior to the site visit regarding paediatrics and psychiatry at DMNB (Supplemental Appendix S1. Information Request Follow Up, page 12). The satisfaction rate of 72.8% with patient exposure in paediatrics DMNB prompted a review and reallocation of students from Upper River Valley to Saint John for a concentrated paediatric experience. Student satisfaction with this has been positive. ISA indicated that the paediatric rotation was meeting expectations (more than 70% of students agreed or strongly agreed that they were satisfied with each query in the ISA on Psychiatry). Student performance on paediatric examinations was equivalent for Halifax and DMNB.

Similarly, the low satisfaction rates at DMNB with psychiatry (2016 GQ) were reviewed, and plans were developed and instituted:

a. Authorization to recruit three new faculty, two of whom are in place.
b. Reorganization of DMNB psychiatry clerkship director's time
c. Regular meetings are taking place between the directors at Halifax and DMNB.
d. A new faculty development plan for new and existing faculty has been put together

On-site, we confirmed the above changes. ISA data on student satisfaction with psychiatry shows the rotation is meeting expectations (more than 70% of students agreed or strongly agreed that they were satisfied with each query in the ISA on Psychiatry). Student performance on psychiatry examinations is equivalent in Halifax vs DMNB.

There appears to be adequate measures in place to ensure the adequacy of clinical experiences at the

many sites used for clinical education. There are 27 sites used by Halifax students and five sites used by New Brunswick students. The DCI reports that the Assistant Dean Clerkship and Assistant Dean Clinical Education (DMNB) work with clerkship directors and preceptors to ensure that each student has access to the types of patients they need to see to acquire the clinical learning experiences required in the Patient/Clinical Encounter Log.

Students are required to log at least one of each encounter or procedure via One45. Logs are reviewed as part of formative and summative ITER completion in each clerkship rotation. Students discuss deficiencies with their preceptors, who ensure they are given the opportunities to complete them. At the end of the year, students self-report any outstanding encounters and procedures, so they can ensure that they complete equivalent experiences by the start of the Med 4 year. On-site, we were able to confirm a robust process of notification to both students and faculty of any impending deficiency in mandatory clinical encounters, resulting in cogent strategies to address these deficiencies. Clerkship directors are able to create alternate experiences (such as video clips or simulation exercises) to fulfill the requirements for any log items that would otherwise have remained incomplete at the end of the academic year.

5.6 CLINICAL INSTRUCTIONAL FACILITIES/INFORMATION RESOURCES

Each hospital or other clinical facility affiliated with a medical school that serves as a major location for required clinical learning experiences has sufficient information resources and instructional facilities for medical student education.

5.6 a Data from the ISA 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 Data from the ISA 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 DCI reports ISA data regarding student satisfaction with clinical facilities, Table 5.6-1. In a review of the data from student years that would be relevant to this question (year 3 and year 4) it is seen that between 80 – 100% of respondents indicate that they are satisfied with the clinical facilities with respect to ambulatory care, teaching space and information resources at both campuses, with the exception of only 60% of third year students at DMNB being satisfied with accesses to information resources. Of note, bi-annual visits are made from the Halifax campus to the DMNB campus to ensure the provision of adequate space and optimal clinical learning opportunities. All affiliated health centre/authority libraries have trained library staff and all Dalhousie students have online access to electronic journals and books through the main university library, regardless of location. The DCI describes how the Med 3 and Med 4 committees monitor resources, in that they describe the situation at New Brunswick, where at one site students had to use public access wifi which was reported as problematic. Through the committee's work students were given access to the health provider wifi.

The on-site teams had the opportunity to visit the facilities in both Saint John and Halifax, and discuss with students, confirming the adequacy of required physical resources at both sites.

5.7 SECURITY, STUDENT SAFETY, AND DISASTER PREPAREDNESS

A medical school ensures that adequate security systems are in place at all locations and publishes policies and procedures to ensure student safety and to address emergency and disaster preparedness.

5.7.a Data from the ISA show that the majority of respondents are satisfied/very satisfied with the adequacy of safety and security at all instructional sites.

5.7.b There are security systems in place to ensure student safety in each of the following situations:

i. on campus during regular classroom hours
ii. on campus outside of regular classroom hours
iii. at clinical teaching sites used for required learning experiences

5.7 c There are protections available to medical students at instructional sites that may pose special physical dangers (e.g., during interactions with potentially violent patients).

5.7 d The medical school's or university's policies and procedures to ensure student safety are communicated to students and faculty.

5.7 e The medical school or university has disaster preparedness policies, procedures, and plans that are communicated to students, faculty and staff.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The DCI reports ISA data (Table 5.7-1) indicating that between 81 – 100% of respondents at both Halifax and DMNB sites are either satisfied or very satisfied with the adequacy of safety and security at instructional sites. Interviews with students confirmed their knowledge of security safeguards that are available and a general sense of "feeling safe" on campus and in the hospitals.

The DCI details the security system available at the Halifax campus including, but not limited to card access readers, alarms and security cameras. Details of steps to ensure security after hours are provided and the university has elaborated a crisis management plan. An on–campus emergency notification system, DalAlert is operational. A mobile app, DalSAFE provides easy access to security services. Recently the medical school has invested $130,000 for up graded security in the Tupper Building. At DMNB there is a WalkSafe program, surveillance cameras and electronic access cards are in regular use.

With respect to security outside of regular hours, access to the Tupper Building requires an access card (Dalcard). A building attendant is hired for the library after hours. Similar security measures are in places at the CHEB building. Security officers circulate the facility, a free ride service is available to all students known as Tiger Patrol and taxi services are offered to students with after hour responsibilities. At the DMNB campus there is a 24-7 SafeWalk program, regular building walk-throughs occur after hours and escort facilities are available through the SafeWalk program. Interviews with students confirmed their use and access of these services.

Details of security systems for the Nova Scotia Heath Authority, the IWK Health Centre, the Horizon Health Network and Health PEI are provided in the DCI.

The DCI describes safety devices such as eyewash stations, emergency decontamination showers and other safety measures at the Halifax campus. The university has a critical incident response procedure in place and an online learning module is being developed for the campus community. At the DMNB campus the DCI indicates that there are numerous protections, which are specifically reviewed with the students through an annual presentation through the Environmental and Safety office and through a Student Affairs presentation during orientation week.

The DCI outlines policies in place for the response to the violent or aggressive persons or situations and for violent behaviours against staff by patients, visitors or staff members. Both of these are for the Nova Scotia Health Authority site (CDHA CC 05-062 Code White – Response to Violent or Aggressive Persons or Situations and CDHA CH 15-096 Violent Behaviour Against Staff by Patients, Visitors or Staff Members). Similar policies exist for Health PEI and Horizon Health Network NB.

The DCI provides three appendices with respect to crisis management, which outline university policies and procedures to ensure student safety. The DCI provides links to nine policy documents in total related to health and safety, critical incident response, disaster preparedness and communicable infections, and exposure to environmental hazards and first aid at the workplace and environmental health and safety and a critical incidence plan. Student Affairs presents an overview of safety and security policies during orientation week. Information notices and updates through the Halifax and DMNB campuses are provided to all faculty, students and staff electronically. All health, safety, disaster preparedness policies and procedures are available on the Faculty of Medicine's website. Information sessions are held regularly to brief faculty, staff and students on disaster preparedness and critical incident response.

5.8 LIBRARY RESOURCES / STAFF

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

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 Data from the ISA 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 The library services is overseen by a professional staff that is familiar with regional and national information resources and data systems and is responsive to the needs of medical students, faculty and others associated with the medical school.

5.8 d Library staff support the medical education program by being involved in curriculum planning; participation in the curriculum committee or its subcommittees; or in the delivery of any part of the medical education program.

5.8 e 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

The DCI reports GQ data showing satisfaction rates with library services at both campuses ranging over the last three years from 61% to 90%. Further analysis reveals that the 60% satisfaction was for the DMNB campus in 2015, however satisfaction rates at that campus were 87% and 90% in 2014 and 2016 respectively. ISA data shows very high satisfaction with library across the four years of medical school ranging from 85% to 100% with the singular exception of 1 metric (quality of library support and services) as responded to by second year DMNB students. Interviews with students confirmed a high degree of satisfaction with information resources and facilities. Library sites at hospital facilities were reviewed by the on-site teams and found to be very satisfactory.

The DCI reports 6.5 professional staff and 14 technical staff who service both the Halifax and DMNB libraries.

Three library professions are specifically assigned to undergraduate medicine, two in Halifax and one at DMNB. They are involved in UGME Med 1 Orientation and provide lectures for MED 1 in evidence – based practice. Librarians participate in a MED 1 pharmacology course working with individual students on systematic reviews or literature training. Librarians also provide scheduled video training sessions and teach or co-teach departmental based evidence-based practice sessions. There is a well-used library guide, one of the most highly used library manuals supporting the UGME curriculum (designed specifically for curriculum support, providing access to UGME curriculum–related information sources).

Librarians are members on nine faculty committees.

Medical students have access to both print and electronic collections at both campuses. Off-site electronic campus is available through a proxy server or VPN and print materials are available through an inter-library loan system.

On site interviews confirmed a high degree of student satisfaction with their access to on-line resources at both campuses. ISA data (Table 5.8-1) reveal favourable student perceptions of library resources availability at all instructional sites.

5.9 INFORMATION TECHNOLOGY RESOURCES / STAFF

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

5.9 a Data from the AAMC CGQ and the AFMC GQ show that the majority of respondents at each campus are satisfied/very satisfied with access to computers and the internet at the medical school.

5.9 b Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with:

i. ease of access to electronic learning materials;
ii. adequacy of wireless network in classrooms;
iii. study spaces in the medical school;
iv. availability of electrical outlets in teaching and study space at the medical school;
v. adequacy of audio-visual technology used to deliver educational sessions (e.g., lectures, academic half-days).

5.9 c If a wireless network is not available in classrooms and study spaces at each campus, there are adequate internet access points in large classrooms, small group classrooms and student study spaces.

5.9 d The IT services staff members support the medical education program in at least one of the following ways:

i. being involved in curriculum planning and delivery;
ii. assisting faculty in developing instructional materials;
iii. assisting in developing or maintaining the curriculum database or other curriculum management applications; or
iv. assisting faculty to learn to use the technology for distance education.

RATING

☒ Satisfactory
☐ Satisfactory with a need for monitoring
☐ Unsatisfactory

Evidence to support the above rating

The DCI reports, from the 2015 and 2016 GQ, that satisfaction with access to computers and the internet range from 78% to 100% at the Halifax and DMNB campuses.

Data in the DCI, from the ISA, shows satisfaction with accessibility to electronic materials, wireless internet availability, and outlet capacity, for both Halifax and DMNB campuses, with satisfaction with these elements ranging from 58% to 100% across the four years. The 58% was for outlets by respondents in Year 2 medical school. On site, students were very satisfied with the internet access, videoconferencing facilities and the IT staff.

The DCI reports that wireless networks are available in all campus classrooms and study spaces. The DCI goes into detail about the IT infrastructure available at both campuses, and specifically describes the video conferencing facilities which are based on a provincially provided backbone known as CANARIE.

All students, residents, and faculty have access to the comprehensive IT systems of the housing university through a net ID, and are all enrolled in the university LMS.

The medical school has its own IT staff who interact well with the Dalhousie central IT operation. There is a Director of the Information Technology unit and he or she is a member of the curriculum committee and is on the education council. An on-site meeting with the Director of IT was extremely positive. It is clear that Dalhousie has made significant investments in technology, and that technology solutions have been a cornerstone of the success of mounting a distributed campus. The IT group supports curriculum delivery through supporting and coordinating webinar tools, video conferencing facilities, assessment and scheduling, the LMS, and video productions. They maintain and develop applications to support elements of the UGME program such as examination banks, standardized patient databases, and clerkship rotations. This group provides videos, training sessions, and instruction on use of technology. They provide support for an annual update of the online curriculum map.

5.10 RESOURCES USED BY TRANSFER / VISITING STUDENTS

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

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

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Data from the DCI confirm that Dalhousie has no transfer students other than those that come through a special program from the International Medical University (IMU) emanating from Malaysia. In the last three academic years there were four, six, and four such students respectively. Dalhousie does accommodate visiting students completing clinical electives in other courses and they number 743 in 2013-14 and 744 in 2014-15. The DCI indicates that elective students are excepted if and only if there is capacity for their clinical electives.

Visiting elective students have access to the same resources that Dalhousie students have.

5.11 STUDY / LOUNGE / STORAGE SPACE / CALL ROOMS

A medical school ensures that its medical students have, at each campus and affiliated clinical site, adequate study space, lounge areas, personal lockers or other secure storage facilities, and secure call rooms if students are required to participate in late night or overnight clinical learning experiences.

5.11 a Data from the AAMC CGQ, the AFMC GQ and ISA show that the majority of respondents at each campus are satisfied/very satisfied with the adequacy of student study space at the medical school.

5.11 b Data from the AAMC CGQ, the AFMC GQ and ISA 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 c If study space is not available in the medical school at a campus, or in an affiliated clinical facility, study space is available to students at another accessible location.

5.11 d Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with storage space at the medical school.

5.11 e Data from the ISA 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 f 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 g Data from the ISA 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

Data from the GQ shows that the adequacy of student study space for the last three years in the Halifax campus ranged from 75-81%. ISA data also reveals a majority of students (64%), from all four years, are satisfied or very satisfied with study space. On-site teams toured the facilities at both sites and can confirm excellent resources for all Dalhousie students. In the ISA, students were concerned about the closure of the old library and the opening of the Collaborative Health Education Building (CHEB), however, a tour of the CHEB and discussions with students proved that the new space is excellent and offers excellent study space.

Data from the GQ show satisfaction rates for relaxation space ranging from 73% to 85%. ISA data reveal satisfaction rates across the four years ranging from 58% to 88%. On-site teams toured the student lounge facilities at both sites and can confirm excellent resources for all Dalhousie students.

Data from the ISA reports student satisfaction regarding storage space for the Dalhousie and DMNB campuses ranging from 75% to 94%.

Storage space at the clinical sites in Dalhousie is reported to be satisfactory by the majority of year 3 and year 4 students (56% - 71% at Dalhousie and 57%-81% at DMNB).

Call rooms are available at all 14 sites where students are required to take call.

Data for the ISA shows that the majority of Year 3 and Year 4 respondents confirm satisfaction with on call facilities in Halifax and DMNB (65%-84%). This was an area of noncompliance in 2009.

5.12 REQUIRED NOTIFICATIONS TO THE CACMS

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

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

5.12 a Since the time of the last full survey, the medical school has not increased the number of medical students admitted to the program above a threshold of 10 percent or 15 medical students in one year or 20 percent in three years without notifying the CACMS.

5.12 b Since the time of the last full survey, the medical school has notified the CACMS with any required notification a)-e) and has provided in the DCI for this element, the CACMS/LCME transmittal letter(s) in response to notifications made by the medical school.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

There have been no increases in class size above the thresholds and there have been no required notifications. Class size in 2009-10 was 102. In 2010-11, with the opening of a 30-seat DMNB campus, the Dalhousie campus, which historically housed 20 New Brunswick students decreased in class size to 80 students, resulting in an overall increase for the medical school in 10 seats. Data confirming the exact numbers for the last 8 years is presented in DCI Table 5.12-1, with modulations of only 1-2 students.

STANDARD 6
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 6: COMPETENCIES, CURRICULAR OBJECTIVES, AND CURRICULAR DESIGN

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

Site Visit Team
Standard 6 Element Rating Table

Standard 6	Competencies, Curricular Objectives, and Curricular Design
Element	
6.1	Program and Learning Objectives
6.2	Required Clinical Learning Experiences
6.3	Self-Directed and Life-Long Learning
6.4	Inpatient/Outpatient Experiences
6.5	Elective Opportunities
6.6	Service-Learning
6.7	Academic Environments - Deleted
6.8	Education Program Duration

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 6.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 6 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 6 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 6 – Competencies, Curricular Objectives, and Curriculum Design

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

6.1 PROGRAM AND LEARNING OBJECTIVES

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

6.1 a The medical education program objectives are framed in competency-based terms that reflect CanMEDs and CanMEDs FM competencies.

6.1 b The medical education program objectives were reviewed and revised at least once since the time of the last full survey and approved formally by appropriate key committees of the medical school.

6.1 c The medical education program objectives are linked to the relevant specific physician competency.

6.1 d The medical school has selected appropriate and sufficiently specific assessment methods/instruments to measure medical students' progress in developing the required competencies throughout the medical education program i.e., meeting the medical education program objectives.

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

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The MD program objectives are framed in competency-based terms that reflect the CanMEDS competencies, the Association of Medical Colleges (AAMC) Medical School Objectives Project, the American Board of Specialties (AMBS), and the Accreditation Council for Graduate Medical Education (ACGME) general competencies of physicians (Core Appendix C-23). The competencies to be achieved by the end of the four-year program are expressed as four domains: Community contributor, Professional, Life-long learner, Skilled clinician.

The competencies were developed, reviewed and approved by the Med 1&2 Committee2, the Med 3&4 Committee and the Undergraduate Medical Education Curriculum Committee (UMECC) in 2009-10.

Faculty Council approved the program objectives on March 16, 2010.

The Committee on the Assessment of Student Performance is a subcommittee of UMECC, and reviews processes and develops assessment tools to measure medical students' progress in developing the required competencies. The appropriateness of multiple choice questions as a means of assessing Professional Competency in the first and second year is debatable, as identified by the students in the ISA. However, in general, assessment methods appear to be appropriate to the domain tested.

The medical education program objectives are disseminated to students and faculty members with leadership roles by being made available on the university and medical school websites, university calendar, unit/clerkship syllabi and the online management system. Learning objectives for each required learning experience are available on the unit/clerkship syllabus which is posted online on the management system. Meetings on-site revealed that rotation-specific objectives are also emailed to clinical faculty and residents in advance of them spending time with students. Rotation-specific objectives are provided to residents through an e-learning module, as well as being sent via email from the PGME office.
This was an area of noncompliance in 2009.

6.2 REQUIRED CLINICAL LEARNING EXPERIENCES

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.

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 faculty has described each patient type, clinical condition, required procedure/skill and the clinical setting in which they take place for each required clinical learning experience. This list of required patient encounters and procedural skills require students to be active participants during the clinical learning experiences, and explicitly defines the level of student responsibility as being commensurate with their level of ability. The majority of required patient encounters is specified to be completed on real patients in an adequately supervised setting.

The list of required patient encounters and procedural skills was reviewed and approved by the Med 3&4 Committee as well as by the Undergraduate Medical Education Curriculum Committee.

This list of required experiences is on-line (Brightspace), and rotation-specific lists are disseminated to the residents via email. The rotation-specific lists are reviewed at the start of every core clerkship rotation, and students are encouraged to discuss this list with residents in order to determine which clinical experiences are most appropriate for that rotation. Faculty and residents can access this list online on One45, Online Web Learning (Brightspace) or through the Clerkship directors.

Alternative experiences may involve one or more of the following: scheduled patient session, standardized patient encounter, electronic or virtual patient encounter. This was an area of non-compliance in 2009.

6.3 SELF-DIRECTED AND LIFE-LONG LEARNING

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

6.3 a There are learning sessions in required learning experiences in the first two years of the curriculum where in the context of a clinical case, students engage in all of the following components of self-directed learning as a unified sequence:

i. identify, analyze, and synthesize information relevant to their learning needs
ii. assess the credibility of information sources
iii. share the information with their peers and tutor/facilitator
iv. apply their knowledge to the resolution of the clinical case
v. receive feedback and are assessed on their skills in self-directed learning

6.3 b There is sufficient scheduled time in the first two years of the medical education program for self-directed learning sessions described in 6.3.a., to allow students to develop the skills for self-directed learning.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

In the pre-clerkship curriculum, Case-Based Learning provides an opportunity for medical students to engage in the five steps of the self-directed learning sequence in the context of a clinical case. Tutorial preceptors perform formative and summative assessment of medical students' self-directed learning skills. Although there are multiple other required learning experiences in the pre-clerkship curriculum described in the narrative, it is less clear that all five steps of the self-directed learning sequence occur including feedback and assessment of self-directed learning skills (step 5) (Core Appendix C-25).

On average, first year medical students have 11.5 hours per week and second year medical students have 7 hours per week to engage in self-directed learning activities (Supplemental Appendix S5. Hours for Med1 and Med2).

6.4 INPATIENT / OUTPATIENT EXPERIENCES

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

6.4 a Medical students spend an appropriate percentage of time in a) inpatient and b) ambulatory care settings to meet the learning objectives of each required clinical learning experience.

6.4 b Data from the AAMC CGQ and the AFMC GQ show that the majority of respondents agree/strongly agree that, when presented with a variety of patients, they have the knowledge and skills to a) care for patients in a hospital setting and b) care for patients in an ambulatory setting.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

With the exception of Emergency Medicine, block clerkship rotations have 20-67% scheduled time on the inpatient service (Core Appendices C-26 and C-27). The Longitudinal Integrated Clerkship preceptors are chosen such that medical students have both inpatient and outpatient time. The objectives for the rotations, with the exception of Emergency Medicine, are written to include both ambulatory and inpatient experiences.

Data from the 2016 AFMC GQ show that 72.7% and 96.3% of DMNB and Halifax students agree that they have the skills and knowledge to care for patients in hospital setting. This percentage has remained essentially unchanged for Halifax students in the previous 2 years, but has fallen from 88.9-95.2% for DMNB students since 2014/2015. Meetings with faculty on-site reveal that this drop at the DMNB site may be related to the significant loss of 3 Psychiatry faculty in late 2015. Following review of the 2016 AFMC GQ data, the Psychiatry Department Head, Education Director (Saint John site) and Associate Dean DMNB initiated a plan which has resulted in, among other things, the hiring of 2 Psychiatry faculty members and reallocation of the Psychiatry Clerkship Director duties to ensure that education becomes a priority (see page 12 of Supplemental Appendix S1. Information Request Follow Up). Meetings with the Saint John (DMNB) Year 3 students revealed significant satisfaction with the Psychiatry clerkship rotation, and no dissatisfaction amongst the current Year 4 students.

Over 90% of DMNB and Halifax students in the last 3 years (2014-2016) agree that they have the skills and knowledge to care for patients in the ambulatory setting.

6.5 ELECTIVE OPPORTUNITIES

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

6.5 a There are opportunities for elective experiences in the medical curriculum particularly in the later years of the educational program.

6.5 b The medical school has polices or practices that require or encourage medical students to use electives to pursue a broad range of interests in addition to their chosen specialty.

6.5 c The medical school has or follows a policy that ensures the diversification of electives. Medical students' elective choices are reviewed and adjustments made to ensure the policy is followed.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

There are opportunities for elective experiences in the first two years of the medical curriculum, along with 18 weeks in the fourth year starting in September of that year. The medical school follows the AFMC Joint UGME/PGME Committee Policy on Electives of 2006 which encourages medical students to have electives in at least 3 disciplines of at least 2 weeks each. While this policy is not appended to the document nor does the medical school have its own policy on diversification of electives, the school has procedures that involve the Assistant Dean Clerkship to ensure elective diversification.

6.6 SERVICE-LEARNING

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

6.6 a There are opportunities for medical students to participate in service-learning activity during their tenure as a student.

6.6 b Data from the ISA 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

Prior to the 2014/2015 academic year, there is no evidence provided that the medical school encouraged opportunities for and student participation in a service-learning activity.

In the 2015/2016 academic year, an unknown number of students participated in self-directed community engagement opportunities. Additionally, 7 students participated in the Social Pediatrics and Local Global Health Electives in 2015.

In the 2016/2017 academic year, formalized service learning opportunities with 9 agencies/departments have allowed 27 second year students (17 in Halifax and 10 in Saint John) to participate in service learning as a non-mandatory component of the Professional Competencies course. Five students participated in the Social Pediatrics elective in 2016.

As this is a new initiative only offered in the last eight months, it is not surprising that the ISA conducted in 2015 revealed that only 29-40% of Halifax students and 5-50% of Saint John (DMNB) students were satisfied with access to opportunities to participate in service-learning activities. However, discussions with the faculty leaders of service-learning revealed that a number of organizations wishing to participate in this initiative could not be accommodated, as the number of organizations exceeded the number of students who had indicated interest.

On-site meetings with second-year students at the Halifax and Saint John sites revealed significant satisfaction with how information is disseminated regarding service-learning opportunities and the quality of the interactions with the organizations participating in service-learning. Second-year students felt that the objectives of service-learning were being adequately met.

The medical school introduces the topic of service learning during the orientation week (presentation by Global Health Office) as well as during the Professional Competencies course in first year. Service

learning opportunities are reinforced via multiple means including emails from the UGME office, posted on the Global Health Office website and promoted via Facebook.

The medical school supports student participation in a service learning activity through active development of opportunities in conjunction with community partnerships – in addition to the 9 agencies/departments available for the 2016/2017 academic year, the medical school is in the process of satisfying legal agreements with another 9 agencies/departments which would allow placement of another 38 students. There is a full-time Program Manager for the service learning program, and a Service Learning Leadership Team consisting of faculty, students, staff and community organizations that advises on program design, implementation, assessment and evaluation (Supplemental Appendix S1. Information Request Follow Up, page 15).

6.7 ACADEMIC ENVIRONMENTS

The faculty of a medical school ensure that medical students have opportunities to learn in academic environments that permit interaction with students enrolled in other health professions, graduate, and professional degree programs, and opportunities to interact with residents in clinical environments and with physicians in continuing medical education activities.

6.7 a There are health professions degree programs taught by the medical school faculty where medical students have the opportunity and are encouraged to interact with these programs' students in academic environments at each campus.

6.7 b There are graduate degree programs taught by the medical school faculty where medical students have the opportunity and are encouraged to interact with these programs' students in academic environments at each campus.

6.7 c There are professional (other than health profession) degree programs taught by the medical school faculty where medical students have the opportunity and are encouraged to interact with these programs' students in academic environments at each campus.

6.7 d Medical students have the opportunity and are encouraged to interact with residents and fellows in CFPC and RCPSC accredited programs in clinical environments at each campus.

6.7 e Medical students learn about continuing medical education activities for physicians and have the opportunity to participate in appropriate CME activities.

RATING

- ☐ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

This element has been deleted as per notification from CACMS sent to Dean Anderson on June 20, 2016.

6.8 EDUCATION PROGRAM DURATION

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

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

RATING

☒ Satisfactory
☐ Unsatisfactory

Evidence to support the above rating

The medical education program contains 149 weeks of instruction.

STANDARD 7
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 7: CURRICULAR CONTENT

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

Site Visit Team
Standard 7 Element Rating Table

Standard 7	Curricular Content
Element	
7.1	Biomedical, Behavioral, Social Sciences
7.2	Organ Systems/Life Cycle/Primary Care/Prevention/ Wellness/ Symptoms/Differential Diagnosis/Treatment Planning/Social and Psychological Determinants of Health
7.3	Scientific Method/Clinical Translational Research
7.4	Critical Judgment/Problem-Solving Skills
7.5	Societal Problems
7.6	Culture and Health Care Disparities
7.7	Medical Ethics
7.8	Communication Skills
7.9	Interprofessional Collaborative Practice Skills

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 7.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 7 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 7 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 7 – Curricular Content

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

7.1 BIOMEDICAL, BEHAVIORAL, SOCIAL SCIENCES

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.

7.1 a The topics listed in Table 7.1-1 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).

7.1 b Data from the AAMC CGQ and the AFMC GQ in Table 7.1-2 of the DCI show that the majority of respondents agree/strongly agree that educational activities in the MD program helped them better prepare for required clinical learning experiences and electives.

7.1 c The topics listed in Table 7.1-3 of the DCI are taught and assessed in the curriculum either as independent required learning experiences or integrated into a required learning experience.

7.1 d Data from the AAMC CGQ and the AFMC GQ in Table 7.1-4 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 Tables 7.1-1 and 7.1-3 of the DCI are taught and assessed in the curriculum. Data from the 2016 AFMC GQ (Core Appendix C-31) show that over 70% of students agree that educational activities for most topics in the preclinical curriculum helped prepare for clinical experiences. Exceptions included Pathology (46.8%), and the areas of Behavioural/Social Sciences, Pharmacology, Biochemistry, Microanatomy/Histology and Nutrition in which only 55.4 – 69.2% of 2016 students agreed with the statement. The percentage of graduating students agreeing with this statement has increased since 2014 due to the appointment of longitudinal heads for Biochemistry, Pharmacology, Anatomy and Pharmacology, mapping to identify curricular gaps, assessment of the anticipated curricular changes brought on by the new MCAT, and an annual UMECC retreat. The response to the 2016 AFMC GQ data has included explicit tagging of assessment items related to these areas, and subsequent feedback to students with respect to exam performance.

Data from the AFMC GQ show that over 80% of 2016 graduating students felt that the curricular time was appropriate for all topics listed in Core Appendix C-32. This data was unchanged or increased slightly from the 2 previous years.

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

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

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

7.2 a The topics listed Table 7.2-1 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).

7.2 b Data from the AAMC CGQ and the AFMC GC provided in Table 7.2-2 of the DCI show that the majority of respondents indicate that the topics listed in Table 7.2-2 are appropriately addressed in the curriculum.

7.2 c AAMC CGQ data and AFMC GQ data presented in Table 7.2-3 of the DCI show that the majority of respondents agree/strongly agree that, when presented with a variety of patients, they have the knowledge and skills to perform the physician tasks listed in Table 7.2-3.

7.2 d The following topics are taught and assessed in the curriculum:

i. normal human development and the life cycle
ii. adolescent medicine
iii. geriatrics
iv. continuity of care
v. end of life care

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The topics listed in DCI Table 7.2-1, as well as the areas of normal human development and the life cycle, adolescent medicine, geriatrics, continuity of care, and end-of-life care are all taught and assessed in the curriculum. Data from the 2014-2016 AAMC CGQ / AFMC GQ show that over 70% of graduating students felt that there was appropriate curricular time spent on each of the topics in Table 7.2-2 (Core Appendix C-33), and similar percentages indicated that they had the knowledge to perform the tasks in Table 7.2-3 (Core Appendix C-34).

7.3 SCIENTIFIC METHOD/CLINICAL/ TRANSLATIONAL RESEARCH

The faculty of a medical school ensure that the medical curriculum includes instruction in the scientific method (including hands-on or simulated exercises in which medical students collect or use data to test and/or verify hypotheses or address questions about biomedical phenomena) and in the basic scientific and ethical principles of clinical and translational research (including the ways in which such research is conducted, evaluated, explained to patients, and applied to patient care).

7.3 a The medical curriculum includes either in an independent required learning experience or integrated in a required learning experience(s), instruction in and assessment of content related to the scientific method. These curricular experiences include hands-on or simulated exercises in which medical students collect or use data to test and/or verify hypotheses or to experimentally study biomedical phenomena.

7.3 b The medical curriculum includes either in an independent required learning experience or integrated into a required learning experience(s), formal learning objectives that address a) the basic scientific and ethical principles of clinical and translational research and b) how this research is conducted, evaluated, explained to patients and applied to patient care.

7.3 c Students' acquisition of knowledge on a) the basic scientific and ethical principles of clinical and translational research, and b) how this research is conducted, evaluated, explained to patients and applied to patient care is assessed.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical curriculum has formal learning objectives in the Research in Medicine course in which students are taught about the scientific and ethical principles of clinical and translational research, and how this research is conducted, evaluated, explained to patients and applied to patient care. All students are mandated to complete a research project, which includes the need to collect and/or analyze data to test/verify hypotheses.

Students are assessed on acquisition of this knowledge formatively throughout the four-year program via progress towards completion of a student-driven research project, as well as summatively using submission of a research product (poster or platform presentation during a peer-reviewed academic conference and/or a manuscript).

7.4 CRITICAL JUDGMENT/PROBLEM-SOLVING SKILLS

The faculty of a medical school ensure that the medical curriculum incorporates the fundamental principles of medicine and provides opportunities for medical students to develop clinical decision-making skills (i.e., clinical reasoning and clinical critical thinking) including critical appraisal of new evidence, and application of the best available information to the care of patients. These required learning experiences enhance medical students' skills to solve problems of health and illness.

7.4 a Clinical decision-making skills including critical appraisal of new evidence related to the care of patients is appropriately taught and assessed either in an independent required learning experience or integrated into a required learning experience.

7.4 b Application of the best available information to the care of patients is appropriately taught and assessed either as a required learning experience or integrated into an independent required learning experience.

7.4 c Medical problem solving skills are appropriately taught and assessed either as a required learning experience or integrated into an independent required learning experience.

7.4 d AAMC CGQ and AFMC GQ data show that the majority of respondents agree/strongly agree that they have the knowledge and skills to perform the following:

i. reason clinically
ii. incorporate evidence-informed decision-making into patient care
iii. access evidence-informed treatment guidelines
iv. use technology to access information at the time of a patient encounter (just in time/point of care) if needed.

RATING

☒ Satisfactory
☐ Satisfactory with a need for monitoring
☐ Unsatisfactory

Evidence to support the above rating

Clinical decision-making skills including critical appraisal of new evidence, application of the best available information to the care of patients and medical problem solving skills are taught and assessed throughout the four year program. Assessment methods evolve from MCQ / tutor assessment using a rubric in the preclerkship years to ITERs and OSCEs in the latter 2 years of the program. Over 90% of graduating students in 2014-2016 agreed that they had the knowledge and skills to incorporate decision making into patient care, access evidence informed treatment guidelines, and use technology to access information at the time of a patient encounter (Core Appendix C-35).

7.5 SOCIETAL PROBLEMS

The faculty of a medical school ensure that the medical curriculum includes instruction in the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of common societal problems.

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 substance abuse.

7.5 c 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 common societal problems.

7.5 d Medical students are assessed on the learning objectives related to the common societal problems included in the curriculum.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The Professional Competencies course includes instruction and has relevant learning objectives that address the diagnosis, prevention, appropriate reporting and treatment of domestic violence/abuse and substance abuse.

The selection of societal problems common to Nova Scotia and New Brunswick for inclusion in the curriculum enlisted approximately 600 faculty members, students, staff and stakeholders. The common societal problems listed (frailty/healthy aging, environmental health and Aboriginal health) has relevant learning objectives that address the diagnosis, prevention, appropriate reporting and treatment of these issues. Additional information supplied by the school in advance of the visit revealed that students' acquisition of knowledge related to common societal problems is assessed through the use of multiple choice questions, tutorial and OSCE performance (Supplemental Appendix S1. Information Request Follow Up, page 17) (Core Appendix C-36).

7.6 CULTURE AND HEALTH CARE DISPARITIES

The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding:

- ***a) the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments;***
- ***b) the basic principles of culturally competent health care;***
- ***c) the recognition and development of solutions for health care disparities;***
- ***d) the importance of meeting the health care needs of medically underserved populations;***
- ***e) the development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society.***

7.6 a There are learning objectives related to cultural competence in health care in required learning experiences including clinical learning experiences in the curriculum.

7.6 b There are explicit learning objectives in required learning experiences including clinical learning experiences related to:

i. identifying and providing solutions for health disparities
ii. identifying demographic influences on health care quality and effectiveness
iii. meeting the health care needs of medically underserved populations

7.6 c Data from the AAMC Canadian Graduation Questionnaire (CGQ) show that the majority of respondents agree/strongly agree with the statement: "I was appropriately trained to care for individuals from backgrounds different from my own" and with the AFMC Graduation Questionnaire (AFMC GQ) statement: "I was appropriately trained to care for individuals from all backgrounds".

7.6 d The curriculum prepares medical students to be aware of their own gender and cultural biases and those of their peers and teachers.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The curriculum has learning objectives in the preclinical years related to cultural competence, identifying and providing solutions for health disparities, identifying demographic influences on health care quality and effectiveness, and meeting the health care needs of medically underserved populations in the Professional Competencies course. The majority of the instruction is through lectures, panel discussion and tutorials. A mandatory clinical experience, Community Immersive Experience (CIE), was offered in the past which linked medical students with a community agency (additional information received from the school in advance of the visit). Feedback from students was mixed and CIE was replaced by a non-mandatory Service Learning experience which was offered to second-year medical students in 2016/2017 for the first time. Twenty-seven second-year medical students have signed up in 2016/2017.

Meetings with second-year students revealed positive experiences with the Service learning organizations to date.

Of the 2016 class, 86.1% agreed with the statement “I was appropriately trained to care for individuals from backgrounds different from my own” / “I was appropriately trained to care for individuals from diverse backgrounds” (Core Appendix C-37).

Students’ awareness of their own gender and cultural biases, as well as those of their peers and teachers, is cultivated through self-reflection and peer assessment in tutorials. A request for additional information revealed that the school also uses multiple choice questions and OSCE performance (Supplemental Appendix S1 Information Request Follow Up, page 18).

7.7 MEDICAL ETHICS

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

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. professionalism

7.7 b AAMC CGQ and the AFMC GQ data show that majority of respondents agree/strongly agree that they understand the ethical and professional values expected of the profession as listed in Table 7.7-2 of the DCI.

7.7 c The methods used for formative and summative assessment of medical students' ethical behavior in the care of patients are appropriate.

7.7 d The medical school uses appropriate methods to remediate medical students' breaches of ethics in patient care.

RATING

☒ Satisfactory
☐ Satisfactory with a need for monitoring
☐ Unsatisfactory

Evidence to support the above rating

The medical curriculum includes instruction and assessment of biomedical ethics, ethical decision-making and professionalism, and 2014-2016 AAMC CGQ / AFMC GQ data show that greater than 85% of students agree with the statement that they understand the ethical and professional values expected of the profession (Core Appendix C-38).

From additional information supplied by the school, the professional and ethical behavior of medical students in the care of patients is formatively and summatively assessed in the pre-clerkship curriculum by small group preceptors in the Skilled Clinician course (Supplemental Appendix S1. Information Request Follow Up, page 18). Formative and summative assessment in the clerkship rotations primarily occurs via ITERS. Professional and ethical behavior is also assessed at Skilled Clinician OSCEs (Med 1 to Med 4), with breaches leading to a failing grade on the exam.

Remediation of breaches of ethics in patient care is individualized to the specific patient and situation identified.

7.8 COMMUNICATION SKILLS

The faculty of a medical school ensure that the medical curriculum includes specific instruction in communication skills as they relate to communication with patients and their families, colleagues, and other health professionals.

7.8 a There are explicit learning objectives and specific educational activities in required learning experiences, including clinical learning experiences, related to:

i. communicating with patients and patient's families
ii. communicating with physicians (e.g., as part of the medical team)
iii. communicating with non-physician health professionals (e.g., as part of the health care team)

7.8 b AAMC CGQ data and AFMC GQ data show that the majority of respondents agree/strongly agree that they have the knowledge and skills related to communication skills listed in Table 7.8-2 of the DCI.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The curriculum contains learning objectives and specific educational activities throughout the four-year program, including clinical learning experiences, related to communicating with patients and patients' families, physicians and non-physician health professionals. Over 86% of 2016 students agreed with the AFMC GQ statement that they had the knowledge and skills to perform the tasks listed in Table 7.8-2 (Core Appendix C-39). For all tasks listed, the 2016 data was similar to the previous 2 years.

7.9 INTERPROFESSIONAL COLLABORATIVE SKILLS

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

7.9 a There is a linkage between the medical education program objectives and the learning objectives of required learning experiences related to interprofessional collaborative practice skills.

7.9 b There are sufficient instances of required learning experiences where medical students are brought together with students or practitioners from other health professions to learn to function collaboratively on health care teams as they provide coordinated services to patients.

7.9 c These educational experiences have learning objectives related to the development of interprofessional collaborative practice skills, and medical students' attainment of the learning objectives is assessed.

7.9 d The sample forms provided in the DCI for the assessment of medical student's attainment of interprofessional collaborative practice skills are explicit and appropriate.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The narrative describes a spiraled curriculum that spans Year 1 to Year 4 relating to interprofessional collaborative practice, with appropriate linkage of medical education program objectives to course objectives. Medical students are brought together with students from other health professions (Nursing, Physiotherapy, Occupational Therapy, Speech Language Pathology, Respiratory Therapy, Health and Human Performance, Kinesiology, Audiology, Pharmacy, Dentistry and Social Work) primarily in the first 2 years of the program but also in the latter 2 years, in order to learn to function collaboratively.

Additional information supplied by the school in advance of the visit (Supplemental Appendix S1. Information Request Follow Up, page 19) and corroborated by in-person meetings revealed that the majority of the interprofessional learning experiences in the pre-clinical curriculum were added since 2015: 6 curricular components in Med 1 (5 components added in 2016) and 4 curricular components for Med 2 (3 components added in 2016). These curricular components enhanced an IPE curriculum that previously had been delivered primarily in the clerkship years. The previous program was not rated highly and new options were explored. Examples of the new curricular inter-professional events are a mandatory Med 1 Dalmazing Interprofessional Challenge involves interactives stations and seminars that takes place at both sites, although the different sites make use of different groups of health professionals. Evaluative feedback is being used to inform modifications to the curriculum for following years.

A second example is the IPE Mini-course Part 1 and Collaborative Stroke Care Part 2; Interprofessional Stroke Clinic Simulation in Med 2. DMNB students participate by videoconference. This is presented as a flipped classroom with online interactions and a team setting involving 60 IPE teams.

A Med 4 mandatory interprofessional elective has been in place since 2008, while IPE simulations in Med 3 Emergency Medicine and Obs/Gyn were introduced in 2014 and 2016 respectively. Meetings with medical students showed high rates of satisfaction with the IPE curriculum, even among clerks who would have been exposed to the pre-clerkship curricular enhancements.

Medical students' attainment of the learning objectives is assessed using multiple methods including self-reflection, written team exercises, and a TOSCE (team observed structured clinical encounter). Three of the four sample forms provided for the assessment of medical students' attainment of interprofessional collaborative skills are appropriate, although the ITER for the Interdisciplinary Elective Med 4 does not explicitly assess these skills.

STANDARD 8
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 8: CURRICULAR MANAGEMENT, EVALUATION, AND ENHANCEMENT

The faculty of a medical school engage in curricular revision and program evaluation activities to ensure that that medical education program quality is maintained and enhanced and that medical students achieve all medical education program objectives and participate in required clinical experiences and settings.

Site Visit Team
Standard 8 Element Rating Table

Standard 8	Curricular Management, Evaluation and Enhancement
Element	
8.1	Curricular Management
8.2	Use of Medical Education Program Objectives
8.3	Curricular Design, Review, Revision/Content Monitoring
8.4	Program Evaluation
8.5	Medical Student Feedback
8.6	Monitoring of Completion of Required Clinical Experiences
8.7	Comparability of Education/Assessment
8.8	Monitoring Time Spent in Educational and Clinical Activities

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 8.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 8 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 8 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 8 – Curricular Management, Evaluation and Enhancement

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

8.1 CURRICULAR MANAGEMENT

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

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

There is an Undergraduate Medical Education Curriculum Committee (UMECC) that is responsible for the MD program curriculum development, approval, review and program evaluation.

Membership of UMECC includes 8 elected voting members (one each from a basic science and a clinical department, and one faculty member whose primary geographic appointment is in New Brunswick and who participates in DMNB); ex officio (5 voting and 10 non-voting members that includes leadership within the MD program, and students (one and an alternate) from each academic year, that include representatives from both DMNB and Halifax.

There are 4 sub-committees of UMECC – a Med 1 & 2 committee, a Med 3 & 4 committee, a Program and Evaluation Committee (PFEC) and a Committee on the Assessment of Student Performance (CASP)

(Core Appendix C-40). The year committees are responsible for the overall management and implementation of their respective years of the program. PFEC provides oversight for evaluation processes relating to the MD program. CASP provides oversight for the development and implementation of student assessment guidelines, policies and procedures. All committees report to UMECC. There is horizontal communication between committees through chairs of each year committee being on the other year committee. Cross pollination of individuals on various sub-committees ensures additional vertical and horizontal communication.

UMECC oversees all matters pertaining to curriculum in the MD program, including curriculum development and approval, review, and program evaluation. This includes developing and reviewing the medical education program objectives with broad input from and consultation with its subcommittees and the Faculty of Medicine as a whole. The terms of reference for this committee outline the role of the committee to undertake a comprehensive review of the entire curriculum at the conclusion of each year, The terms of reference for the committees accurately outline their responsibilities, line of reporting and committee members.

The two years' committees report directly to the UMECC. Unit heads, clerkship directors meet annually at the UME retreat as well as more frequently via videoconferencing between sites.

The UMECC minutes discussed in the paragraph that follows are found in the Supplemental Appendix S6. The UMECC Jun 2015 minutes demonstrated responsibility for curricular content by documenting that the report of the unit review for Neuroscience was presented to UMECC and its recommended changes were approved. The June 2016 minutes demonstrated that the Neuroscience syllabus has been modified (this included changes to objectives in that some were changed and some were removed). The June 2016 minutes demonstrate that the committee is aware that medical assisted dying is not included in the curriculum and various possibilities of where this might best be inserted into the curriculum were discussed, addressing an identified deficiency. A new IPE curriculum was presented at the June 2016 UMECC meeting and the changes were approved. In the January 26, 2017 UMECC meeting, the following curricular topics were discussed with decisions made with regards to the curriculum:

- Removal of Ophthalmology self-study exam (redundant)
- Addition of new Anaesthesia workshop

During the June 23, 2016 UMECC meeting, there was discussion with regard to the continuation of the Child and Family Component of Professional Competencies. A decision was made to discontinue this topic in the unit. Tutor recruitment in Anatomy was addressed in the Sept 2014 UMECC minutes, with comments that there was renewed support from the department in recruiting more faculty, as well as efforts from UME to recruit additional tutors and better align them with the strengths to the curriculum. The minutes from the Aug 25, 2016 and Nov 24 2016 meetings show review and discussion on the MCC Part 1 and 2 results, the CaRMS match results, and the CGQ results. All this is evidence that the overall quality and effectiveness of the program is being addressed. UMECC minutes show that this committee reviews outcome measures such as Part 1 and 2 of the Licensing Council exams, CGQ as well as internal survey data. (all UMECC meeting minutes discussed above are found in Supplemental Appendix S6). This was an area of noncompliance in 2009.

8.2 USE OF MEDICAL EDUCATIONAL PROGRAM OBJECTIVES

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

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 UMECC ensures that program level objectives are used to choose curriculum content and determines the placement in the curriculum. This was confirmed on site by UMECC members, clerkship directors and UMECC minutes.

The MD program uses the four overarching educational program outcomes (community contributor, lifelong learner, professional and skilled clinician) to determine the program effectiveness using a large number of outcome measures. Program level objectives are linked to clerkship/unit objectives, component (clerkship rotation objectives), session (learning) objectives and assessment/outcome measures.

The Pre-clerkship curricular unit heads and clerkship directors are responsible for the linkage between learning objectives and the program objectives using the curriculum map as a guide. The UMECC has the overall responsibility to ensure that all the required learning objectives are linked to achieve all the educational program objectives. The UMECC is aided by PFEC, that looks at program evaluations to ensure linkage of outcome measures to program objectives.

It is clear from the objectives provided for Host Defense and Obstetrics and Gynecology Clerkship that there is an appropriate linkage between the program objectives and the learning objectives of the individual required learning experiences (Core Appendix C-41). This was an area of noncompliance in 2009.

8.3 CURRICULAR DESIGN, REVIEW, REVISION/CONTENT MONITORING

The faculty of a medical school are responsible for the detailed development, design, and implementation of all components of the medical education program, including the medical education program objectives, the learning objectives for each required learning experience, and instructional and assessment methods appropriate for the achievement of those objectives.
The curriculum committee oversees content and content sequencing, ongoing review and updating of content, and evaluation of required learning experiences, and teacher quality.
The medical education program objectives, learning objectives, content, and instructional and assessment methods are subject to ongoing monitoring, review, and revision by the curriculum committee to ensure that the curriculum functions effectively as a whole such that medical students achieve the medical education program objectives.

8.3 a The directors of required learning experiences, teaching faculty and other educational leaders develop and review the objectives for required learning experiences and the 'curriculum committee' reviews, revises as needed, and approves the final versions.

8.3 b The directors of required learning experiences, teaching faculty and other educational leaders identify the content for required learning experiences and the 'curriculum committee' reviews, revises as needed and approves the final versions.

8.3 c The directors of required learning experiences, teaching faculty and other educational leaders identify teaching and assessment methods that are appropriate for the learning objectives and the 'curriculum committee' reviews, revises as needed and approves the final methods.

8.3 d The quality of teaching of individual faculty members is evaluated and the data provided to him or her to improve their teaching. The data are also reviewed by others as needed to ensure assistance is provided for program improvement purposes. The 'curriculum committee' ensures the process occurs and reviews aggregated teaching assessment data as part of program evaluation.

8.3 e The overall quality and outcomes of required learning experiences are reviewed by the directors of each required learning experience and others with responsibility for the educational program and steps are taken to address areas in need of improvement. The 'curriculum committee' reviews the data and ensures program improvement occurs.

8.3 f The formal reviews noted in 8.3.a - 8.3.d of all required learning experiences, and the curriculum as a whole, occur on a regular basis.

8.3 g The reviews of required learning experiences are thorough and useful in identifying areas of strength and areas in need of improvement.

8.3 h Curricular content is monitored on a regular basis to identify gaps and unwanted redundancies. The 'curriculum committee' ensures that the process occurs and that gaps and unwanted redundancies in content areas are addressed.

8.3 i Teaching faculty can directly access information on the content of the curriculum as a whole and for specific required learning experiences, or the information can be provided to them in a timely manner.

8.3 j The system used for curricular mapping is effective in identifying where in the curriculum, and

to what extent, topics are addressed.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Educational leaders including senior leadership, faculty, and directors of required learning experiences participate in the development of all objectives for required learning experiences through their roles in working groups, the UMECC sub-committees and the UMECC, ensuring alignment with program level objectives. Directors of clerkships, unit heads and component heads review the objectives annually, taking into account student feedback and national standards. There is a tiered system that these modifications are first reviewed by the Med 1 & 2 or Med 3 & 4 committee, and then presented to the UMECC for final approval.

Content is identified by senior leadership including directors of required learning experiences, faculty, students and staff, vetted by content experts at subcommittee level and approved through the UMECC.

Assessment methods are determined by the unit/component heads and clerkship directors, using expertise in members of the CASP and the UMECC and best evidence in the literature. The variety and appropriateness of assessment methods are then reviewed by the CASP that has the responsibility of developing and implementing student assessment guidelines, policies and procedures for the medical school. The CASP makes recommendations to the UMECC who ultimately determines what assessment methods will be used in each syllabus.

Regular, systematic review of the quality of teaching is collected and evaluated. Reports on teaching quality are sent to the associate deans in Halifax and Saint John. Feedback is provided to individual faculty and to unit heads and department heads for program and faculty member improvement purposes. The PFEC is the subcommittee tasked with this process and the chair of the PFEC reports annually to the UMECC.

The school has consistently been collecting evaluation data on all preceptors/tutors and in September 2016 starting collecting feedback on individual lecturers. The long standing evaluation system is robust; this recent change now completes collection of evaluation data on all individuals teaching in the MD program.

The overall quality of each required learning experience is reviewed at the end of every unit and clerkship rotation by the directors of each experience and the Unit/Clerkship review committees. Ideas for changes are then put forward to the UMECC. In fourth year, most learning experiences occur in electives. Rotation feedback forms following the end of each rotation are used to collect evaluation data. The UMECC reviews all such suggestions, makes final decisions to ensure program improvement. These reviews are carried out on an ongoing basis throughout the academic year.

There is systematic review of each required learning experience at the end of each unit or clerkship. An Evaluation Summary Report (containing student evaluation data on the unit, cases, tutors and lectures), and the student representative report are discussed at an end of unit meeting. After this meeting, an End of Unit Summary report is reviewed by the Med 1&2 committee and recommendations made to the UMECC. Longitudinal units such as Professional Competencies are reviewed in a similar manner with unit and case data compiled in an end of unit summary report that includes student evaluations, MCC and

CGQ data, and tutor evaluations. The student representative report is another piece of data reviewed at a mid and end of year meeting. Clinical rotations are reviewed through a mid-year summary report generated by the UGME Evaluation Specialist for each department. In fourth year, student evaluations on electives are reviewed by the Assistant Dean Clerkship. Students also complete evaluations of each PIER, resulting in an end of year report. The evaluative reports for each required learning experience in the program are reviewed annually at the UMECC. The UMECC and its four subcommittees formally review the curriculum as a whole on a regular basis, in a multistage, hierarchal process. The Associate Dean UGME presents the results of this evaluation to several senior leadership committees, including the Council of Associate/Assistant Deans, Education Council, Faculty Council and Joint Department Heads. The Associate Dean UGME also provides a written report of the program for review and discussion at the annual faculty meeting.

Examples are provided in the DCI of improvements. In response to student feedback and recommendations from the Clerkship Renewal Committee (an ad hoc committee), the Clinical Skills Program was changed into a four-year longitudinal Skilled Clinician Program with a change in approach to acquire skills and demonstrating competence over time and the addition of student learning portfolios including self-reflection and peer assessment.

Two examples are provided in the DCI of how curricular monitoring identified gaps and led to changes to the program. For example, in Professional Competencies, in response to student feedback, reviews were held to determine how best to integrate the course content in this course with clinical competencies and clinical learning. The decision was made to make this a four year course, integrating with all four years of the curriculum. The UMECC meeting minutes of Jan 2017 show discussion regarding the topic of Medical Assistance in Dying and its inclusion in the curriculum.

Unit heads, clerkship directors, faculty and staff can all use the searchable curriculum map to search for a particular required learning objective and search the objectives and learning sessions mapped to it. As well, syllabi are available on the online learning management system for all required learning objectives that include learning objectives, curricular content and teaching and assessment methods.

The online management system has the online curriculum map that is easily searchable (https://projects.cs.dal.ca/daedalus_med/daedalus/medical/browse/ugmesearch). It can be used to determine what topics are covered in the curriculum. It was confirmed on site that faculty regularly use the curriculum map for its intended purpose and it was found to be easy to use and accurate in identifying where and to what extent “Genetics” and “Nutrition” are taught in the curriculum. This was an area of noncompliance in 2009.

8.4 PROGRAM EVALUATION

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

8.4 a The medical school 'curriculum committee' uses all of the outcome measures listed in Table 8.4-1 to evaluate the extent to which medical students are achieving the medical education program objectives.

8.4 b The outcome measures listed in Table 8.4-1 of the DCI are reviewed by the 'curriculum committee' on an annual basis and appropriate steps are taken to improve the quality of the medical education program.

8.4 c Medical students' performance on the LMCCQE Part 1 and Part 2 exams at each campus is within the national mean for Canadian first-time test takers for the last three academic years.

8.4 d AAMC CGQ and AFMC GQ data provided in the DCI for this element show that the majority of respondents agree/strongly agree that they have developed the clinical skills required to begin a residency program.

8.4 e AAMC CGQ and AFMC GQ data provided in the DCI for this element show that the majority of respondents rate the quality of the medical education program as good/very good/excellent (aggregated).

8.4 f Relevant outcome measures are used by the medical school/'curriculum committee' to evaluate the extent to which the medical education program objectives, in the domains of knowledge, skills and behaviours, are being met.

8.4 g Since the time of the last full survey, the medical school 'curriculum committee' has taken appropriate steps to address gaps between desired and actual outcomes when medical students'/graduates' performance is suboptimal in one or more medical education program objectives.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The UMECC uses all of the outcome measures listed in Table 8.4-1 of the DCI to evaluate the extent to which medical students are achieving the medical education program objectives (Core Appendix C-42).

The outcome measures listed in Table 8.4-1 are presented to the UMECC annually and used to direct program changes.

The LMCCQE Part 1 and Part 2 exam results at each campus are above the national mean for first-time test takers for the last three academic years (the 2016 data was provided as an update). (Core Appendices C-43 and C-44).

AAMC CGQ and AFMC GQ data provided in the DCI for this element show that for the Halifax site 98.1% of students agree/strongly agree that they have developed the clinical skills required to begin a residency program. For the DMNB site, 100% of the students agree/strongly agree that they have developed the clinical skills required to begin a residency program (Core Appendix C-45).

AFMC GQ data provided in the DCI show that in 2016, 98.2% of the Halifax site respondents and 100% of the DMNB site respondents rated the quality of the medical education program as good/very good/excellent (Core Appendix C-46).

Relevant outcome measures such as CGQ, Results of MCCQE Part 1 and 2, OSCE results, student performance in required learning experiences, feedback from PGY1s on preparedness, etc. are used by the UMECC to evaluate the extent to which the medical education program objectives, in the domains of knowledge, skills and behaviours, are being met.

The following examples provide evidence that the UMECC has taken steps to address gaps between desired and actual outcomes when medical students'/graduates' performance is suboptimal in one or more medical education program objectives.

> Program Objectives: Professional: Previously, the students' inter-professional learning occurred through the Health Mentors program. This program was not rated highly and new options were explored. Two new curricular inter-professional events were added to Med 1 and Med 2. A mandatory Med 1 Dalmazing Interprofessional Challenge involves interactives stations and seminars that takes place at both sites, although the different sites make use of different groups of health professionals. Evaluative feedback is being used to inform modifications to the curriculum for following years.
>
> A second example is the IPE Mini-course Part 1 and Collaborative Stroke Care Part 2; Interprofessional Stroke Clinic Simulation in Med 2. DMNB students participate by videoconference. This is presented as a flipped classroom with online interactions and a team setting involving 60 IPE teams.

8.5 MEDICAL STUDENT FEEDBACK

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

8.5 a Medical student evaluation data of all required learning experiences are systematically collected by the medical school.

8.5 b The participation rate of medical students in responding to the evaluation form for required learning experiences is sufficient to provide reliable data for program evaluation purposes.

8.5 c The 'curriculum committee' (or its subcommittee) uses evaluation data to identify problem areas related to required learning experiences or to curriculum structure and/or delivery and takes effective steps to address these identified problems.

8.5 d The evaluation summary data for required learning experiences show that the majority of medical students provide feedback and that problems and strengths are identified that can be used for program improvement.

8.5 e Medical students' evaluation data on individual faculty, residents, and others who teach and supervise them in required learning experiences, are collected by the medical school.

8.5 f The evaluation data described in 8.5.e. provided by medical students are used to improve the teaching of faculty, residents and others who teach and supervise medical students in required learning experiences.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Student evaluative data is systematically collected from every required learning experience. Unit evaluations for Med 1 & 2 block units are completed by students at the end of each unit using One45 and included in the Evaluation Summary Report sent to the unit and component heads by UGME. Case and lecture evaluations are completed by students at the conclusion of each case and lecture in each unit using Opinio. Student evaluations of their tutors are completed using One45. A student rep report is also collected. All this evaluative data, plus MCC and CGQ data is part of an end of unit meeting, from which an End of Unit Summary Report is generated for presentation at Med 1&2 Committee meeting and the UMECC. For the longitudinal units such as Professional Competencies, unit evaluations are collected similarly to the block units described above. The clerkships are evaluated by students using One45 and a mid-year and end of year report is developed for each department and the UMECC. Med 4 rotations are evaluated in a similar manner.

The participation rates provided in the DCI show response rates for the year 1 and 2 courses ranging from 29% to 79% with an average response rate of 46%. Response rates for year 3 range from 46 to 92%. In year 4, response rates are 42% and 57% for PIER 3 and 4 respectively. For 2014/15 Metabolism and Homeostasis II, response rates for DMNB were particularly low – 1 student. However, this was based on a previous system of data gathering. UGME worked with all departments in 2014 and launched a

revamped method of collecting data on rotations that was site specific and would help alleviate low response rates from both campuses. This has dramatically increased the response rates in 2016 to 73% at DMNB and 76% at Halifax (Supplemental Appendix S7. Accreditation Follow Up Questions Feb 14th FINAL, page 4).

The UMECC uses evaluation data from students to identify problem areas related to curriculum and takes effective steps to address these identified problems as shown in the following examples:

> Program Objectives: Professional: Previously, the students' inter-professional leaning occurred through the Health Mentors program. This program was not rated highly by students and new options were explored. Two new curricular inter-professional events were added to Med 1 and Med 2. A mandatory Med 1 Dalmazing Interprofessional Challenge involves interactives stations and seminars that takes place at both sites, although the different sites make use of different groups of health professionals. Evaluative feedback is being used to inform modifications to the curriculum for following years.
>
> A second example to improve inter-professional learning is the development of the IPE Mini-course Part 1 and Collaborative Stroke Care Part 2; Interprofessional Stroke Clinic Simulation in Med 2. DMNB students participate by videoconference. This is presented as a flipped classroom with online interactions and a team setting involving 60 IPE teams.

The data presented above shows a good proportion of medical students provide feedback and the examples provided show that problems and strengths are identified and changes are put in place for program improvement.

Medical students' evaluation data on individual faculty, residents, and others who teach and supervise them in required learning experiences, are collected by the medical school, integrated into the summary reports generated on each learning experience and used for curricular improvements as described above.

The evaluation data on individuals teaching to medical students is included in End of Unit Summary Reports sent to unit heads as part of the annual unit review described above. Any faculty member, lecturer, tutor, preceptor, and resident who scores below the median rating on 3 out of 5 on any Likert scale question is highlighted, as is any negative feedback. Resource sheets prepared by Faculty Development are distributed to the individual in a conversation regarding the recommendations of these resources to assist with development of teaching skills. All feedback on individual faculty members is also sent to respective department heads and the Associate Dean in Halifax and DMNB. A representative from Faculty Development is an ex officio member of the UMECC and makes recommendations to address any deficiencies in teaching skills. This was an area of noncompliance in 2009.

8.6 MONITORING OF COMPLETION OF REQUIRED CLINICAL LEARNING EXPERIENCES

A medical school has in place a system with central oversight that monitors, remedies any gaps, and ensures completion of the required patient encounters, clinical conditions, skills and procedures to be performed by all medical students.

8.6 a Virtually every student completed (either with real or alternative experiences) all of the required patient encounters and clinical procedures by the time of graduation at each campus over the last three academic years.

8.6 b At least 80% of medical students completed the required patient encounters and clinical procedures with real patients at each campus over the last three academic years.

8.6 c Standardized patients, simulations, or virtual patients are used to remediate identified gaps in medical students' completion of the required patient encounters and procedures.

8.6 d The medical school uses an effective system for students to log their required patient encounters and procedures that can be monitored in real time.

8.6 e The completion of the required patient encounters and procedures of each medical student is monitored during all required clinical learning experiences. These data are discussed with the student at the mid-point of a required clinical learning experience by the student's preceptor, director of the required clinical learning experience, site director or designated faculty member. The student's clinical experience is appropriately altered if needed to optimize completion of the required patient encounters and procedures.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Data presented in the DCI demonstrates that 100% of all students at both campuses completed all the required patient encounters for the last three academic years (Core Appendix C-47).

Table 8.6-2 in the DCI outlines that at least 80% of all students complete the required patient encounters and procedural skills with real patients (Core Appendix C-48).

Computer-assisted Learning in Pediatrics Program (CLIPP) cases are one example of alternate ways of completing some mandatory log items. Standardized patients and simulations are also used.

Students use One45 to centrally log all patient encounters and procedures. Students are required to complete a self-report at the end of clerkship indicating completion of all required log items. This is monitored in real time.

Logs are reviewed with the student by their preceptor at both the midpoint and end of all rotations. Clerkship directors review all student logs at both the midpoint and end of all rotations. At midpoint, gaps are identified and remediation plans instituted to ensure completion during the rotation. If a gap persists at the end of the rotation, plans are made to ensure it is completed either in another year 3 rotation, or by returning to the clerkship for a specific case or by some alternative means. At the end of

Med 3, the Assistant Dean Clerkship reviews the One45 data to identify any uncompleted clinical encounters. All required clinical encounters must be completed as a condition to promotion to Med 4. This was an area of noncompliance in 2009.

8.7 COMPARABILITY OF EDUCATION/ASSESSMENT

A medical school ensures that the medical curriculum includes comparable educational experiences and equivalent methods of assessment across all locations within a given required learning experience to ensure that all medical students achieve the same learning objectives.

8.7 a The overview data in DCI Tables 6.0-1 through 6.0-3 and DCI Tables 9.4-2 through 9.4-5 show that medical curriculum includes comparable/similar educational experiences and equivalent/same methods of assessment across all locations within a given required learning experience.

8.7 b The faculty at each instructional site at each campus are informed of, and oriented to the learning objectives, required patient encounters and procedural skills (when relevant) and assessment methods for the required learning experience in which they participate.

8.7 c Faculty members with responsibility for each required learning experience at each instructional sites communicate with each other regarding planning and implementation of the educational experience, student assessment, and evaluation of the required learning experience to ensure that educational experiences are comparable and methods of assessment are equivalent.

8.7 d There are mechanism for the review and dissemination of student evaluations of their educational experience, data regarding students' completion of required patient encounters and procedural skills (when relevant), and student performance data, and any other information reflecting the comparability of learning experiences across instructional sites.

8.7 e The 'curriculum committee' (or its subcommittee) reviews the data described in 8.7.d and takes steps when needed to address lack of comparability in the educational experience identified in the data.

8.7 f The strategies used by the medical school to address inconsistencies across instructional sites that were identified in student satisfaction data and/or student performance data are appropriate and likely to address identified problems.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The overview data in DCI Tables 6.0-1 through 6.0-3 and DCI Tables 9.4-2 through 9.4-5 show that the medical curriculum is equivalent in Halifax and DMNB.

The faculty at each instructional site at each campus are informed of, and oriented to the learning objectives and assessment methodologies through the online management system in the course syllabi and the tutor guides for faculty. There are also faculty development sessions offered explaining the objectives and assessment methodologies and the powerpoint presentation is available to those who cannot attend in person. This information is also sent to all tutors prior to each component. Unit heads and clerkship directors are also responsible for ensuring that all faculty members in their respective units, regardless of site, are oriented to the objectives and assessments. Logging patient encounters and procedural skills is a student responsibility, however faculty are able to review using One45 and the online management

system and clerkship directors review as the student proceeds through clerkship. For procedural skills in Skilled Clinician Med 2, faculty are recruited and trained prior to the sessions. Tutors in Skilled Clinician in Med 1 receive online training as well as a workshop. There are also scheduled opportunities for tutors to interact with colleagues and unit heads in person about the week's upcoming patient encounters. All content to be covered by faculty for patient encounters is available via the online management system.

Faculty members with responsibility for each required learning experience at each instructional site have multiple, regular means of communicating with each other regarding planning and implementation of the educational experience, student assessment, and evaluation of the required learning experience to ensure comparable educational experiences at all sites. This includes inclusion of DMNB faculty on committees as outlined in the DCI. Tele- and video-conferencing are used across all distributed medical education sites with minutes and notes provided via email. Clerkship directors, senior administrative staff and the Assistant Dean Clerkship and Assistant Dean Clinical Education travel to teaching locations including LIC sites throughout the Maritimes on a rotating basis to meet with leadership, faculty, administration and students. At these meetings, any issue regarding comparability of experiences can be discussed.

The annual unit review process provides the opportunity for evaluating comparability of learning experiences across sites. All feedback is provided by campus. The End of Unit report is reviewed by the appropriate year committee and the UMECC. Data reviewed includes:

Student Evaluations

- Unit review process which compares both sites and disseminations to appropriate faculty
- Data collected from student evaluation is provided by specific site, not only by campus, and is disseminated to academic leaders (e.g. Clerkship directors) to allow review and ensure comparability.
- Clerkship evaluations
- Longitudinal Integrated Clerkship evaluation

Required Patient Encounters and Procedural Skills

- Clerkship director reviews both sites

Student Performance Data

- Exam reviews have representation from both sites (looks at performance)
- Comparability of exam performance
- Information goes to the CASP which may lead to the Progress Committee (the medical student advancement/promotions committee)
- Committees have representatives from both sites

DMNB Annual Report

- GQ compares data from both sites and is reviewed by the Associate Dean, UGME, the Associate Dean, DMNB and curriculum committees, Education Council, Faculty Council and Joint Department Heads
- DMNB overall program evaluation report
- The annual Accountability and Oversight Supplemental Report contains detailed program evaluation data with the DMNB program, comparability across sites for the undergraduate medical education program and preliminary outcomes data for postgraduate medical education. This report is reviewed by the Associate Dean, UGME, Associate Dean, DMNB, the Dean, the DMNB Accountability and Oversight Committee, the Program and Faculty Evaluation Committee, and the UMECC. Issues related to comparability between sites are identified and appropriate actions taken to address. Data contained in this report includes the

following:

- Student assessment and program evaluation data: Medical Council of Canada Examination Part 1; DMNB graduate residency choice and location; and, student performance data.
- Student performance in the undergraduate medical education program.
- Student perception data for the undergraduate medical education program: student perception of Med 1, 2 and 3 units; year over year comparison of student perceptions associated with clinical skills program; and, Research in Medicine

The UMECC reviews the data described above and takes steps when needed to address lack of comparability in the educational experience identified in the data.

Examples provided by the school on how a perceived lack of comparability between DMNB and Halifax were resolved show that the UMECC is responsive and able to address identified problems. An example is that students felt that in DMNB there were more comprehensive learning opportunities in ophthalmology than students in Halifax and this led to the development of "ophthalmology evenings" added to the curriculum in the Halifax schedule, where learners rotate in small groups through 5 different stations exposing them to the most relevant ophthalmological conditions. Student satisfaction with Psychiatry in DMNB was lower than at the Halifax campus and the Assistant Dean, Clinical Education DMNB and the DMNB Clerkship Director ran focus groups to explore the issues. The feeling of a lack of appropriate supervision due to understaffing following the departure of two staff psychiatrists and a lack of outpatient experience was addressed by hiring of 2 new psychiatrists (with one additional position to be filled), assigning students to individual preceptors, reallocation of duties to the clerkship director to ensure sufficient time for education as a priority, ensuring frequent interactions between Psychiatry clerkship director/Clerkship co-ordinator, advocating for more administrative support for Psychiatry, and adding specific faculty development programs to directly address issues brought up by ISA/GQ/Dept members for Psychiatry. This was an area of noncompliance in 2009.

8.8 MONITORING TIME SPENT IN EDUCATIONAL AND CLINICAL ACTIVITIES

The curriculum committee and the program's administration and leadership implement effective policies and procedures regarding the amount of time medical students spend in required activities, including the total number of hours medical students are required to spend in clinical and educational activities during required clinical learning experiences.

8.8 a There is a policy or equivalent document(s) related to the amount of time per week that students spend in required learning activities including required activities assigned to be completed outside of scheduled class time during the first two years of the curriculum.

8.8 b This policy was approved by the 'curriculum committee' and is disseminated to students, faculty, residents and others involved in required learning experiences in the first two years of the curriculum.

8.8 c The 'curriculum committee' (or its subcommittee) monitors the spent in educational activities of medical students and the time available for study in the first two years of the program on a regular basis.

8.8 d There are mechanisms for students to report violations of the policy described in 8.8.a. and steps are taken to rectify identified problems.

8.8 e 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 f The policy described in 8.8.e. 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 g The 'curriculum committee' (or its subcommittee) monitors the effective application of the policies for required clinical learning experiences on a regular basis.

8.8 h There are mechanisms for students to report violations of the policy described in 8.8.e., and steps are taken to rectify identified problems.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

There is a "typical week" document related to the amount of time per week that students spend in required learning activities in year one and two. It outlines a typical weekly schedule showing the amount of mandatory and non-mandatory class time for Med 1 & Med 2 including (in Med 1):

- tutorial group meeting for 2-3 hours, two times a week
- 3-5 hours of lectures
- a patient contact experience for 3-4 hours, emphasizing patient-doctor relationships
- a 1/2 day for Research in Medicine

- a 1/2 day of electives in second semester
- a 3-hour laboratory related to the cases under study

Information on time spent in learning activities is also included in the syllabus for each required learning experience which is posted on the online curriculum management system. It was confirmed during the site visit that this document acts as the policy on time spent in educational activities. Due to the complexity of providing equivalent education to DMNB, there are few changes to this typical week, other than those induced by extreme weather.

This schedule was approved by the UMECC and is available online on the UGME website for all students and faculty. The UMECC does not approve syllabi that do not follow the typical week format. A broad knowledge about the typical week schedule was confirmed during the visit.

The UMECC defines a typical week and the time spent in educational activities and review this requirement annually. This is done through the unit review process.

The UGME staff can detect anomalies to the typical week schedule and students can report violations to the Dalhousie Medical Student Society (DMSS) student committee representative. These individuals sit on the Med 1 & 2 and Med 3 & 4 committees and the UMECC. In addition, the DMSS reps meet bi-weekly with the associate deans of UGME and DMNB where violations can be raised. The dean also meets monthly with students over lunch and any issues can be brought forward. The end of course, end of clerkship and end of year surveys bring forward any discrepancies in the scheduling, and effectiveness of monitoring the time spent in required learning activities in discussed at the UMECC along with annual review of units and clerkships. Conversations with students on site confirmed that they are comfortable reporting any violations, and these are usually scheduling errors that are readily resolved.

There are rules outlining the hours for clerkship students outlined in the Med 3 and Med 4 Clerkship Manual, including the hours of call.

The policy related to the time students spend in educational and clinical activities during required clinical learning experiences, including on-call requirements was developed by faculty, including Clerkship Directors, vetted by the Med 3&4 committee and approved by the UMECC and disseminated to students, faculty, residents and others involved in required clinical learning experiences by the UGME website, the clerkship syllabi, direct email to groups/individuals and through orientation sessions.

The UMECC monitors the effective application of the policies for required clinical learning experiences annually.

There are mechanisms for students to report violations as described above, and appropriate steps are taken to rectify identified problems. The on site visit confirmed that students are confident in the resolution of any violations, which by their accounts are rare and usually due to scheduling errors which are readily corrected prior to the experience.

STANDARD 9
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

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

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

Site Visit Team
Standard 9 Element Rating Table

Standard 9	Teaching, Supervision, Assessment and Student and Patient Safety
Element	
9.1	Preparation of Resident and non-Faculty Instructors
9.2	Faculty Appointments
9.3	Clinical Supervision of Medical Students
9.4	Assessment System
9.5	Narrative Assessment
9.6	Setting Standards of Achievement
9.7	Timely Formative Assessment and Feedback
9.8	Fair and Timely Summative Assessment
9.9	Student Advancement and Appeal Process

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 9.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 9 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 9 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 9 –Teaching, Supervision, Assessment and Student and Patient Safety
SM	9.3 Clinical Supervision of Medical Students
	Finding: Although majority of student responses are satisfied with the level of clinical supervision, less than half of students were satisfied with Psychiatry at DMNB. The school has responded with additional resources that have been recently implemented.
SM	9.4 Assessment System
	Finding: The GQ data demonstrate a decrease from 2015 to 2016 in the percentage of students being observed with History Taking and Physical Examination in Psychiatry at DMNB. Less than half of the students were observed at this clerkship at this site. The school has responded with additional resources in Psychiatry that have been recently implemented.

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

9.1 PREPARATION OF RESIDENT AND NON-FACULTY INSTRUCTORS

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

9.1 a The learning objectives and the methods of assessment of the required learning experience are explained to residents, graduate students, postdoctoral fellows and other non-faculty instructors who supervise, teach or assess medical students before engaging in teaching and assessment activities at all instructional sites.

9.1 b Residents at all instructional sites participate in centrally or departmentally delivered faculty development activities to enhance their skills in teaching and assessing medical students.

9.1 c The faculty development activities noted in 9.1.b. are mandatory for residents who supervise, teach or assess medical students and attendance is centrally monitored.

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

All residents complete a brief, mandatory e-learning module that encompasses the medical education program objectives and learning objectives specific to particular rotations, as well as teaching, feedback, and assessment skill development tips (Core Appendices C-49 and C-50). The office of Postgraduate Medical Education (PGME) centrally tracks compliance with this requirement. The PGME office offers an optional, two-part resident-as-teacher (RAT) program that is mandatory only for residents in family medicine; several departments offer variations on this program to its residents. The PGME office also offers an optional four-week elective that prepares residents for their roles as teachers and assessors of medical students and that provides support for improvement of these skills. Residents' teaching of medical students is evaluated at all instructional sites by both medical students through their clinical clerkship evaluation forms and by faculty members through in-training evaluation reports (ITERs). This was an area of noncompliance in 2009.

9.2 FACULTY APPOINTMENTS

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

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 medical school has policies and processes in place to ensure that all physicians who supervise, teach, and assess medical students hold faculty appointments. Non-faculty physicians do not assess medical students and only instruct students under the direction of a faculty member, who is responsible for ensuring alignment with the learning objectives, quality of instruction, and appropriateness of the learning environment. It was confirmed on site that 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.

9.3 CLINICAL SUPERVISION OF MEDICAL STUDENTS

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

9.3 a The medical school central administration and the departments ensure that medical students in clinical learning situations involving patient care are appropriately supervised at all times to ensure patient and student safety.

9.3 b The medical school has policies or guidelines related to medical student supervision during clinical learning experiences involving patient care that ensure student and patient safety.

9.3 c There are mechanisms by which medical students can express concern about the adequacy and availability of supervision. The concerns raised by medical students are acted upon.

9.3 d The medical school ensures that the level of responsibility delegated to a medical student is appropriate to the student's level of training and experience.

9.3 e The activities delegated to a student and supervised by a health professional, who is not a physician, are within the scope of practice of that health care professional.

9.3 f 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 g 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

The medical school has policies in place regarding supervision of students by faculty to ensure patient and student safety. However, the school does not explicitly articulate the level of responsibility expected of medical students in their required clinical encounters. Rather, the school states that the level of student responsibility in clinical encounters is graded, progressive and consistent with the student's capabilities, and that the responsibility for ensuring an appropriate level of student responsibility is shared among the clinical departments, students, and medical school. The school ensures that the activities delegated to a student under the guidance of a non-physician health professional are within that professional's scope of practice by ensuring that only licensed professionals provide instruction to students, and that this instruction occurs only after a faculty physician determines that these activities are within the licensed health professional's scope of practice and appropriate for the student's clinical abilities.

Students can express concern about availability and adequacy of supervision in several ways, including on ITERs and through direct reporting of concerns to clerkship directors, assistant deans and student affairs. The school provides no examples of how student concerns regarding clinical supervision are

identified through internal student clerkship evaluations. The examples given describe responses to data obtained via the AAMC 2014 CGQ (DCI Table 9.3-1) or the AFMC 2015 and 2016 GQs (DCI Table 9.3-2).

These data show student concern about level of supervision and responsibility in Obstetrics & Gynaecology in Halifax (65.9% satisfaction with appropriate level of responsibility) and Psychiatry at DMNB with 45.5% of the respondents agree that they are given appropriate responsibility. The low satisfaction with supervision in Obstetrics & Gynaecology and Psychiatry indicated in the CGQ triggered a review with Clerkship directors and students. This revealed that in Obstetrics & Gynaecology, students felt they received too much supervision and not enough clinical experience opportunities. The Clerkship directors took this feedback into account and addressed it with faculty members in their departments. Subsequent focus groups with clerks held in May and June 2016 indicated significant improvements with students' satisfaction with their experience in Obstetrics & Gynaecology.

The issue regarding level of supervision of clerks in Psychiatry at the Saint John site was reviewed with the DMNB Psychiatry Clerkship Director. This review found that the main problem at this site was that clerks are assigned to the service and not a particular preceptor. The medical school identified steps that would remedy this issue, including: 1) decreasing the reliance on a small number of DMNB faculty to deliver didactic sessions and making more use of video conferenced sessions from Halifax; and 2) changing to a system in which learners are assigned to single preceptors within the department.
A plan was put in place including:
1. The Saint John department has recruited 3 new faculty. Two are now in place.
2. The DMNB Psychiatry Clerkship director has had a reorganization of her duties to provide an opportunity for her to carry out her clerkship responsibilities more effectively.
3. The Dalhousie Psychiatry Clerkship director arranged regular meetings with her Saint John counterpart to help assist in addressing the patient issues.
4. The DMNB Director of Faculty Development met with the Saint John department to put together a Faculty development plan for both new and existing faculty.

The ISA 2016 indicated that the Psychiatry rotation is meeting expectations of students. A student focus group discussion with Med 3 students in Halifax prompted by the GQ survey did not identify any specific student concerns regarding safety during their Psychiatry rotation.

The school continues to monitor the educational experiences through clerkship evaluations, GQ data, assessment review etc.

9.4 ASSESSMENT SYSTEM

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

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

9.4 b Student achievement of the learning objectives of each required learning experience and of the medical education program as a whole is systematically assessed using a variety of measures (including direct observation).

9.4 c Appropriate methods specifically designed to assess medical students' acquisition of knowledge, core clinical skills, behaviours and attitudes, are used in relevant required learning experiences.

9.4 d There is comprehensive assessment of students' clinical skills (e.g., OSCE or standardized patient assessment) at appropriate points in the program.

9.4 e The 'curriculum committee' (or other relevant governance body) sets the standard of achievement (i.e., establishing the grading policy for all required learning experiences and graduation).

9.4 f The assessment system ensures that only competent students advance, and remediation plans are developed and monitored to ensure that identified deficiencies are effectively addressed.

9.4 g There is central oversight of the process used to set the exam schedule particularly in the early years of the program.

9.4 h 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 i 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

The Undergraduate Medical Education Curriculum Committee (UMECC) oversees both the curriculum and assessment systems of the undergraduate medical education program; it also annually approves all examinations. Two subcommittees of the UMECC oversee the assessment program. The Committee for Assessment of Student Performance (CASP) annually reviews the assessment system to ensure that the medical education program objectives are appropriately assessed. The Progress Committee (PC) systematically monitors student achievement of those objectives as measured by performance on a variety of assessments, including direct observation (Core Appendices C52-C-55)). However, data from the AFMC GQ (Core Appendix C-51)) show a decrease from 2015 to 2016 in the percent of respondents reporting having been observed doing a history and physical in the Psychiatry Clerkship at DMNB (from 69.2% to 45.5%); 45.5% of students reported having been observed doing a physical examination in this clerkship at this site. Comprehensive assessment of clinical skills occurs at multiple and appropriate times in the educational program.

The issue regarding Psychiatry at the Saint John site was reviewed with the DMNB Psychiatry Clerkship Director. This review found that the main problem at this site was that clerks are assigned to the service and not a particular preceptor. The medical school identified steps that would remedy this issue, including: 1) decreasing the reliance on a small number of DMNB faculty to deliver didactic sessions and making more use of video conferenced sessions from Halifax; and 2) changing to a system in which learners are assigned to single preceptors within the department.
A plan was put in place including:
1. The Saint John department has recruited 3 new faculty. Two are now in place.
2. The DMNB Psychiatry Clerkship Director has had a reorganization of her duties to provide an opportunity for her to carry out her clerkship responsibilities more effectively.
3. The Dalhousie Psychiatry Clerkship Director arranged regular meetings with her Saint John counterpart to help assist in addressing issues.
4. The DMNB Director of Faculty Development met with the Saint John department to put together a Faculty development plan for both new and existing faculty.

The UMECC, through recommendations provided by the CASP, sets the standards of achievement for all required learning experiences in and for graduation from the undergraduate medical education program. The PC ensures that only competent students advance and, when necessary, develops and monitors remediation plans. The promotions regulations and guidelines were completely re-written in 2016 to reflect the changes to the curriculum and to provide methods of identifying students in difficulty earlier in their training. These changes have been approved and will be implemented in AY 2017-18.

9.5 NARRATIVE ASSESSMENT

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

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

Students receive both formative and summative narrative assessments of their cognitive and non-cognitive achievements at multiple and appropriate points throughout the medical education program. These points include all required small group learning experiences of at least four-weeks in duration and learning activities with 1:1 interaction between a student and a tutor/preceptor.

In the pre-clerkship years, some examples of narrative include:

- For formative assessment: the four-year Skilled Clinician unit (continual written formative assessment within each component)
- Professional Competencies 1 and 2 (tutors provide written formative feedback twice in the year)
- OSCE (may receive written formative feedback)
- mid-unit tutorial performance assessments
- Research in Medicine (RIM)

For summative assessment:

- Skilled Clinician (narratives may appear from the OSCE and year-end performance by tutors)
- Professional Competences 1 and 2 (tutors provide written summative feedback at the end of each year)
- all unit-based tutorials Research in Medicine (RIM)

In Clinical experiences, examples included as part of formative assessment include:

- Med 3 and Med 4 (provided as part of the ITER) mid-point and final
- OSCE
- Skilled Clinician (Mini-CEX)

And as part of the final grade for the clerkship, narratives are provided as part of the final ITER in the clerkship.

9.6 SETTING STANDARDS OF ACHIEVEMENT

A medical school ensures that faculty members with appropriate knowledge and expertise set standards of achievement in each required learning experience in the medical education program.

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

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Faculty members with appropriate knowledge and expertise, though unit examination review subcommittees of the CASP, set standards of achievement in each required experience of the medical education program and for the curriculum as a whole.

Examples include formalized standard setting for examinations using the modified Angoff method of setting standards, standardization for OSCEs using borderline linear regression method and tutorial assessment supported by training documents (a tutor training manual), half day training sessions and explanatory performance-level descriptors on the assessment forms themselves.

9.7 TIMELY FORMATIVE ASSESSMENT AND FEEDBACK

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

9.7 a Formative assessment consisting of appropriate measures by which a medical student can measure his or her progress in learning is provided in all required learning experiences.

9.7 b Provision of formative assessment in required learning experiences is monitored.

9.7 c Each medical student is assessed and provided with formal formative feedback early enough during each required learning experience four or more weeks in length to allow sufficient time for remediation.

i. Formal feedback occurs at least at the mid-point of the learning experience or
ii. Formal feedback occurs approximately every six weeks for required learning experiences that are semester or year-long (e.g., longitudinal integrated clerkship).

9.7 d Provision of formal feedback described in 9.7.c., is monitored to ensure it occurs at all instructional sites.

9.7 e Alternate means are provided by which a medical student can measure his or her progress in learning in required learning experiences less than four weeks in length.

9.7 f AAMC CGQ data in Table 9.7-2 show that the majority of respondents at each campus agree/strongly agree that they received mid-point feedback on their performance, and AFMC GQ data in Table 9.7-2 show that the majority of respondents at each campus agree/strongly agree that they received feedback early enough in the experience to allow them to improve their performance.

9.7 g Evaluation data from required clinical learning experiences for the most recently completed academic year or the ISA show that the majority of respondents at each campus agree/strongly agree that they received mid-point feedback for the required learning experiences in Table 9.7-3.

9.7 h Administrative data or evaluation data for the last three academic years show that students in longer educational experiences (one semester, year-long required experiences) receive formal feedback approximately every six weeks at all instructional sites.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

All required learning experiences in years one and two include formative assessments consisting of appropriate measures by which a student can gauge his or her learning progress within a timeframe that allows remediation (DCI, Table 9.7-1). All students receive formative assessment via ITERs at the midpoint of each clerkship rotation. The 2014 AAMC CGQ and the 2015 and 2016 AFMC GQ data (Core Appendix C-56) and school-derived and ISA data (Core Appendices C-57 and C-58) show that 63.6% - 100% of respondents agree that they received timely and sufficient feedback in all required clinical experiences (the 63.3% being in Psychiatry at DMNB, otherwise values range from 81.8% to 100%). ISA data ranged from 87% to 100% with Psychiatry at DMNB at 94%. LIC data on feedback ranged from 84.5% to 100% (data from One45). Adherence is monitored by the unit heads, clerkship coordinators and UGME administrators. The school centrally monitors provision of this feedback electronically to ensure that it occurs at all instructional sites.

In required learning experiences of less than four-weeks in duration, students receive formative feedback through mandatory completion of mini-CEX experiences.

9.8 FAIR AND TIMELY SUMMATIVE ASSESSMENT

A medical school has in place a system of fair and timely summative assessment of medical student achievement in each required learning experience of the medical education program. Final grades are available within six weeks after the end of a required learning experience.

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

The school has a policy (Promotions and Assessment Regulations) that specifies the timeline for provision of final grades in all required learning experiences; it also has a process for monitoring and ensuring that the policy is being followed. All students at both campuses receive their final grades within no more than six weeks after the end of each required learning experience (Core Appendix C-59). This was an area of noncompliance in 2009.

9.9 STUDENT ADVANCEMENT AND APPEAL PROCESS

A medical school ensures that the medical education program has a single standard for the advancement and graduation of medical students across all locations and a fair and formal process for taking any action that may affect the status of a medical student, including timely notice of the impending action, disclosure of the evidence on which the action would be based, an opportunity for the medical student to respond, and an opportunity to appeal any adverse decision related to promotion, graduation, or dismissal.

9.9 a The requirements for advancement (i.e., passing each required learning experience and segment of the curriculum) and graduation (i.e. completing the program as a whole) are the same at all instructional sites.

9.9 b A mechanism exists that ensures that the same principles are consistently applied in analyzing student performance data and making pass/fail and advancement decisions at all instructional sites.

9.9 c The medical school's requirements for promotion and graduation are made known to students and teaching faculty.

9.9 d There is a fair and formal (documented) process for taking any action that may adversely affect the status of a medical student that includes timely notice of impending action, disclosure of the evidence on which the action would be based, an opportunity for the medical student to respond, and an opportunity to appeal any adverse decision related to promotion, graduation, or dismissal in a fair and impartial hearing.

9.9 e A description of the process for taking any action that may adversely affect the status of a medical student, and a description of the appeals process are made known to all medical students and teaching faculty.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The school has a single set of standards for advancement and graduation across both campuses. These standards are consistently applied by the Progress Committee (PC) whose membership includes basic and clinical faculty members from both Halifax and DMNB, the Assistant Dean Student Affairs, students, and the associate deans from both campuses. Students learn about the PC during orientation and are told to familiarize themselves with the promotions and assessment regulations, which are available on the website, as well as with the assessment policies, which are available in syllabi, clerkship manuals and the online curriculum management system.

There is a formal, documented process for taking any action, including dismissal that might adversely affect a medical student's status. The process begins with a meeting with the Associate Dean for UGME or DMNB, each of whom is on the PC, who decides whether he or she "feels the student should be dismissed" and recommends that adverse action to the committee. The student receives all evidence upon which the action would be based and is given ample time to respond after the adverse action has been

recommended to the PC. In the event of an adverse action decision, the student may appeal to the Appeals Committee of the Faculty Council; the policies and processes do not provide for an appeal to the dean.

STANDARD 10
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

STANDARD 10: MEDICAL STUDENT SELECTION, ASSIGNMENT, AND PROGRESS

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

Site Visit Team
Standard 10 Element Rating Table

Standard 10	Medical Student Selection, Assignment and Progress
Element	
10.1	Premedical Education/Required Coursework
10.2	Final Authority of Admission Committee
10.3	Policies Regarding Student Selection/Progress and their Dissemination
10.4	Characteristics of Accepted Applicants
10.5	Technical Standards
10.6	Content of Informational Materials
10.7	Transfer Students
10.9	Visiting Students
10.11	Student Assignment

Note: Currently, there are no elements 10.8 and 10.10

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 10.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 10 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 10 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 10 – Medical Student Selection, Assignment and Progress

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

10.1 PREMEDICAL EDUCATION/REQUIRED COURSEWORK

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

10.1 a The medical school's course requirements for admission encourage potential applicants to the medical education program to acquire a broad undergraduate education that includes the study of the humanities, natural sciences, and social sciences.

10.1 b The courses required for admission to the MD program are restricted to those deemed essential preparation for the successful completion of the medical education program.

10.1 c The courses required for admission to the medical education program were reviewed and revised, as needed, since the time of the last full survey.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Dalhousie Medical School does not require specific prerequisite courses for admission. Requirements include:

1) undergraduate baccalaureate degree in any discipline from an accredited post-secondary institution recognized by Dalhousie University
2) a full-time course load
3) an acceptable performance level in all components of the MCAT

The MCAT is used to assess applicants' basic knowledge in disciplines relevant to the study of medicine including psychological/social sciences, biological sciences, physical and chemical sciences and critical analysis and reasoning.

Academic requirements are reviewed on an ongoing basis by the Admissions Office and annually by the Admissions Committee.

10.2 FINAL AUTHORITY OF ADMISSION COMMITTEE

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.

10.2 a The authority and composition of the admissions committee (and its subcommittees if any) and its rules of operation, including voting privileges and definition of a quorum are specified in bylaws or other medical school policies.

10.2 b The composition of the admissions committee is appropriate, and the terms of appointment allow sufficient overlap.

10.2 c Faculty members constitute a majority of voting members at all meetings.

10.2 d Members of the admissions committee and subcommittee members, if applicable, are oriented to the admissions committee's policies and processes, and receive specific training appropriate to their role in the admissions process.

10.2 e The admission committee has the final authority for making decisions for entry into the MD program including admission into any combined degree programs. There have been no instances over the past three admission cycles where a decision of the admissions committee regarding the admission of a student into the MD program was challenged, overruled, or rejected.

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

10.2 g The criteria used to evaluate applicants, and the process that culminates in the offer of admission, are fair, evidence-based and objective, and not influenced by political or financial factors.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The Admissions Committee has appropriate and final authority, is appropriately constituted with faculty constituting the majority of voting members (Appendix LLL of the DCI). The committee is subject to the Dalhousie University conflict of interest policy (Appendix C of the DCI). The criteria and process are fair and objective, and not influenced by political or financial factors. Members are oriented to the Admissions Committee's policies and procedures and trained appropriately. This was an area of monitoring in 2012.

10.3 POLICIES REGARDING STUDENT SELECTION / PROGRESS AND THEIR DISSEMINATION

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

10.3 a The faculty of the medical school developed and approved the policies, procedures, and criteria for medical student selection.

10.3 b The policies, procedures, and criteria for medical student selection are disseminated to potential and actual applicants and their advisors.

10.3 c In each of the steps in the admission process to the MD program listed below, standardized procedures are followed, and standardized criteria are used to make the relevant decision by the appropriate individuals or groups (e.g., the admission committee, admission subcommittee or interview committee).

i. Preliminary screening for applicants to receive a secondary/supplementary application
ii. Selection for the interview
iii. The interview
iv. The acceptance decision
v. The offer of admission

10.3 d In each of the steps in the admission process to any joint baccalaureate-MD program or dual degree programs (e.g., MD-PhD) listed below, standardized procedures are followed, and standardized criteria are used to make the relevant decision by the appropriate individuals or groups (e.g., the admission committee, admission subcommittee, or interview committee).

i. Preliminary screening for applicants to receive a secondary/supplementary application
ii. Selection for the interview
iii. The interview
iv. The offer of admission

10.3 e The authority and composition of the promotion committee (or promotion committees, if there is more than one) and its rules of operation, including voting privileges and definition of a quorum are specified in bylaws or other medical school policies.

10.3 f The composition of the medical student promotion committee (or promotion committees if there are more than one) is appropriate to enable the committee to make objective and informed decisions on student promotion.

10.3 g There are policies for the assessment, advancement (promotion) and graduation of medical students and the policies for disciplinary action that are available to medical students and teaching faculty.

10.3 h Decisions on the advancement of a medical student to the next academic year, phase or segment of the curriculum, and on the graduation of a medical student is made by the committee with the authority to make those decisions.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Student selection criteria, policies and procedures are appropriate, are established by the Admissions Committee and approved by Faculty Council and ultimately Dalhousie University Senate; they are available on the University website and the Academic Calendar. In each of the steps in the admission process to the MD program, standardized procedures and criteria are used to make the relevant decision by the Admissions Committee.

The Progress Committee is appropriately composed and has the appropriate authority (Appendix OOO of the DCI). Policies regarding assessment, advancement and graduation of medical students, as well as the policies for disciplinary action are described to students during orientation, and are available on the medical school website (Appendix NNN of the DCI)

10.4 CHARACTERISTICS OF ACCEPTED APPLICANTS

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

10.4 a The mean overall premedical student performance data for new first year students admitted to the medical school for the last three years provided in Table 10.4-1 of the DCI, indicate that the medical school selects applicants who possess the intelligence necessary for them to become competent physicians.

10.4 b The personal and emotional characteristics of applicants considered during the admission process are necessary for them to become competent physicians.

10.4 c The personal and emotional characteristics of applicants considered during the admission process were developed, reviewed, and approved by appropriate individuals or groups.

10.4 d Members of the admission committee and the individuals who interview applicants (if different than members of the admission committee) are prepared and trained to assess applicants' personal and emotional characteristics.

10.4 e There are standard forms used to guide and/or evaluate the results of applicant interview.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The Admissions Committee developed and revises the criteria and process for admissions. Premedical GPA of the first year class has been 3.8/4 for the past 3 years (Core Appendix C-60). Personal and emotional characteristics of applicants are assessed through review of their personal statements and supplemental information, as well as in a Multiple Mini-Interview (MMI). The MMI uses standardized evaluation forms (Appendix PPP of the DCI). The desired attributes of the applicants are reviewed, discussed and approved by the Admissions Committee annually. Members of the Admissions Committee are given an orientation and review the committee's tasks and responsibilities. MMI interviewers are provided with mandatory orientation workshops. This was an area of monitoring in 2012.

10.5 TECHNICAL STANDARDS

A medical school develops and publishes technical standards for the admission, retention, and graduation of applicants or medical students with disabilities, in accordance with legal requirements.

10.5 a The medical school has technical standards for the admission, retention, and graduation of applicants and students.

10.5 b The medical school's technical standards noted in 10.5.a. were developed and approved by the faculty. These technical standards are reviewed and revised when needed on a regular basis.

10.5 c The medical school's technical standards noted in 10.5.b. are disseminated to potential and actual applicants, enrolled students and teaching faculty.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The Technical Standards Document for Dalhousie Medical School (Appendix QQQ of the DCI) was approved by the UMECC in August 2016 and Faculty Council in September 2016. This document was posted on the Faculty of Medicine Policies and Guidelines website and the Faculty of Medicine Admissions Website in December 2016. It has been submitted for inclusion in the next edition of the official Academic Calendar for 2017.

10.6 CONTENT OF INFORMATIONAL MATERIALS

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

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

10.6 b The materials noted in 10.6.a. are regularly reviewed by leadership in the medical education program to ensure they are accurate.

10.6 c Recruitment materials about the medical education program are made available to potential and actual applicants, career advisors, and the public.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The Academic Calendar and website contain the required informational, advertising and recruitment materials. The medical school's website presents the mission and objectives of the medical education program, the academic and other requirements of the medical program, the academic schedule and required learning experiences. Senior leaders of the Dean's Office are responsible for reviewing and updating information for their units on an annual basis as reviewed by the UMECC and the UGME Office. Recruitment materials are disseminated widely.

10.7 TRANSFER STUDENTS

A medical school ensures that any student accepted for transfer or admission with advanced standing demonstrates academic achievements, completion of relevant prior coursework, and other relevant characteristics comparable to those of the medical students in the class that he or she would join. A medical school accepts a transfer medical student into the final year of a medical education program only in rare and extraordinary personal or educational circumstances.

10.7 a The medical school has policies and procedures related to transfer/admission with advanced standing that are made known to potential applicants for transfer and advanced standing and their advisors.

10.7 b There are procedures in place for the selection of applicants for transfer or admission with advanced standing whereby the medical school determines the comparability of the applicant's educational program and prior academic achievement to those of medical students in the class they would join.

10.7 c In making decisions of accepting transfer students or admitting students with advanced standing, the admission committee or other governance body with the appropriate authority and members of the medical school administrative leadership determine if space and resources are adequate.

10.7 d The transfer students and students admitted with advanced standing listed in Table 10.7-1 of the DCI demonstrated academic achievements, completion of relevant prior coursework, and had other characteristics comparable to the medical students in the class that they joined.

10.7 e Only rare and extraordinary personal or educational circumstances accounted for the decisions to accept any transfer students into the final year of the curriculum during any year since the last full survey visit.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

A Partnership Agreement with the International Medical University in Malaysia (Appendix XXX-2 of the DCI) describes the policies and procedures for transfers for 4-6 students per year into Year 3 at Dalhousie. Policies for the International Medical Graduate Clerkship program exist (Appendix XXX-1 of the DCI) and affect 2 students per year into Year 3 at Dalhousie. There have been no transfers into other years of the program (DCI Table 10.7-1 and 10.7-2)

10.8 Currently, there is no element 10.8

10.9 VISITING STUDENTS

A medical school oversees, manages and ensures the following:

- ***a) verification of the credentials of each visiting medical student***
- ***b) each visiting medical student demonstrates qualifications comparable to those of the medical students he or she would joint in educational experiences***
- ***c) maintenance of a complete roster of visiting medical students***
- ***d) approval of each visiting medical student's assignments***
- ***e) provision of a performance assessment for each visiting medical student***
- ***f) establishment of health-related protocols for visiting medical students***

10.9 a The medical school verifies the academic credentials and immunization status of each visiting student.

10.9 b There are procedures and criteria used by the medical school to determine if the qualifications of potential visiting medical students are comparable to those of the medical students they would join in a clinical experience.

10.9 c The process of evaluating whether potential visiting students have comparable qualifications to those of the school's own students is centrally overseen and managed within the medical school.

10.9 d The medical school approves the assignment of a visiting student after ensuring there are adequate resources (including clinical resources) and appropriate supervision at the site for both the visiting student and any of the medical school's own students.

10.9 e The medical school ensures that a performance assessment is provided for each visiting student.

10.9 f An accurate and up-to-date roster of visiting medical students is maintained by medical school or university administrative personnel who ensure that the medical school's requirements for visiting medical students are met.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

For Canadian visiting electives, the AFMC Electives Portal is used to verify academic credentials and immunization status; for international electives, applicants must attend a school listed in the FAIMER directory and supply appropriate academic and immunization information.

Eligibility requirements are listed on the AFMC Electives Portal. They are:

<u>International Visiting Electives</u>

UGME ensures that international students have completed the required prerequisite core rotations and provided a police background check, correct immunization records, valid malpractice insurance, proof-of-language competency, a letter of good standing and other necessary paperwork.

The Associate Dean UGME, Assistant Dean Clerkship and Dean of Medicine consult with clinical departments to determine if space and resources are available to accept visiting students and make the

final decision on capacity.

Canadian Visiting Electives

UGME ensures that Canadian students have completed the required core rotations and provided a police and vulnerable sector screening check, a signed pledge of confidentiality and proof of their N95 mask fitting.

The procedures used for verification and acceptance as well as ensuring assessments are completed include:

Canadian Visiting Electives

1. The home school is sent a request via the AFMC electives portal to verify the student's qualifications. Dalhousie then confirms that the student has been verified prior to processing the elective request. Dalhousie confirms that all educational requirements have been met.
2. The department in which the student is completing the visiting elective is responsible for ensuring that there are adequate resources and appropriate supervision at the site.
3. Visiting students are told that if they require an evaluation, they must bring the appropriate form from their home school for the host department to complete.

International Visiting Electives

1. Students must attend a FAIMER medical school. Their attendance and good standing is verified by a series of questions answered by their Dean of Medicine's office. Students must get a physician to complete and certify a Dalhousie immunization record form and include their immunization records.
2. The UGME Office facilitates the application process, ensuring that students possess the necessary requirements before passing their requests to the relevant department. After placing first Dalhousie, then Canadian students, the department decides if it has adequate resources to supervise international students.
3. The UGME Office advises students in their confirmation letter that, should an evaluation form for the elective be required, the appropriate form must be given to the preceptor at the beginning of an elective.

The process is centralized and overseen in the UGME Office by 2 UGME staff members. Potential students submit applications through the AFMC Portal.

A roster of visiting medical students is maintained by the UGME Office.

10.10 Currently, there is no element 10.10

10.11 STUDENT ASSIGNMENT

A medical school assumes ultimate responsibility for the selection and assignment of medical students to each location and/or parallel curriculum (i.e., alternative curricular track) and uses a centralized process to fulfill this responsibility. The medical school considers the preferences of students and uses a fair process in determining the initial placement. A process exists whereby a medical student with an appropriate rationale can request an alternative assignment when circumstances allow for it.

10.11 a There is a process for medical student assignment in the following circumstances that are relevant to the medical school, wherein students are informed about the assignment process; the student has the ability to select or rank options; and decisions are made using a fair process in determining the initial placement.

i. geographically distributed campus
ii. parallel curriculum site (e.g., longitudinal integrated clerkship site)
iii. required clinical learning experience site (e.g., a hospital)

10.11 b There are procedures whereby a student with an appropriate rationale can formally request an alternative assignment which are made known to medical students.

10.11 c There are criteria used to evaluate the request for the change taking into consideration the rationale for the request and whether circumstances can allow for the reassignment of the student.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Processes for student assignment to the DMNB campus, as well as to longitudinal integrated clerkships and to clerkship streams and sites are clear and fair. (DCI 10.11 1,2,3).

Procedures to request and criteria to evaluate alternate clerkship assignments, or site assignment are clear and appropriate (Appendix ZZZ of the DCI).

STANDARD 11
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

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

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

Site Visit Team
Standard 11 Element Rating Table

Standard 11	Medical Student Academic Support, Career Advising and Educational Records
Element	
11.1	Academic Advising
11.2	Career Advising
11.3	Oversight of Extramural Electives
11.4	Provision of the MSPR
11.5	Confidentiality of Student Educational Records
11.6	Student Access to Educational Records

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 11.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 11 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 11 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 11 – Medical Student Academic Support, Career Advising and Educational Records
SM	11.2 Career Advising
	Finding: Student satisfaction on career advising has been suboptimal (for Years 2-4, satisfaction with career advising by campus ranged from 21 to 59%, with 66% satisfaction in Year 1 (Core Appendix C-68). Similarly, for electives advising, the ISA and GQ indicate satisfaction rates between 10-63%, with most years scoring less than 50%. A newly developed 4-year career advising program is in the process of being rolled out and will need to be evaluated.

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

11.1 ACADEMIC ADVISING

A medical school has an effective system of academic advising in place for medical students that integrates the efforts of faculty members, 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.

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 Medical students can self-refer for academic counseling if they perceive the need.

11.1 d Medical students at each campus are informed about the availability of academic advising and how they may be identified as needing these services, or how they can access these services if they perceive the need for academic advising.

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

11.1 h The data provided in Table 11.1-5 of the DCI show that a small number of medical students at each campus in years 1-4 over the past two academic years:

i. withdrew or were dismissed
ii. were required to repeat the entire academic year
iii. were required to repeat one or more required learning experience
iv. moved to a decelerated curriculum
v. took a leave of absence as a result of academic problems

11.1 i The overall graduation rate, and the percentage of medical students that graduated in four years at each campus is very high.

11.1 j 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.

11.1 k Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with academic advising/counseling services.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

There is a comprehensive and integrated system for academic advising, described in the DCI narrative response 11.1 a-c. The school systematically identifies students requiring support, and students may self-identify confidentially to receive support through multiple avenues (Core Appendices C-61to C-66). Academic progress is monitored throughout by examination and evaluation results or unprofessional behaviours. Concerning or failing results are flagged by all unit heads, the Assistant Dean Pre-Clerkship or Clerkship and the Associate Dean UGME or DMNB and a meeting is held with the student to develop a personalized learning plan. The Student Affairs Office encourages students to self-identify if they have any learning concerns at any time and is a source of support and referral. Interventions range from mentorship and academic support from a resident or faculty member, to medical and cognitive assessment, personal counseling may also be a part of the process. Significant support services are available through the university structures at Halifax and DMNB including the Advising and Access Services Centre in Halifax and the Student Accessibility Centre in DMNB. A description of academic advising services and encouragement for students to self-identify is provided in the introductory sessions of each year.

The school ensures that all individuals involved in academic counseling for a student does not have any role in making assessment or advancement decisions about them. All assistant and associate deans, component heads, etc are not directly involved in any aspect of direct student assessment. All psychoeducational assessments are conducted away from the campuses by individual not involved in medical education. Referral for psychological or medical care is sought within the general health care community, where the student's privacy and confidentiality can be held in trust with that professional. Information is shared only with Student Affairs or other Dalhousie Medical School offices with the specific consent of the student.

Faculty or residents recruited and assigned to academic advising roles are not those who are also assessing that same student's progress. This independence of support and assessment is reviewed and assured by Student Affairs (when involved), by the Associate Dean UGME or DMNB (if directing remediation), and/or by the unit head. Faculty members are reminded regularly by email and through unit and department heads to assess each encounter or role for potential bias and conflict of interest. The Progress Committee, Professionalism Committee and other faculty committees review the conflict of interest policies as a reminder at the start of every meeting and members would recuse themselves from any discussions involving students for whom they may have provided academic counseling.

During the site visit, students described positive experiences; they feel well supported both informally by various faculty, and formally through Student Affairs.

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

Table 11.1-4 | Attrition and Academic Difficulty

Source: School-Reported

Provide the percentage of first-year medical students and the percentage of all medical students who withdrew or were dismissed from the medical school in the indicated academic years. Add rows as needed for each campus.

Campus		AY 2013-14	AY 2014-15	AY 2015-16
Halifax	First-year students	0	0	1% (1/90)
	All medical students	0	1% (1/89)	0
DMNB	First-year students	0	3% (1/30)	0
	All medical students	0	0	0

The data provided in Table 11.1-5 of the DCI showed that a very few medical students (usually 0 students, with 4 students being required to repeat one or more required learning experiences for 2016) at each campus in years 1-4 over the past two academic years withdrew or were dismissed, were required to repeat the entire academic year, were required to repeat one or more required learning experience, moved to a decelerated curriculum, or took a leave of absence as a result of academic problems.

The overall graduation rate, and the percentage of medical students that graduated in four years at each campus is 97% at Halifax and 100% for DMNB overall graduate rate: 96% for Halifax and 100% for DMNB for four year graduation rate).

AAMC CGQ and AFMC GQ data over the last three academic years show that 84.3% of Halifax respondents and 63.7% of DMNB respondents were satisfied/very satisfied with academic advising/counseling. The ISA data demonstrated that 43.3% to 61.9% of respondents in Halifax and 21.4% - 55.6% of respondents in DMNB were satisfied with academic advising. However, students interviewed onsite felt that these satisfaction rates misrepresented the academic advising at Dalhousie. Students felt that there was a lack of understanding about “academic advising” and that the low scores were a results of the fact that the majority of students would not have made use of academic supports and therefore unable to score appropriately.

11.2 CAREER ADVISING

A medical school has an effective and where appropriate confidential career advising system in place that integrates the efforts of faculty members, clerkship directors, and student affairs staff to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs.

11.2 a Faculty members, clerkship directors, and student affairs staff provide career advising to medical students at the main campus and any geographically distributed campuses.

11.2 b The career advising system provides appropriate mandatory and optional, and where appropriate confidential career advising activities to students in each year of the program to assist them in evaluating career options, choosing electives and applying to residency programs.

11.2 c The medical school provides career advising to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).

11.2 d There are print or online resources available to medical students to support their career investigations.

11.2 e There is an individual(s) who is primarily responsible for providing guidance to medical students on their choice of intramural and extramural electives during each year of the curriculum at each campus and to students who are away from the medical school for a six-month or more consecutive period.

11.2 f A faculty member is responsible for formally approving medical students' elective choices.

11.2 g The percentage of participating medical students who remained unmatched at the end of the second iteration of the Canadian Residency Match Service (CaRMS) match has been low for the last three academic years.

11.2 h AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus were satisfied/very satisfied with career planning services and information about specialties.

11.2 i Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with career advising.

11.2 j AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus were satisfied/very satisfied with guidance when choosing electives.

11.2 k Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with guidance when choosing electives.

RATING

- ☐ Satisfactory
- ☒ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The MSS and DCI describe a career and electives advising system that is comprehensive, with multiple individuals involved, and with resources available in a variety of formats including lectures, small-group sessions, individual sessions, along with web and print resources (Core Appendix C-67). Key personnel include 3 individuals in Halifax for a total of 1.1 FTE, in Saint John, 6 individuals with an FTE of .8 FTE. In addition, generalists are available to medical students throughout the core university counseling services in Halifax and Saint John. The system includes individual meetings with advisors, panel discussions with 4th year students, panel discussions with residents, group sessions, an annual Career Day and presentations to the class. Print materials include Career Curriculum and Resources Guides, printed elective planning templates, AAMC Careers in Medicine modules, CMA specialty profiles, video recordings of panel sessions etc.

First and second year students are required to complete half-day horizontal electives; the school provides guidance for elective choice. Additional guidance is offered to help students select clinical electives in their fourth year. Despite this, student satisfaction was low: for Years 2-4, satisfaction with career advising by campus ranged from 21 to 59%, with 66% satisfaction in Year 1 (Core Appendix C-68). Similarly, for electives advising, the ISA and GQ indicate satisfaction rates between 10-63%, with most years scoring less than 50% (Core Appendix C-69 and C-70). Subsequent focus groups with students in each year resulted in changes to communication with students, and the addition of annual focus groups as requested by students. Despite this, ISA re-analysis indicates ongoing low satisfaction in both campuses. Career advising is offered to students in Saint John NB and in LICs through personnel located in the LIC site, visits from campus personnel, email/videoconference and student travel to the central campus.

Formal review and approval of elective choices is provided by:

- Pre-Clerkship: Dr. Mohsin Rashid, Unit Head, Med 1 and 2 Electives
- Clerkship: Dr. Simon Field, Assistant Dean Clerkship

Developed in collaboration with students, the revised 4-year program for career advising is being implemented since 2016. Some changes include commencing earlier in first year; adding a career day; and creating opportunities for input from senior students. Elective/career advisors have recently been made available from each department. The school is revising its electronic resources for career advising on the curriculum management system, tailored by year. Additionally, as students report feeling inundated with electronic communication and are asking for personal attention, the school has implemented mandatory one-on-one meetings with the Assistant Dean Student Affairs for all first-year students; and has provided notices for posting on bulletin boards. All Student Affairs activities are organized under the idea of Prepare to Practice, encouraging students in the progressive transitions and necessary skills and activities from Pre-Clerkship to the more direct and broad clinical care responsibilities of clerkship and on to understanding and proactive preparation and application for residencies in specialties they have had repeated group and individual routes to assess their choice.

These changes are student-centered and a reasonable response. Monitoring is required regarding student satisfaction with the revised career/elective advising system.

Canadian Residency Match Service (CaRMS) match rates are high with the percentage of participating medical students who remained unmatched at the end of the second iteration of the match low for the last 3 years as shown below.

Table 11.2-7 | Residency Match Rates

Provide the percentage of participating medical students who remained unmatched at the end of the second iteration of the Canadian Residency Match Service (CaRMS) match. Add rows as needed for each campus.			
Campus	**% unmatched**		
	AY 2013-14	**AY 2014-15**	**AY 2015-16**
Halifax & DMNB	6	2	3

This was an area of noncompliance in 2009.

11.3 OVERSIGHT OF EXTRAMURAL ELECTIVES

If a medical student at a medical school is permitted to take an elective under the auspices of another medical school, institution, or organization, a centralized system exists in the dean's office at the home school to review the proposed extramural elective prior to approval and to ensure the return of a performance assessment of the student and an evaluation of the elective by the student. Information about such issues as the following are available, as appropriate, to the student and the medical school in order to inform the student's and the school's review of the experience prior to its approval:

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

11.3 a There is a centralized system in the dean's office of the home school at each campus to review and approve the proposal for electives to be taken by the school's own students under the auspices of another medical school, institution, or organization before the medical student is permitted to begin the elective.

11.3 b There is an appropriate mechanism for the review of the following points for extramural electives where is a potential risk to medical student and patient safety:

i. potential risks to the health and safety of patients, students, and the community;
ii. the availability of emergency care;
iii. the possibility of natural disasters, political instability, and exposure to disease;
iv. the need for additional preparation prior to, support during, and follow-up after the elective;
v. the level and quality of supervision;
vi. any potential challenges to the code of medical ethics adopted by the home school.

11.3 c The medical school effectively prepares and supports medical students before, during, and after electives where there is a risk to student and patient safety.

11.3 d The centralized system described in 11.3a ensures that a performance assessment of the student and an evaluation of the elective experience by the student are returned to the medical school.

11.3 e The evaluation data on extramural electives provided by students to the centralized system in the dean's office of the home medical school at each campus is used to inform, among other things, future decisions regarding approval of other requests for the same elective experience from other medical students.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The policies, procedures and processes described in the MSS and DCI demonstrate appropriate oversight of extramural electives.

All students are required to submit a proposal of their planned elective experience using the One45 system. Each proposal is individually reviewed and approved by the relevant head for electives.

An international electives policy was developed and approved by the UMECC and Faculty Council. The roles and responsibilities for international electives are clearly outlined in this policy https://medicine.dal.ca/content/dam/dalhousie/pdf/faculty/medicine/departments/core-units/global-health/education/gho_int%20electives_2014_approved_final.pdf.

Students who wish to complete an international elective must submit an application to the Global Health Office for approval. Applications are reviewed and approved by the Global Health Office Program Manager based on the international electives policy. When approved, students must submit an elective proposal to the UGME Office via One45.

Students may participate in electives only with an approved partner institution or joint approval from the Global Health Office and the UGME Office. Other electives may take place at other institutions while meeting the same criteria as described in the International Elective Policy for Undergraduate Medical Education Students.

This criteria requires that the following information be assessed and available before the approval of international electives:

- potential risks to the health and safety of patients, students and the community
- availability of emergency care
- possibility of natural disasters, political instability and exposure to disease
- need for additional preparation prior to, support during and follow-up after the elective
- level and quality of supervision
- potential challenges to the code of medical ethics adopted by the home institution

There are appropriate policies and procedures in place to ensure these are adequately addressed prior to the elective taking place.

The major risk management tool is the development of "approved partner institutions" in low and middle income countries. Electives in these institutions are pre-approved, and risk is evaluated periodically. Electives in other institutions are allowed, and are considered on an individual basis. These are required to meet partner criteria and approval from the UGME and Global Health Offices. The Global Health Office and the UGME Office work together to prepare and support medical students before, during, and after electives where there is a risk to student and patient safety.

A performance assessment of the student and an evaluation of the elective experience by the student are completed and returned to the medical school in the following ways:

Assessments: Med 4 rotations are added to the rotation schedule by the UGME Office. On the first day of the elective, students are required to schedule their rotation. The scheduling of the rotation creates the ITER, which the students are responsible for sending to their preceptor. International electives must adhere to the same evaluation procedures. ITERs are distributed by the student and completed electronically by the preceptors at the partner institution. It is the student's responsibility to ensure that their preceptor submits a completed ITER within four weeks of completing the elective.

Feedback: All students must complete and submit a rotation feedback form at the end of the elective. International electives students must complete and submit an elective feedback report to the Global Health Office within one month of their return to Canada. In addition, they must participate in a post-elective debriefing to provide feedback.

Rotation feedback forms are reviewed to ensure that the experience is relevant to the students' learning. Any relevant comments are noted and may lead to further discussion with the supervisor or students. Remediation may be instituted if significant clinical or non-clinical concerns are raised. International elective students must complete a debriefing report containing reflection questions and a site evaluation. Upon their return, they must attend a debriefing session. Topics include:

- adequacy of their pre-departure training
- discussion and lessons learned in their elective experience
- discussion of re-entry experience and recommendations for the electives program

Program data is presented in the annual report to the President's Office through the International Centre and Faculty of Medicine's Education Council and the Undergraduate Medical Education Curriculum Committee.

11.4 PROVISION OF THE MEDICAL STUDENT PERFORMANCE RECORD

A medical school provides a Medical Student Performance Record required for the residency application of a medical student only on or after October 1 of the student's final year of the medical education program.

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

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The MSPRs are released 3 to 4 weeks before the CaRMS application due date, always after Oct 1st of the student's final year.

11.5 CONFIDENTIALITY OF STUDENT EDUCATIONAL RECORDS

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

11.5 a The medical school at each campus has and follows policy(ies) for the collection, storage, disclosure and retrieval of student academic/educational records that is in compliance with relevant privacy legislation.

11.5 b A medical student's academic/educational record/file is kept in a separate location from his or her health record/file at each campus.

11.5 c There is a policy and procedure that specifies which individuals have the right to review a medical student's academic/educational file. The individual(s) at each campus who is responsible for providing access to a student's academic/educational file ensures that only those authorized individuals are given access.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school has appropriate policies for the management of student academic records, including which individuals are authorized to review the academic file (including Student Education, Records Policy and Dalhousie Release of Information About Students Policy).

Academic records are stored in a separate location from health records, both stored in locked cabinets.

Individuals who have permission to access files are defined in the Student Education Records Policy.

11.6 STUDENT ACCESS TO EDUCATIONAL RECORDS

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

11.6 a The medical school has policies and procedures in place that permit a medical student to review all components of their educational records including the Medical Student Performance Record. Students do not have access to any reference letter used in the admission process when the referee was assured the letter would not be provided to the student.

11.6 b Medical students are given access to review their educational records in a reasonably short period of time after the request has been made at each campus.

11.6 c A medical student can challenge the following if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.

i. content of the Medical Student Performance Record
ii. examination performance, tutor/preceptor assessment in a required learning experience
iii. final grade for a required learning experience

11.6 d Formal medical school policies and procedures related to medical students' ability to review and challenge their records, including the length of time it takes for students to gain access to their records are made known to students and teaching faculty at each campus.

11.6 e The Medical Student Performance Record is completed using objective data by an individual(s) who has had no role in providing personal counseling, or health services including psychiatric/psychological counseling.

11.6 f The medical school corrects factual errors, and removes misleading and/or inappropriate information from the educational record of a medical student once the error, misleading and/or inappropriate information has been identified, investigated and confirmed.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

Appropriate policies and procedures are in place that allow students to access their academic files within a reasonably short time period. Policies for students to challenge the information in their file exist (Appendix CCCC of the DCI). The MSPR is prepared by staff in the UGME Office, who have no role in providing healthcare to students. The contents of the MSPR (Core Appendix C-72) can be appealed to the Associate Dean UGME.

STANDARD 12
ELEMENT RATING TABLE and ELEMENT EVALUATION FORMS

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

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

Site Visit Team
Standard 12 Element Rating Table

Standard 12	Medical Student Health Services, Personal Counseling and Financial Aid Services
Element	
12.1	Financial Aid/Debt Management Counseling/Student Educational Debt
12.2	Tuition Refund Policy
12.3	Personal Counseling/Well-being Programs
12.4	Student Access to Health Care Services
12.5	Non-involvement of Providers of Student Health Services in Student Assessment/Location of Student Health Records
12.6	Student Access to Health and Disability Insurance
12.7	Immunization Requirements and Monitoring
12.8	Student Exposure Policies and Procedures

Label the number of the element using the following code.

Labeling Code	Color
Satisfactory	
Satisfactory with a need for monitoring	
Unsatisfactory	

Note: If element 12.1 was rated as Satisfactory, the cell with the corresponding element number would be shaded green as shown above as an example.

Standard 12 Summary of Findings

The following is the Summary of Site Visit Team Findings for Standard 12 that are linked to elements rated as Satisfactory with a need for Monitoring (SM) or Unsatisfactory (U). The findings are listed in order by the number of the element. Delete elements rated as satisfactory.

Element Rating SM, U	Standard 12 – Medical Student Health Services, Personal Counseling and Financial Aid Services
SM	12.3 Personal Counseling/Well-being Programs
	Finding: Overall there is a varying level of satisfaction with personal counseling and services to promote well-being. A series of new wellness programs has been implemented and will require ongoing monitoring.

Note: See Site Visit Team Evaluation of Elements in section D of the Site Visit Report Guide regarding the formulation of findings.

12.1 FINANCIAL AID / DEBT MANAGEMENT COUNSELING/ STUDENT EDUCATIONAL DEBT

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

12.1 a The medical school ensures that required and optional financial aid and debt management counseling/advising activities (including one-on-one sessions) are available to medical students in each year of the curriculum at each campus.

12.1 b The medical school ensures that financial aid management services are available to students who are away from the medical school for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).

12.1 c The medical school initially determines and subsequently evaluates the adequacy of financial aid staffing.

12.1 d The medical school ensures that conflicts of interests for those providing debt management counselling and information on student loans are identified and appropriately managed.

12.1 e The medical school has awarded bursaries, grants and scholarships and extended loans to students over the past three academic years.

12.1 f Since the time of the last full survey, the medical school or university has engaged in activities to increase the amount and availability of scholarship, bursary, grant and loan support for medical students.

12.1 g The medical school and the university have worked to limit tuition increases or limit student debt since the time of the last full survey.

12.1 h AAMC CGQ and AFMC GQ data show that the average medical education debt of all graduating students over the last three years is comparable to that of other Canadian medical schools.

12.1 i Data from the AAMC CGQ and the AFMC GQ and the ISA show that the majority of respondents at each campus are satisfied/very satisfied with financial aid administrative services, and overall educational debt management counselling.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school has reported a high level of concern over the level of indebtedness of students in the MSS. Since 2009, tuition rates have increased (by about $5,000) however bursaries have also increased ($830K to $1.5 million). According to 2016 GQ, 64.6% of Dalhousie students enter medical school with no debt. For those students entering medical school with debt, the median debt is $30,000. The median debt accumulated over medical studies in 2016 is $125,000 whereas the national median debt for 2016 was $80,000 (Core Appendix C-75).

As per the 2016 GQ, 48.3% of students indicated that the financial assistance available through grants and loans from the university and the government only partially met their financial needs. 31.7% reported that this financial assistance provided did not meet their financial needs. As per the 2016 ISA, 36.23% of students expressed difficulty with affording the cost of medical education (question 73) while 30% of students expressed dissatisfaction with the resources (e.g. loans and bursaries) offered to help fund their medical education.

However, only 5.1% of students (according to the 2016 GQ) to 10.73% of students (according to the 2016 ISA) expressed dissatisfaction with financial aid and administrative services of the medical school (Core Appendices C-73 and C-74).

There are several options of financial support available to medical students, and the majority of students receive some form of financial aid during their studies:

- 61% of students received scholarship funding (based on merit), with a median of 8,000$ awarded.
- According to the Medical School Self-Study 75% or more of students have received some form of financial aid over the 4 years of medical school.
- 85.9% of students received bursary funding, grant funding or sponsorship based on financial need.
- All students receive funding ($5,000) to carry out their Research in Medicine project during the summer of their first year of medical studies.
- Students are compensated for the cost of travel for academic reasons between the DMNB and Halifax campuses.

The faculty ensures adequate access to information on financial matters and provides group and individual financial counseling sessions for students during all four years of medical school, with a particular focus on the different phases of medical training. MD Financial Management plays an integral role in the delivery of these sessions, both to individuals and groups, and the Faculty oversees the group session for tone and accuracy of information. There is an overall high level of satisfaction with the involvement of MD Financial Management and the services provided through this organization as per the Independent Student Analysis and discussions with students on site (Appendix C-74).

The Faculty of Medicine of Dalhousie has clearly indicated awareness of the remaining issues for this standard and is continuously monitoring areas of concern. Steps have been taken to better meet the needs of students, notably via a proposal in early 2017 to make new use of endowment funds in order to better support fourth year students who travel across Canada for electives and the CaRMS tour.

On site, both pre-clerkship and clerkship students reported a low level of concern over their ability to afford their medical studies, and expressed confidence that the Faculty has been supportive of, and receptive to their financial needs.

12.2 TUITION REFUND POLICY

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

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

12.2 b These policies are disseminated to and are accessible by medical students.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school has a clear policy on tuition refunds (DCI Appendix EEEE), which explicitly states the conditions for refunds and the scheduled deadlines for refunds. The policy can easily be found on the website of Dalhousie University. Students have the option of meeting with the Assistant Dean Student Affairs to discuss the reasons for withdrawing from the MD program. It is also possible to receive refunds for any additional charges incurred for late tuition payments when the reasons for the delay were outside of the students' control.

Students met at the site visit expressed no dissatisfaction with this policy.

12.3 PERSONAL COUNSELING / WELL-BEING PROGRAMS

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

12.3 a The medical school provides personal counseling and well-being programs to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).

12.3 b Medical students are informed about the availability of personal counseling and well-being programs provided by the medical school at each campus.

12.3 c Data from the AAMC CGQ and the AFMC GQ over the past three academic years show that the majority of respondents at each campus are satisfied/very satisfied with personal counseling provided by the medical school.

12.3 d Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with the availability and confidentiality of personal counseling services provided by the medical school.

12.3 e Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with well-being programs provided by the medical school.

12.3 f 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 Canadian Graduation Questionnaires report stable and high levels of satisfaction with personal counseling from 2014 to 2016 (66.7% in 2014; 85.8% in 2015; 76.9% in 2016 of respondents who answered satisfied/very satisfied) (Core Appendix C-76). However, the proportion of students from the DMNB campus who claimed to be satisfied/very satisfied with personal counseling services dropped from 83.4% to 50% between the 2015 and 2016 AFMC GQ. As per the 2016 GQ, 87.7% of students reported being satisfied/very satisfied that the medical school promoted student success and wellness (Core Appendix C-77).

Students in Halifax report high levels of satisfaction with confidentiality of personal counseling services as per the 2016 GQ (77.8% satisfied/very satisfied) (Core Appendix C-78) and the ISA (81.0% agree/strongly agree that personal counseling services are confidential). In DMNB, the number of students who were satisfied with the confidentiality of personal counseling was low.

A DMNB focus group particularly endorsed the confidentiality, accessibility and satisfaction with the UNBSJ Counselling Service. Student support activity at both SA offices continues to be conducted

largely in private, tailored to the issue and student need, and conducted at times of convenience after hours, at site of student's choice, at a distance even when on elective at other schools, by telephone, Facetime, or Skype as the student prefers and requests. Student confidentiality and consent directs all interventions.

Moreover, a majority of students (69.57% Halifax; 79.30% DMNB) agree that there is adequate effort made by Student Affairs to aid in the wellbeing of students. However the ISA reports high levels of (24.5% Halifax; 17.4% DMNB) disagreement with the statement "Dalhousie provides resources that allow me to follow a healthy lifestyle in medical school (e.g., eat nutritious food, exercise regularly, etc.)". Students at the site visit referenced dated gym facilities, which are awaiting renovation as an explanation for the high level of disagreement with this statement.

The Student Affairs Office conducted focus groups with both Halifax and DMNB students in November 2016 in an effort to further understand the results of the ISA and GQ. In the supplemental information provided by the medical school, it was indicated that the faculty and student leadership, particularly Student Affair Wellness Liaisons, partnered to offer additional wellness sessions and targeted wellness activities such as the "Prepare to Clerkship" talks designed to help reduce anxiety of students starting clerkship, a series of presentations led by the Assistant Dean as well as staff and residents on resiliency. (See document titled "Standard 12.3-12.4 – Student Affairs Focus Group Reflections" for additional details) (Supplemental Appendix S13). Students and faculty alike spoke to the responsiveness of the faculty to student concerns, and noted that existing personal counseling and well-being resources are readily available to students who required it.

The medical school also indicated that more directed communication to specific years regarding resources available to students would be carried out over the coming academic year. The new initiatives are in the process of being rolled out and the medical school has not yet been able to demonstrate their efficacy or impact on student satisfaction.

12.4 STUDENT ACCESS TO HEALTH CARE SERVICES

A medical school facilitates medical students' timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required learning experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care.

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.

12.4 f Data from the ISA 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

Medical students in Halifax receive healthcare and mental health services either via central student health services or community resources. DMNB students receive services via the University of New Brunswick's resources. These are provided to students during Orientation Week, via the *Don't' Panic Guide*, through the Student Affairs website, and information is posted in printed form in the medical student lounge and Student Affairs Office.

There are policies to inform students about taking a day off (a personal day) to make personal or health appointments without notice of application of leave of absence support. Student do not need to request personal days however, they must inform the UGME Office and relevant faculty members they will be absent. The protocol is found at: https://medicine.dal.ca/content/dam/dalhousie/pdf/faculty/medicine/departments/core-units/undergrad/Pre-Clerkship%20-%20Time%20off%20protocol.pdf.

There is an Absence due to Illness Protocol and a Pre-clerkship Short-term leave/Leave of Absence Protocol and a Clerkship Short and Long-Term Leave of Absence Protocol which are available online at: http://medicine.dal.ca/departments/core-units/undergraduate/current-students/policies-regulations.html. These are explained to students during Orientation week and information is also available in the Clerkship

manual.

According to the Independent Student Analysis addendum, only 10.5% of Halifax students and 7.2% of DMNB students indicated dissatisfaction with *access* to Counseling and Mental Health Service. However, only 34.35% of Halifax students and 22.08% of DMNB students indicated *satisfaction* with the Counseling and Mental Health Services themselves. It is important to note that the majority (58.3% Halifax, 70.6% DMNB) answered the question with "neither agree nor disagree", making this result difficult to interpret.

As per the ISA, 53.71% of Halifax students and 49.28% of DMNB students agreed or strongly agreed that they felt comfortable taking absences for health related matters; 28.4% of Halifax students and 29.0% of DMNB students disagreed or strongly disagreed with the statement. During the site visit, interviewed students reported adequate support from their Assistant Dean Clerkship and Assistant Dean Student Affairs when such absences were necessary.

Only 34.35% of Halifax students and 22.08% of DMNB students agreed or strongly agreed that Mental Health Services were satisfactory, while the majority responded "neither disagree nor agree" (58.3% Halifax; 70.6% DMNB). Only a small subset of students (7.4% at each campus) expressed dissatisfaction with student mental health services.

Moreover, the 2016 AFMC GQ, showed improvement of student satisfaction with mental health over the years. In 2016, 73.8% and 80.9% of students in Halifax were satisfied or very satisfied with student mental health services and student health services respectively. These figures rose to 80% and 90% of DMNB students for the same questions.

During the site visit, students alluded to a long wait time (in the order of weeks to month) to access mental health follow-up through Dalhousie Health, the central campus health services in Halifax and the Student Health Center of the University of New Brunswick (which provides services to DMNB students). The Student Affairs Office now offers drop-in sessions with a Dalhousie Health Social Worker, and a new partnership with the Mental Health Commission of Canada. Moreover, students readily noted the ability of the Student Affairs Office to refer students to health professionals within the community in a timely manner, and the reliable access to the Doctors Nova Scotia and Medical Society New Brunswick Physician Support Programs.

12.5 NON-INVOLVEMENT OF PROVIDERS OF STUDENT HEALTH SERVICES IN STUDENT ASSESSMENT / LOCATION OF STUDENT HEALTH RECORDS

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

12.5 a The medical school has and follows a policy that no provider of health and/or psychiatric/psychological services to a medical student has no current or future involvement in the academic assessment of, or in decisions about, the promotion of that student.

12.5 b The medical school informs students, residents and faculty of this policy mentioned in 12.5a.

12.5 c The medical school maintains medical student health records in accordance with legal requirements for security, privacy, confidentiality, and accessibility.

12.5 d There is a policy and procedure that specifies which individuals have the right to review a medical student's health record/file. The individual(s) at each campus who is responsible for providing access to a student's health record/file ensures that only those authorized individuals are given access.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school has a policy in place (Policy on Independence of Health Care Providers from Student Assessment or Promotion) to ensure non-involvement of providers of health services in assessment of students. These standards of non-disclosure, and recognition of bias and boundary risks, are professional responsibilities of faculty physicians, reinforced by Faculty Council, department and unit heads and clinical clerkship directors. Student health services can be sought and supported with help from Student Affairs who would identify an appropriate non-faculty physician. At the Saint John DMNB campus, students may be referred to psychiatrists who have private practices to lessen concerns about encountering other allied health professionals with whom the students might be working. Again, the faculty physician is responsible for not taking on the role of education/clinical supervisor and would be excluded from all deliberations of the department's learner evaluation process. The Associate Dean DMNB and Student Affairs Office ensures that these procedures are enforced, and it is also emphasized that ensuring non-involvement in healthcare services of students is part of the professional responsibilities of each faculty member. All students interviewed on site were aware of this policy.

Providers and institutions outside of the medical school keep hold of student health records, and there is a clear procedure in place to outline where student health records are to be stored when required for student support or accommodation. Only the Assistant Dean Student Affairs and Director of Student Affairs have access to these records.

The Independent Student Analysis suggested through a student quote that there were no tailored mental health services specific for medical students at the DMNBcampus, and that when asked, students had

been referred to staff members integrated into student and academic life. These events had led to a student becoming hesitant to consult staff members for help. In supplemental information, the medical school indicated that due to attrition, a shortage of available physicians had occurred, however new hires have rectified the situation.

Family physicians continue to provide the primary care for all students, making referrals independent of Student Affairs, utilizing non-physician clinicians where possible or the Professional Support Program staff from the provincial medical professional organizations. Increased awareness and communication with faculty, residents and students reinforces the high standards of confidentiality if urgent assessment or care is necessary to provide the student with optimal care. If such an emergent situation were to arise, the faculty member is then responsible for making certain they no longer could be in a teaching or evaluation role with this student. Student Affairs is often involved in these urgent circumstances and acts as the advocate and monitor of the student's privacy and confidentiality concerns. Student Affairs would then ensure the student does not have future clinical exposure to the treating physician or team, and will accommodate changes in schedule or venue to assure this. In the instance of sensitive illness/diagnosis or hospitalization this can be arranged through Student Affairs in facilities in other cities in either province, as long as the student's quality of care isn't compromised.

Students interviewed at the Halifax and DMNB campuses indicated no concern over confidentiality of their health services, or the involvement of faculty members in their health care. Students requiring emergency care will be seen by whichever physician is available, particularly at DMNB, however the faculty ensures that individuals who treat students are never tasked with teaching these specific students going forward, without penalty to students or to their learning experience. The Associate Dean and Student Affairs Office ensures that these procedures are enforced, and it is also emphasized that ensuring non-involvement in healthcare services of students is part of the professional responsibilities of each faculty member.

In selected cases, if necessary, students may receive help of the Assistant Dean Student Affairs to change their schedule or venue of training so as to minimize future clinical exposure to the treating physician or team. As well, students who have a sensitive illness or hospitalization may require to be relocated to other locations (which in NB is never a great distance), with the support of the medical school. Students interviewed cited positive examples where the Associate Dean DMNB offered numerous sensible options to students experiencing a health issue at a distributed site, including the possibility of being relocated closer to their usual healthcare provider within a same clerkship rotation.

12.6 STUDENT ACCESS TO HEALTH AND DISABILITY INSURANCE

A medical school ensures that health insurance is available to each medical student and his or her dependents and that each medical student has access to disability insurance.

12.6 a Health insurance is available to each medical student and his or her dependents at each campus.

12.6 b Medical students at each campus are informed of the availability of health insurance on entry into the medical education program.

12.6 c AAMC CGQ, AFMC GQ and ISA data show that the majority of respondents at each campus are satisfied/very satisfied with the availability of health insurance.

12.6 d Disability insurance is available to each medical student at each campus.7.9

12.6 e Medical students are informed about the availability of disability insurance on entry into the medical education program.

12.6 f AAMC CGQ, AFMC GQ and ISA data show that the majority of respondents at each campus are satisfied/very satisfied with the availability of disability insurance.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school affirms that health and disability insurance is made available to each medical student at each campus, and that medical students are made aware of the availability of insurance upon entry into the MD program and with periodical reminders throughout the four years. Students receive advice and information about health and disability insurance via the MD Management information sessions, which are supervised by the Student Affairs Office.

Health insurance for all students is obtained through the Dalhousie Student Union, which offers in-person and online resources to assist students with their insurance plans. Disability and life insurance is provided via the OMA with a special benefits program for Atlantic members.

As per the results of the Independent Student Analysis, 79.79% of students agree or strongly agree that they receive adequate disability insurance counseling, while 66.55% agree or strongly agree that they receive adequate student health insurance counseling. These numbers are comparable to the 2016 AFMC GQ: 77.5% of Halifax students and 77.8% of DMNB students are satisfied or very satisfied with access to and awareness of student disability insurance. This information was consistent with the reports of students at the site visit, who indicated they were overall well informed of, and satisfied with the health and disability insurance coverage they receive.

12.7 IMMUNIZATION REQUIREMENTS AND MONITORING

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

12.7 a The immunization requirements for students in the medical education program follow national and provincial recommendations.

12.7 b Immunizations are provided at locations close to where students participate in required learning experiences including required clinical learning experiences.

12.7 c Immunizations are provided at low or no cost to medical students.

12.7 d There is an effective system at each campus to monitor students' immunization status to ensure compliance with immunization requirements prior to involvement in patient care activities.

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The faculty provides a very clear document on immunizations with step-by-step instructions for students on how to achieve satisfactory immunization status. The medical school has provided a clear policy (DCI Appendix IIII Immunization Requirements) stating immunization requirements and outlining steps to achieve these requirements.

Dalhousie immunization requirements meet Nova Scotia, New Brunswick and Prince Edward Island health requirements. Students must pay the cost of their immunizations (available at both campuses) although the cost is in large part or fully reimbursed by most student health plans. The flu vaccine is offered annually at no cost.

The Student Affairs administrative staff reviews student immunization records on a yearly basis. Immunization records of visiting elective students are reviewed as the applications are received throughout the year. The school uses a web-based form system which allows the medical school to collect and track immunization documents more easily. Students are required to comply with immunization requirements before starting in the medical program and must update their immunization status on a yearly basis for annually required immunizations. There is a clearly defined procedure to assist students who have not met the immunization requirements, and to ensure that they remain compliant with the requirements prior to patient encounters.

12.8 STUDENT EXPOSURE POLICIES / PROCEDURES

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

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

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

12.8 a The medical school has policies in place that address medical student exposure to infectious and environmental hazards that include:

i. education of medical students about methods of prevention;
ii. procedures for care and treatment after exposure, including the definition of financial responsibility;
iii. effects of infectious and environmental disease or disability on medical student learning activities.

12.8 b Medical students and visiting medical students learn how to prevent exposure to infectious diseases, especially from contaminated body fluids al all instructional sites before students are permitted to participate in patient-care activities.

12.8 c Medical students and visiting medical students are informed of the medical school's policies and procedures related to exposure to infectious and environmental hazards (contaminated body fluids, infectious disease screening and follow-up, hepatitis B vaccination, and HIV testing) at all instructional sites before students are permitted to participate in patient-care activities.

12.8 d Medical students and visiting students at all instructional sites learn about the procedures to be followed in the event of exposure to blood-borne (e.g., needle-stick injury) or air-borne pathogens.

12.8 e AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with the education about exposure to and prevention of infectious diseases (e.g., needle-stick).

12.8 f AAMC CGQ and AFMC GQ data show that a very high percentage of respondents at each campus indicate that: "I know what to do if I am exposed to an infectious or environmental hazard like a needle-stick injury".

12.8 g Data from the ISA show that a very high percentage of respondents at each campus indicate that "I know what to do if am exposed to an infectious or environmental hazard".

RATING

- ☒ Satisfactory
- ☐ Satisfactory with a need for monitoring
- ☐ Unsatisfactory

Evidence to support the above rating

The medical school has clear policies in place that address medical student exposure to infectious and environmental hazards that include a Policy on Exposure to Infectious and Environmental Hazards (http://medicine.dal.ca/content/dam/dalhousie/pdf/faculty/medicine/departments/core-units/undergrad/UGMEPolicyonExposuretoInfectious_102011.pdf), and a UGME Infectious Disease Policy http://medicine.dal.ca/content/dam/dalhousie/pdf/faculty/medicine/departments/core-units/undergrad/March2010InfectiousDiseasepolicyforUndergraduatestudents.pdf (Core Appendix C-81). Policies are disseminated via faculty communications (email and website postings) as well as through the help of student leaders.

The medical school holds dedicated mandatory sessions to teach students about infectious disease prevention and the procedures to follow if one is exposed in first, second and third year. All medical students receive at least one mandatory session on hazardous exposures prior to starting their first clinical elective (in first year) and receive a pocket card outlining steps to take if exposed.

The UGME Policy on Exposure to Infectious or Environmental Hazards states that students should report exposure to their nit Head or Clerkship director, and follow requirements of individual health care center's relevant policies. During the site visit, students reported good knowledge of these policies and of the steps to take if exposed to infectious and environmental hazards. Students also indicated being able to go directly to their Associate Deans at the Halifax and DMNB campuses for support if they were unsure about the steps to take once exposed.

As per the AFMC GQ (2016), 80.4% of medical students at Halifax and 90% of DMNB students are satisfied or very satisfied with their education about exposure to, and prevention of infectious diseases (Core Appendix C-79). In contrast, 23.23% of responders to the ISA disagree or strongly disagree with the statement "I know what to do if I have been exposed to an infectious or environmental hazard". Students are made aware of the policies in place for post-exposure treatment (Core Appendix C-80 and Core Appendix -81).