



FMEC 2020:

One vision forward

2010 – UGME

2012 – PGME

2019 – CPD

Reigniting our
common vision
for the Future of
Medical Education
in Canada

CONSULTATION REPORT
AUGUST 2020

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A. Introduction

The Future of Medical Education in Canada (FMEC) MD Project (2010), Postgraduate Project (2012) and CPD Project (2019) have led to a series of bold recommendations that became the compass that the medical education system in Canada uses to guide us towards our social accountability. The FMEC MD and PG recommendations are in the process of being implemented by Faculties of Medicine and national medical education organizations alike for nearly a decade and FMEC CPD is off to a good start.

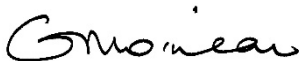
So much has been accomplished as a result of the dedication of educators, leaders and administrators in our schools and our organizations. In 2015, AFMC published the [FMEC MD 2015 Innovations Report](#), highlighting the impressive accomplishments of each medical school pertaining to the 10 FMEC MD recommendations.

It is time to again take stock of FMEC MD by checking in with schools about their advancements in the last five years. It is also time to explore the progress of implementing the FMEC PG recommendations, spearheaded by national organizations eight years following the launch. Now that the FMEC CPD recommendations are published, we need to consider opportunities for alignment between the three projects.

AFMC surveyed our Faculties, our partners and the medical education community to map our collective progress to date. This reflective report card summarizes progress made to date and provides the results of the surveys and polls that were conducted during the winter of 2020, prior to the pandemic.

Ten years is a long time in a rapidly changing health care environment and the medical education system must keep up. We must determine whether current recommendations should change, be removed or new recommendations added. This way, we can adjust the compass' needle and chart our new course aligning the continuum of medical education with the health care system of the future.

As a united community, we will carve out a clear and actionable way forward to address the gaps in our medical education system.



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Acronyms Commonly Used in This Report

Acronym	Full Title
AFMC	Association of Faculties of Medicine of Canada
CAME	Canadian Association for Medical Education
CFMS	Canadian Federation of Medical Students
CFPC	College of Family Physicians of Canada
CMA	Canadian Medical Association
CMQ	Collège des Médecins du Québec
CPD	Continuing Professional Development
FMEC	Future of Medical Education in Canada
FMEQ	Fédération médicale étudiante du Québec
FMRAC	Federation of Medical Regulatory Authorities of Canada
FMRQ	Fédération des médecins résidents du Québec
MCC	Medical Council of Canada
MD	Medical Doctor
PG	Postgraduate
RDoC	Resident Doctors of Canada
Royal College	Royal College of Physicians and Surgeons of Canada

Executive Summary

In the first three months of 2020, the AFMC has collected an extensive amount of information regarding the Canadian medical education communities' perspective on FMEC MD, PG and CPD. This includes our Faculties' work towards the FMEC MD recommendations, our PG partners perspective of the advancement of the FMEC PG recommendations, the communities at large focused view on the future of medical education and an open survey of what our priorities should be moving forward. It should be noted that the majority of this data was received prior to the COVID-19 pandemic. Some PG responses were modified in the late Spring of 2020 and may contain references to the COVID-19 pandemic.

The four sources of consultation led to responses from 127 individuals, 23 organizations and lead to approximately 1,342 datapoints in addition to a fulsome guided discussion with key medical education stakeholders during focus group sessions. These responses lead to a rich, honest and comprehensive compilation of information from a wide range of stakeholders.

Responses from our Faculties demonstrate the outstanding work to date to address the FMEC MD recommendations. So much has been accomplished over the last decade. Anyone who wants to know how to move forward in undergraduate medical education should review this section in detail. When asked if the FMEC MD recommendations were still relevant the response was positive across all the recommendations with the highest priority moving forward being to Address Individual and Community Needs and Valuing Generalism, Promoting Prevention and Public Health, Enhancing Admission Processes and Addressing the Hidden Curriculum. Potential suggested enhanced or new areas of importance include Indigenous health, Equity Diversity Inclusion (EDI), wellness, learning environment, health systems, public health, climate change and environmental health, virtual medical education, and artificial intelligence.

Our PG partners responses provided an update on their accomplishments in the implementation of the FMEC PG recommendations and important insights on their perspectives on current priorities and future opportunities and challenges. The highest overall importance was centred on three recommendations: 1) Ensure the Right Mix, Distribution, and Number of Physicians to Meet Societal Needs, 2) Cultivate Social Accountability through Experience in Diverse Learning and Work Environments and 3) Create Positive and Supportive Learning and Work Environments.

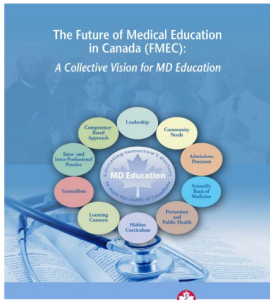


In-depth conversations from our Focus Groups were an essential part of our consultation as public and community members had an opportunity to contribute. They highlighted the importance of increased engagement with patient representatives and communities in any future work on medical education along the continuum. The key priorities identified in the focus group include enhancing the social accountability mandate and improving the learning and working environment along the continuum of medical education.

From our Continuum Poll of medical education community at large, 80% of respondents affirmed that the current recommendations continue to be important. From this source, of all recommendations along the continuum, 1) Ensure the Right Mix, Distribution, and Number of Physicians to Meet Societal Needs, 2) Addressing the Hidden Curriculum/Cultivate Social Accountability through Experience in Diverse Learning and Work Environments and 3) Ensure effective integration and transitions along the educational continuum had the highest number of responses. Adapting curriculum content, financial considerations and technology were considered areas of future consideration.

The AFMC will share this report broadly and engage with Faculty leadership and medical education partners to receive input on FMEC 2020 prior to bringing to the AFMC Board of Directors for consideration as part of the AFMC Board Strategic Planning Retreat in October 2020.

FMEC Reports – Building our Collective Vision for the Future

The Future of Medical Education in Canada (FMEC) is a comprehensive suite of projects focused on ensuring that Canada’s medical education system continues to meet the changing needs of Canadians, both now and into the future. Implementing the recommendations arising from these reports will significantly enhance Canadian physician education, optimize health care delivery, and ultimately improve the health of all Canadians.

 <p>The Future of Medical Education in Canada (FMEC): A Collective Vision for MD Education</p> <p>An AFMC project</p>	<p>The FMEC MD report looks at how education programs leading to the Medical Doctor (MD) degree in Canada can best respond to society’s evolving needs.</p> <p>AFMC published the FMEC MD report and its 10 recommendations in 2010. Health Canada is graciously acknowledged for its generous funding provided in support.</p> <p>Access the FMEC MD report here.</p>
 <p>THE FUTURE OF MEDICAL EDUCATION IN CANADA A COLLECTIVE VISION FOR POSTGRADUATE MEDICAL EDUCATION IN CANADA</p> <p>2012</p>	<p>As a consortium and with the support of Health Canada, the AFMC, CFPC, CMQ and RCPSC, released 10 FMEC PG recommendations in 2012, building on the work of the FMEC MD project and exploring Postgraduate medical education (PGME) as part of the learning continuum for physicians, focusing on medical students as they move into postgraduate training and, later, into practice.</p> <p>Access the FMEC PG report here.</p>
 <p>THE FUTURE OF MEDICAL EDUCATION IN CANADA SUPPORTING LEARNING AND CONTINUOUS PRACTICE IMPROVEMENT FOR PHYSICIANS IN CANADA: A NEW WAY FORWARD</p> <p>2019</p>	<p>The third report on FMEC sets out 11 enabling recommendations to support physician learning and continuing practice improvement. This report was released in 2019 and is the result of further collective visioning involving seven Partners – the AFMC, CFPC, CMA, CMPA, FMRAC, MCC and RCPSC.</p> <p>Access the FMEC CPD report here.</p>

FMEC Recommendations - Overview

Recommendations from the FUTURE OF MEDICAL EDUCATION IN CANADA suite of initiatives										
The Future of Medical Education in Canada: Medical Doctor (FMEC MD)										
1	Address Individual and Community Needs	2	Enhance Admissions Processes	3	Build on the Scientific Basis of Medicine	4	Promote Prevention and Public Health	5	Address the Hidden Curriculum	
6	Diversify Learning Contexts	7	Value Generalism	8	Advance Inter- and Intra-Professional Practice	9	Adopt a Competency-Based and Flexible Approach	10	Foster Medical Leadership	
The Future of Medical Education in Canada Postgraduate (FMEC PG)										
1	Ensure the Right Mix, Distribution, and Number of Physicians to Meet Societal Needs	2	Cultivate Social Accountability through Experience in Diverse Learning and Work Environments	3	Create Positive and Supportive Learning and Work Environments	4	Integrate Competency-Based Curricula in Postgraduate Programs	5	Ensure Effective Integration and Transitions along the Educational Continuum	
6	Implement Effective Assessment Systems	7	Develop, Support, and Recognize Clinical Teachers	8	Foster Leadership Development	9	Establish Effective Collaborative Governance in PGME	10	Align Accreditation Standards	
The Future of Medical Education in Canada Continuing Professional Development (FMEC CPD)										
1	Physicians should be provided with tools or strategies to document and periodically revise a description of their scope of practice to create, implement, and evaluate the impact of a practice-specific education plan that is intentionally responsive to patient, institutional, and personal needs.	2	Physician learning and improvement must focus on the competencies required for physicians to function within teams and to learn from members of the health care teams in which they participate.	3	Accreditation and certification bodies, educational providers, and other relevant health professions organizations should collaborate to identify system changes required to implement and “certify” interprofessional continuing professional development.	4	Prioritize and support activities that facilitate collaborative learning within formal or informal communities of practice.			
5	Develop curricular resources that facilitate understanding and the acquisition of effective lifelong learning skills for physicians in practice.	6	Create national training programs to enable CPD developers and providers to acquire the core competences required to design, implement, and evaluate educational interventions.	7	Collaborate with provincial and national CPD stakeholders to identify funding strategies for the development of programs, resources, and tools to address emerging public health needs, regional health priorities, and interprofessional CPD.	8	Each specialty should identify the core and emerging competencies relevant to all members of the specialty and use the CanMEDS/ CanMEDS FM competency frameworks to design or recommend activities, tools, and data sources for learning and practice improvement within the specialty’s main scopes of practice.			
9	All physicians will be expected to participate in a continuous cycle of practice improvement that is supported by understandable, relevant, and trusted individual or aggregate practice data with facilitated feedback for the benefit of patients.	10	Establish a national repository of learning activities with a data structure to identify gaps in activity development; facilitate physician access to learning activities to address their practice needs; and support national reporting and research to enable an analysis of the impact of physician participation in CPD on performance improvement, quality and safety of care, and patient outcomes.	11	Create or strengthen provincial or regional CPD networks to facilitate the monitoring, planning, and evaluation of educational interventions required to address patient, community, and population health needs and priorities using the best available evidence.					

B. FMEC 2020

Innovations by Recommendation

This section of the report examines the responses of stakeholders and Faculties of Medicine on the FMEC 2020 MD, PG, and Continuum surveys. Responses for the MD and PG responses are provided verbatim as received by AFMC. The views expressed in these responses do not necessarily reflect those of the AFMC.

FMEC MD

Quantitative Results

Average Importance of FMEC MD Recommendations

Each Faculty was asked to rate the importance of each FMEC MD recommendation on a five-point Likert scale ranging from “Not Important” to “Very Important”. To facilitate analysis of the data responses were converted to numeric values with “Not Important” being rated as 1 to “Very Important” being rated as 5. Therefore, higher average importance rankings correspond to recommendations that were considered more important.



Figure 1: Average importance ratings for the FMEC MD recommendations

Two Faculties rated each recommendation on an Ordinal scale from most to least important. Their rankings were not compatible with the other Faculties responses and were excluded from these analyses. Four Faculties did not provide any rankings and one faculty ranked three recommendations. All available and compatible data was included in the analyses (see Figure 1).

Overall, all FMEC MD recommendations were ranked as important (Figure 1). Nonetheless, there was variation across the recommendations. The Faculties of Medicine that responded indicated that “Address Individual and Community Needs” as well as “Value Generalism” were ranked as the most important. The least important recommendations were “Build on the Scientific Basis of Medicine” and “Diversify Learning Contexts”.

Top FMEC MD Recommendations Addressed as a Priority

The Faculties of Medicine were asked to indicate their top three FMEC MD recommendations that need to be addressed as a priority. When all the top three recommendations were combined (see Table 1) the results closely paralleled those of the average importance rankings (Figure 1).

Table 1: Number of times each FMEC MD recommendation were mentioned as needed to be addressed as a priority.

FMEC MD Recommendation	Count
Address Individual and Community Needs	8
Enhance Admissions Processes	7
Value Generalism	7
Promote Prevention and Public Health	5
Adopt a Competency-Based and Flexible Approach	4
Build on the Scientific Basis of Medicine	3
Address the Hidden Curriculum	3
Foster Medical Leadership	3
Diversify learning Contexts	1
Advance Inter- and Intra-Professional Practice	1

For example, the recommendations: Address Individual and Community Needs, Enhance Admission Processes, and Value Generalism were mentioned the most often needing to be addressed as a priority (Table 1). All three of these recommendations were in the top four most important recommendations (Figure 1).

Updates from Faculties of Medicine on the Implementation of FMEC MD Recommendations

All 17 Faculties of Medicine were asked to provide an update on their implementation of the FMEC recommendations. They were also provided with a copy of their updates from 2015 for their reference. The responses from each faculty are presented by recommendation in geographic order heading west to east.

Recommendation 1: Address Individual and Community Needs

Social responsibility and accountability are core values underpinning the roles of Canadian physicians and Faculties of Medicine. This commitment means that, both individually and collectively, physicians and Faculties must respond to the diverse needs of individuals and communities throughout Canada, as well as meet international responsibilities to the global community.

University of British Columbia

At UBC, our contract with society is at the core of Faculty of Medicine’s strategic plan. Our commitment to social responsibility and accountability is deeply rooted in the MD Undergraduate Program (MDUP). We direct education activities towards addressing the needs of communities in British Columbia (BC), and we measure longitudinally and robustly the contributions of medical education to addressing health needs.

As one of the largest distributed medical programs, MDUP strategically aligns with Ministry of Advanced Education, Skills and Training and Ministry of Health goals to address current and future health needs of British Columbians. Evaluation data indicate that expansion and distribution of MDUP has a positive impact on physician supply across BC:

- MDUP graduates increased from 129 (2003) to 286 (2018). Postgraduate medical education (PGME) entrants rose from 171 (2003) to 378 (2018).
- MDUP graduates who entered independent practice grew from 119 (2003) to 240 (2007)*. For Family Medicine, this increased from 46 (2003) to 97 (2007) and then 105 (2011)*.
- MDUP graduates practicing in BC increased from 66% (2003) to 72% (2007)*. For Family Medicine, the proportion practicing in BC rose from 74% (2003) to 78% (2011)*.
- MDUP graduates practicing in rural BC grew from 17 (2003) to 29 (2007)*. For Family Medicine, the number grew from 10 (2003) to 18 (2011).
- With regard to MDUP training location and residency choice, 57% of Northern Medical Program (NMP), 49% of Island Medical Program (IMP) and 47% of Southern Medical Program (SMP) students enter Family Medicine.

University of Calgary

The University of Calgary Cumming School of Medicine Strategic Plan 2015 - 2020 reaffirms the commitment of the Cumming School of medicine to address individual and community needs. Of the three main goals identified in this document, the first is to “Serve our diverse communities by understanding and responding to their health needs and by effectively stewarding the resources entrusted to us by Albertans”.

With our current first year medical class, we initiated a new community engagement learning pilot which allows students to spend time with a community service provider in Calgary. This includes exposure to underserved and indigenous population health issues. Importantly, our evaluation of this

program not only involves student assessments but also assessments from the community partners themselves. In this way, we will be able to refine this learning experience to not only optimize student learning but also identify and focus on community needs. The initial feedback from community partners has been excellent.

Dr. Lindsay Crowshoe directs our Indigenous Health Program. This program is committed to supporting Indigenous learners and confronting issues faced by Indigenous people in the healthcare system and in our institution. The program seeks to address under representation of Indigenous people within the profession of medicine, and to provide support and professional development initiatives for indigenous medical students. Additionally, the Indigenous Health Program provides training opportunities regarding Indigenous health for learners throughout our curriculum.

University of Alberta

We hold social accountability as a core value in the strategic plan for the Faculty and within the MD Program. The curriculum was developed with that end in mind and reflects societal needs, including LGBTQ2S+ health, organ donation, human trafficking, refugee health, opiate crisis and pharmacare. Modules have been developed collaboratively with community stakeholders, students, and faculty. Several of these initiatives have been shared with the community on social media. Innovations in the curriculum have resulted in increased graduation and alumni questionnaire scores in areas of social accountability and social responsibility since 2015.

To meet our rural mandate, in addition to the longstanding family practice based rural clerkship opportunities, we have introduced an option for some students to complete their fourth-year training in a community hospital in Grande Prairie, Alberta and added a rural component to the Longitudinal Clinical Experience (LCE) for years 1 and 2.

To further fulfill our social accountability mandate we have taken concrete steps based on the AFMC Joint Commitment to Action and in response to the Truth and Reconciliation Commission Calls to Action. Progress on this is shared on our website. Changes to admissions have more than doubled the number of Indigenous students admitted to the program this past year. We have a pilot project of an elder in residence to further support students once admitted. We have added a 12 module “Indigenous Canada” course to be completed prior to starting the program and have added more than 40 new curricular hours on Indigenous Health.

We have “made space” for leaders from our Indigenous Medical Students association to sit on the Curriculum Committee and other key program committees.

University of Saskatchewan

Current Status

The commitment to authentic community engagement (CE) and mutually beneficial partnerships is clearly outlined in the College’s current mission and strategic plan. Since 2015, the College of Medicine adopted a new 5-year strategic plan (2017-2022), which lists social accountability and community engagement, as one of the 9 strategic priorities.

The Division of Social Accountability (DSA) was created to advance community engagement, including identifying priority health needs of community, and operationalizing social accountability within medical education. The DSA, now with four staff and a .4FTE Director, works closely with community to bring the voice and priorities of community to medical education. The Making the Links program has continued with 15 medical students graduating with a co-curricular global health certificate each year, Additional opportunities for CE exist through Medicine and Society course.

The DSA also transforms learning through:

- The development and dissemination of an annual *Social Inequity and Pressing Health Needs* publication for the College of Medicine’s Curriculum Committee outlining priority health statistics for Saskatchewan (to be incorporated into curriculum).
- Raising awareness of current and emerging community health needs through learning events such as the Health Equity learning series and the Indigenous Health series
- The Social Accountability Lab for Learning and Teaching (SALLT) fund, which supports health equity related student projects
- The development of a *Social Accountability Lens*, a tool used in curriculum review

Looking to the future, the DSA’s new strategic framework (2020-2022) prioritizes the principles of equity, anti-oppression, authentic engagement and excellence. The new operational plan will incorporate:

1. Decolonizing and Indigenizing – and their integration into medical education
2. Strengthening efforts toward authentic integration of community-held knowledge in medical education
3. Fostering a climate of community responsiveness in medical education
 - I. Expand opportunities for community responsive curriculum
 - II. Expand opportunities for student engagement in service-learning and community advocacy
 - III. Integration and alignment of social accountability competencies across the medical curriculum

University of Manitoba

- Habitat for humanity 2 years
- Service learning with community partners; 24 hours in Med I, 22 hours in Med II
- Breakfast with community partners
- Faculty Social Accountability Committee

Northern Ontario School of Medicine

Social accountability continues to be a foundational value embedded in all of NOSM’s work and has been our mandate from the beginning. We have been the recipient of many awards for our commitment to SA, including the ASPIRE award and the AFMC Charles Boelen award. As NOSM was explicitly founded upon the concept of social accountability we measure our impact on this and early

evidence shows NOSM is benefiting Northern Ontario by retaining NOSM graduates¹, training rural generalists², and bringing new economic opportunities to the north³. As a first strategic planning activity for 2020-2024, a workshop was developed for the NOSM Board of Directors retreat on November 27th, 2019 in Thunder Bay. The goal of this workshop was to reaffirm the values and principles for social accountability and identify potential indicators for measuring NOSM's success. As well throughout this year's consultations on the new strategic plan the concept of social accountability will remain as a major enabling theme for NOSM's future. However the concept is being viewed as being more than workforce (MD) production and more about impact on Northern health. All NOSM activities will be evaluated through a 'social accountability lens' with advocacy, addressing health inequity and policy reform for marginalized populations will be key foci.

Schulich School of Medicine and Dentistry, Western University

Schulich Medicine & Dentistry (the School) is committed to scholarship, care and education through our new social accountability statement:

https://www.schulich.uwo.ca/medicine/undergraduate/about_us/accreditation/social_accountability/index.html

Our MD Program (Program) integrates diversity into case, experiential and clinical learning. Our competency-based curriculum focuses on context for care in our region, province and country. Students are offered parallel certificate and Masters programs in collaboration with Western and Windsor Universities to improve competency for societal needs.

Distributed education across Southwestern Ontario affords students regional learning mandated in Years 1,3 and during protected days for self-directed clinical learning, scholarship and service in Years 1,2. Our Windsor Campus and Distributed Education deliver excellent education under regional faculty.

We are prioritizing Reconciliation with Indigenous Peoples. Initial steps include the recent appointment of a new senior leader – Indigenous Leader in Residence - to advance regional relationships, improve learning, scholarship and organizational alignment with Western's Indigenous Strategic Plans. Curriculum innovation focuses on Indigenous Peoples' health, culture, history and practices.

Admissions prioritizes students from Indigenous, rural, financially disadvantaged and female applicants. Our School is expanding financial supports for students with financial need.

Our School partners with schools across four continents for education and scholarship. Students receive financial and leadership support for international learning.

Meeting a school mandate of regional and national social accountability and a University mandate of internationalization drives continually improving curriculum and experiential learning. Establishing international collaborations with meaningful reciprocal relationships in a complex world is impacted by risk management challenges, resource availability and demands on faculty.

¹ (Hogenbirk et al., 2015)

² (Cheu et al., 2019)

³ (Strasser et al., 2013)

McMaster University

We have been fortunate at McMaster to have attracted, since the school's inception, a cadre of faculty and students with a strong orientation towards social accountability, social justice, patient- and community-centredness, and a global orientation. These concepts are particularly well-covered in our Professional Competencies curriculum through a variety of sessions from more conceptual topics, such as epistemology and narrative, to more concrete applications of these topics, particularly to an understanding of the social determinants of health and the manifestations of social determinants within various groups. In particular, the health concerns of typically marginalized groups within Canadian healthcare are reviewed, including Indigenous Peoples, women's health, LGBTQ+ health, and newcomer and refugee health.

An understanding of social accountability is also distributed throughout our problem-based learning cases and we are continuing to review how to make this more explicit for students. There will be a particular focus on understanding the uneven distribution of the social determinants of health, not just as a manifestation of demographic distribution, but also as a manifestation of historical, political, social, etc. forces acting to produce the maldistribution of health in the population. An additional focus on opportunities for physicians to intervene will be included to enable students to move beyond merely knowing about social need, and to enable them to understand opportunities for addressing these issues.

Finally, we have also been heavily focused on the development of the inclusive clinical exam. Students at McMaster have overwhelmingly learned clinical examination skills on our cohort of white, older male simulated patients. We have identified several dimensions of demographic identity where students had particularly strong skill deficits: patients with physical and cognitive disabilities; patients with a variety of skin tones, including brown and black patients; Indigenous patients; and patients from the LGBTQ+ community, and particularly transgendered people. We are working closely with our simulated patient program to improve representation of these groups; and we are working to further refine our clinical skills teaching to provide explicit teaching to our students to address perceived gaps related to providing care to these groups.

University of Toronto

Excellence Through Equity is one of the three domains of strategic focus in the U of T Faculty of Medicine [Academic Strategic Plan 2018-2023](#). This reflects the Faculty's commitment to making inclusion and equity essential components of how we define and foster excellence in scholarship, practice and health outcomes.

The expansion of the mandate of our Office of Indigenous Medical Education to support learners, faculty and staff across the education continuum is an initial *Excellence Through Equity* priority for action.

The MD Program appointed its inaugural Black Health Theme Lead in November 2016. Working in collaboration with curriculum leaders, including the MD Program's Indigenous Health and LGBTQ2S Health Theme Leads, the Black Health Theme Lead has developed curricular content informed by the following two principles: (i) provide medical students with intersectional cultural safety and anti-racist teaching that relevant to all equity seeking and underrepresented groups, and (i) provide population-based content and case-based teaching that is integrated into the core curriculum.

Recruitment and interviewing practices for Faculty of Medicine departmental chairs and directors as well as for MD Program leadership positions have been revised to include the promotion of positions in a variety of venues and with different networks; providing unconscious/implicit bias education and resources to search committee members; explicit positioning of the importance of equity, diversity and inclusion at the outset of every search, and; a standard interview question in which candidates are asked how they would apply the principles of equity, diversity and inclusion.

Queen's University

Since 2015:

- Expansion of the mandate of the Diversity Panel to explicitly address issues of diversity, equity and inclusion.
- Creation and dissemination of a Statement on Diversity
- Development of teaching sessions during Orientation Week which address issues of inclusion, diversity and safe space
- Expanded curriculum on Indigenous Health Issues in Health Determinants course
- Support of service learning opportunities within the community involving disadvantaged and marginalized populations, including working with a street health clinic to facilitate student involvement

Re-structuring of admission criteria to our Queen's University Accelerated Route to Medical School (QuARMS) program to promote admission of socioeconomically disadvantaged and Indigenous applicants.

University of Ottawa

We approached recommendation 1 by building infrastructure, including a Social Accountability Leadership Committee, and a Social Accountability Student Advisory committee. We worked at promoting Social Accountability along with Social Determinants of Health throughout the undergraduate program. We developed committees on Community Clinic engagement and Cultural Safety. Students led an initiative to introduce a mandatory Social Accountability objective in clerkship. Social Accountability is promoted at an annual half day Social Accountability Forum, and has become a standing agenda item at our monthly Clerkship committee meetings.

We identified Indigenous and Francophone health as priorities and have worked at developing community engagement through annual advisory meetings with community leaders and elders, as well as communicating with community-based leadership teams at both levels. However, having valid community engagement proved difficult. Challenges included identifying the appropriate individuals, defining their roles, and clarifying their reporting. Without this level of engagement, defining our community needs, became difficult.

We are especially proud of developing a student run interdisciplinary social determinants of health clinic. Still in its infancy, NORTH (Navigating Ottawa resources to improve Health) has medicine and law students working together, as navigators, seeing clients referred for social need.

The greatest challenge we faced was in the actual nature of the leadership role in that it only covered UGME and had a mandate limited to UGME. However this is currently changing as the Director of SA role

will become an Assistant Dean, Social Accountability, reporting to the Dean, and inclusive of all portfolios of learners and research.

McGill University

Block A entitled *Molecules to Global Health* of the MDCM curriculum forms the entering class's first exposure to medicine. In this block, there is extensive exposure to social determinants of health, marginalized populations, downstream and upstream factors contributing to health. The Longitudinal Family Medicine Experience (LFME) has been a successful element of the new MDCM curriculum. Students have the opportunity to work with family physicians in community practice during their first year of training. In second year, the Community Health Alliance Project (CHAP) course focuses on community-sensitive models of care, and clients/patients from marginalized populations. Students spend approximately 21 hours over four months with a local community organization or community project with a primarily social mission. They are given an opportunity to reflect on the social context that they observe from the perspective of one or several individuals from this experience. During their clerkship, all students complete a four-week rotation in rural family medicine in addition to an urban rotation. These rural rotations are organized in an integrated health care network (RUIS) assigned to McGill University, which includes Montérégie, Abitibi-Témiscamingue, Outaouais and Northern Quebec. Finally, students complete a public health and preventive medicine course during their last clerkship year, with the focus on addressing health promotion, disease prevention, and health surveillance for individuals, communities and populations. Also, woven in the MDCM curriculum, the Social Accountability, Population Health and Health Advocacy theme integrated the key concepts and current issues related to this theme throughout the different courses. For example, during the Human Behaviour course, the social impact of dementia is addressed, in addition to pathophysiology and clinical presentation.

Université de Montréal

The numerous efforts made by the Faculty of Medicine in recent years have been recognised in 2019 by the ASPIRE award in social responsibility from the AMEE.

The Office of Social Responsibility, established in 2017, collaborates in teaching and involves students in its development projects.

Starting with the Symposium at the beginning of the academic year, students are invited to lectures given by people involved in social responsibility and patient-partnership initiatives. First-year students participate in an introductory workshop on social responsibility and a First Nations Elder pays them a visit.

Students are very enthusiastic about the involvement of patient partners. From patient testimonials to ethics workshops offered to students at all levels of training, all of our initiatives generate a great deal of enthusiasm.

The Social Engagement placement during the clerkship also provides exposure to vulnerable patients as well as the health care providers involved in their care.

Three Citizen Forums on Indigenous Health were held in the spring of 2019. This citizen consultation process conducted in conjunction with Indigenous communities aims to provide a better understanding

of the specific health training needs of Indigenous populations. More specifically, it is necessary to identify the issues related to accessibility of care, co-construct a concerted action plan and ensure its implementation as well as the evaluation of the impacts after the fact. The forums also help to raise our students' awareness of Aboriginal realities and cultures. This approach will serve as a model for future projects planned with other vulnerable populations.

The University of Montreal joined a partnership with Laval University in January 2018 to support the Faculty of Medicine of the Université d'État de Haïti in a revised curriculum eligible for international accreditation, strengthened governance and increased social responsibility.

Université Laval

In 2017, the Faculty of Medicine undertook an ambitious project to relocate the MD program to two sites located at 25 km (Lévis) and 300 km (Rimouski) from Laval University. This relocation project aims to expose more students to medical practice in the regions so that they can take an interest and choose this practice to meet the needs of populations in regions of Quebec that lack medical resources. The training sites are scheduled to open in the fall of 2022. At the end of the deployment, these sites will accommodate approximately 20% of students admitted to the MD program. This project also affects the clinical portion of the Undergraduate training since it aims to increase the offer of integrated longitudinal clerkships (ELI). Already in the Fall of 2019, the Baie-Comeau ELI was receiving its first students. The University of Quebec in Rimouski and the Integrated Health and Social Services Centres of Eastern Quebec are collaborating on the project.

Since 2015, the program management has continued its work aimed at better integrating, throughout undergraduate training, the teaching of the social and cultural aspects of health and the responsibilities of the physician and the medical profession with respect to the health of the population. This work had an impact on the Physician, Medicine and Society courses (I to IV) of the pre-clerkship as well as the internship in public health and preventive medicine of the clerkship.

Université de Sherbrooke

The Faculty of Medicine and Health Sciences (FMHS) of the University of Sherbrooke continues its actions to better meet the needs of the communities by :

- creating a Social Responsibility (SR) Faculty Office whose mission is to accelerate SR actions at the faculty level, particularly by acting in support of study programs. The Office of SR will facilitate the identification of interventions and outcome measures to achieve our SR objectives.
- continuing the work of the *Committee for Learning through Community Service* (Comité d'apprentissage par le service à la communauté) (ASC) in support of the development of the new curriculum.

Since 2017: creation and addition of 2 ASC pedagogical activities (1st and 2nd year) and a project management pedagogical activity (2nd year) in the community.

ASC activities include

- pairing with a home community;
- 30 hours of service in community organizations;
- meetings with a family or citizen to analyze their needs and offer possible solutions;

- stages of reflection, presentation of their experience and multi-source feedback;
- interactive workshops on the determinants of health to better understand the situation of communities or individuals in vulnerable situations.

The Project Leadership in Partnership with Organizations activity involves :

- needs assessment, proposal and planning;
- project implementation;
- project presentation and multi-source feedback;
- financial support from the FMHS.

Furthermore, the addition of patient experience workshops involving patient partners, aimed at developing empathy.

Dalhousie University

Base medical curricula on an increasingly patient-, family- and community-centered approach:

Dalhousie Medical School's curriculum is founded in patient, family and community centered approaches.

Consult with community stakeholders and other professions in curriculum design within each faculty:

A new Assistant Dean, Serving and Engaging Society, has been appointed and has agreed to participate on a newly struck committee for curriculum refresh. We continue to improve our engagement of rural community members, refugees, those with language barriers, patients living with mental health conditions and those living in poverty.

Provide greater support to medical students and faculty as they work in community advocacy and develop closer relationships with the communities they serve:

Through its social accountability mandate, Dalhousie Medicine offers a Service Learning Program (aligned with Professional Competencies 1 and 2) available to pre-clerkship Undergraduate Medical Education students. The Service Learning Program includes community-based service learning experiences and enables students to practice skills and test classroom knowledge through related service experiences in the community.

The Faculty also supports the Micro Research program, which provides community-focused research training, mentorship and small grants for health research projects conceived and conducted locally.

The Faculty of Medicine has established the Dr. Allan Cohen Memorial Award for Community Service, which honors the late Dr. Allan Cohen, a distinguished member of Dalhousie Medical School. This award recognizes faculty, staff, and students who work to fulfill the mission of the Medical School by displaying outstanding community service with health-related organizations and causes.

Provide students with opportunities to learn in low-resource and marginalized communities as well as international settings:

The percentage of students participating in Service Learning projects has increased annually, as has the number of community organizations involved in the program. The Longitudinal integrated clerkship (LIC) has expanded to NS, with new sites in Cape Breton in 2019 (New Waterford and North Sydney) and a new site on the South Shore of Nova Scotia starts in fall 2020.

Support faculty members in role-modeling social accountability by providing leadership in redesigning the medical education curriculum to link more closely with local, regional, national and international needs:

Through initiatives such as the Longitudinal Integrated Clerkship (LIC), the Aboriginal Health

Sciences Initiative (AHSI), the Social Accountability Committee, and the African Nova Scotian Advisory Committee, faculty members are supported in developing their leadership skills in relation to meeting the needs of the populations the school is mandated to serve.

In addition to those initiatives, positions within the Faculty of Medicine have been established such as the James R. Johnston Chair in Black Canadian Studies, an Assistant Dean, Serving and Engaging Society, and a Program Manager, Indigenous Health.

Memorial University

Memorial's curriculum review in 2018 recommended that the spiral curriculum content be reorganized into themes which center around patient presentations, integration of basic and clinical sciences into clinical encounters and better align the clinical skills course with the delivery of the program. The theme-based curriculum integrates topics within the phase and across all phases, enabling learners in each phase to build upon the knowledge and skills acquired in previous phases.

Social Accountability continues to be a strong focus for the Community Engagement Course, emphasizing health equity, advocacy and social justice. Key elements of the curriculum include community profiles and community-based experiences, case based learning, and longitudinal integrated clerkships. Social accountability is currently part of the vision statement for the faculty of medicine "Through excellence, we will integrate education, research and social accountability to advance the health of the people and populations we serve."

The Social Accountability mandate in our strategic plan, *Destination Excellence*, has strengthened the service learning program and will increase existing opportunities for experiences in Refugee Health, Inner City Health and Addictions, and support key programs in Indigenous health and global health. The programs will be overseen by a newly created position of Assistant Dean of Social Accountability.

In line with the strategic plan, *Destination Excellence 2018-2023*, Memorial aims to put the needs of our learners and communities at the forefront of everything we do, graduating learners who are prepared to respond to population needs and to be tomorrow's scientific and clinical leaders. Memorial is developing partnerships that strengthen community capacity in underserved populations, rural and remote areas. Memorial takes a community-engaged, respectful and inclusive approach to ensure our understanding of the priorities of the communities we serve, developing partnerships that strengthen community capacity in underserved populations, rural and remote areas. Annually, the Dean, Associate Dean, Undergraduate Medical Education, and the Chair of the Discipline of Family Medicine visit numerous communities across Newfoundland and Labrador as well as New Brunswick.

Recommendation 2: Enhance Admissions Processes

Given the broad range of attitudes, values, and skills required of physicians, Faculties of Medicine must enhance admissions processes to include the assessment of key values and personal characteristics of future physicians—such as communication, interpersonal and collaborative skills, and a range of professional interests—as well as cognitive abilities. In addition, in order to achieve the desired diversity in our physician workforce, Faculties of Medicine must recruit, select, and support a representative mix of medical students.

University of British Columbia

UBC's MDUP admits applicants from diverse backgrounds. Applicants are considered without regard to age, ancestry, colour, economic status, place of origin, race, religion, family status, marital status, physical or mental disability, political belief, gender, or sexual orientation. Annually up to 44 seats are allocated for applicants from rural and remote backgrounds. The Indigenous MD admissions program has an annual complement of entry seats – by 2020, it will have graduated over 100 Indigenous doctors, doubling the original estimated number.

Admissions criteria are competitive, but holistic in nature, allowing applicants from a wide range of backgrounds to succeed. This includes positive valuation of activities that fall outside of those traditionally completed by pre-medical students, such as employment experiences, exceptional life circumstances, and non-traditional academic career paths.

Traditional prerequisite courses have been removed to encourage a more diverse group of applicants. Historically, only Canadian citizens and Permanent Residents could apply. We have recently removed barriers and we welcome qualified applications from individuals with Refugee status in Canada.

Diversity indicators for students entering the MDUP in 2018/19 show a close to 50% divide between males and females, 51% visible minorities and 27% from lower socioeconomic backgrounds.

University of Calgary

The Pathways to Medicine Scholarship program mentioned in our 2015 responses now been fully implemented. It is designed for graduating high school students with an explicit interest in pursuing a career in medicine, but who may face barriers due to socioeconomic status, Indigenous ancestry, or the fact that they reside in a rural community. This program offers tuition and fee support, a relocation allowance and a paid summer internship

We have transitioned our medical school interview process to the use of Multiple Mini Interviews (MMI). Interviewers are drawn from faculty members, allied-health professionals, current students and members of the community at large. The questions are designed to assess non-cognitive traits. This has resulted in a more objective admissions process that allows us to more fully assess characteristics such as communication, ethical reasoning and interpersonal skills.

University of Alberta

We have made significant progress in increasing the overall diversity of our student body in both visible and invisible or deep dimensions diversity since our previous report. A comprehensive review of our admissions processes was completed in 2016 with the goal of identifying and removing barriers to equity and diversity in our admissions processes. The review committee included clinicians, faculty, students, residents, members of our Indigenous Health Initiatives Program and a community member who works with agencies supporting populations which are underrepresented in our medical school student body. The group identified core personal competencies concordant with those in the literature (Koenig, 2013) of ethical responsibility to self and others; reliability and dependability, service orientation; social skills; capacity for improvement; resilience and adaptability; cultural competence; oral communication skills; teamwork ability.

The recommendations from the review led changes to our admissions to address equity and diversity. One key aspect of this review was to identify a flat threshold GPA of 3.3 for admission, which allowed for greater emphasis to be placed on other entrance competencies for medical students. This step set the groundwork and critically enabled further changes which have resulted in a more than double number of Indigenous students admitted in our last admissions cycle. We now require bias and stigma training for all admissions reviewers and interviewers including the faculty, students and community members involved.

Every year, since the implementation of these changes, analysis is done following the admissions cycle to look for new or developing barriers to specific groups of students.

University of Saskatchewan

Current Status

The University of Saskatchewan College of Medicine admits 100 undergraduate students per year in our distributed education model, where 40% of the class goes to the Regina campus starting in year 2 of the program. We have four admission streams: Saskatchewan resident (84 seats), Indigenous Admissions Program (10 seats), Diversity and Social Accountability Program (6 seats) and non-Saskatchewan resident (5 seats). These streams were designed to achieve cultural and social diversity in the incoming class and to ensure that the majority of incoming students have a strong connection to the province.

We encourage candidates to apply with diverse educational and personal backgrounds. To broaden our assessment of non-academic characteristics, we plan to introduce CASPer to initially rule out applicants prior to the multiple mini interview if their CASPer score is below -2 SD.

Barriers we face to achieve our admissions goals:

- static Saskatchewan resident and indigenous admissions pool → improve and diversify our recruitment and support efforts to target these groups
- incongruity between our Admission goals and policies → elicit stakeholder feedback to assist in the development of a new vision for Admissions, which will help inform our future policy decisions

- unclear linkage between Admissions metrics to future program performance and establishment of a future career in Saskatchewan → retrospectively perform these analyses and prospectively integrate this work into our program evaluation metrics
- outdated application software and IT infrastructure → modernize our application software and IT infrastructure to streamline the admissions process, improve the user interface and integrate data seamlessly

University of Manitoba

- There are no longer any course pre-requisites.
- The CaSPER™ text was added to the class of 2019.
- We have more outreach to inner city and northern youth.
- Scoring for socio-cultural determinants established (first in Canada).

Northern Ontario School of Medicine

The NOSM's admissions process continues to successfully focus efforts on recruiting individuals who have significant living experiences in Northern Ontario, rural and remote parts of Canada and/or who self-identify as Indigenous or Francophone and have a commitment to serving the North as physicians. The incoming class profiles for 2015-2019 indicates that NOSM continues to meet its demographic mandate, where 90% of admitted students have significant living experience in Northern Ontario, 29% of those from Northern Ontario are from rural communities, 11% are Indigenous and 20% are Francophone.

A review of the admissions data resulted in changes to the context algorithm and the autobiographical sketch and question submission. Changes to the context algorithm have increased the percentage of Indigenous students admitted to NOSM from 7% to 13% which reflects the demographics of Northern Ontario. These changes aim to better select applicants who are committed to serving the North as well demonstrating the attributes and characteristics of a person who will thrive in the self-directed curriculum delivered across the communities of Northern Ontario.

NOSM Admissions will continue to research and develop selection tools that better select applicants likely to practice medicine in the underserved rural communities of Northern Ontario and that minimize the over-coached-applicant effect. Furthermore, efforts are beginning to develop dual degree programs that will provide underserved rural and remote communities with medical technology innovations that contribute to our mission of a healthier North.

Schulich School of Medicine and Dentistry, Western University

Admissions has been enhanced to meet the visions of FMEC, Western University and our School with innovations that support a broader cohort of matriculants. We focus on: learner selection for competency-based education and promotion of learner diversity, equity, and inclusion within an academic excellence profile.

A new holistic Admissions model has been implemented, assessing academic metrics in addition to student attributes, values and life experiences. We value social accountability, offering streams for those

who completed secondary school within local Southwestern counties and who self-identify as Indigenous. We introduced the ACCESS pathway for applicants who may have faced sociocultural, financial, and/or medical (disability or life-threatening illness) barriers. The ability of students to highlight their experiences in relation to the school's core values of teamwork and leadership, higher learning skills, social accountability and responsibility, and respect for diversity has earned high acceptability by community and faculty reviewers and students. The incoming class demographics related to low socioeconomic status (23%) and rural/small town upbringing (19%) match applicant demographics. We are establishing partnerships and supporting identified cohorts for Admissions addressing social barriers and providing support for those in need.

Through stakeholder partnership, we aim to foster applications from individuals under-represented in medicine. Admission processes include community members to ensure the community is heard. Opportunities for success will be focused on prospective applicant outreach, faculty and community member engagement, continuous quality improvement, and provision of supports to this broader cohort of learners to support a diverse physician workforce for the future.

McMaster University

McMaster continues to strongly endorse admissions approaches and tools that are: psychometrically sound, sample a broad variety of applicant attributes for suitability to enter medical training, and that optimize fairness for the broadest spectrum of applicants possible. To this end, sampling of cognitive and non-cognitive capabilities continues to be carefully and thoughtfully distributed across our selection tools.

We continue to use CASPer and MMI to enable consideration from multiple perspectives on each candidate. These tools also enable candidates to provide some opportunities to share important personal information that is not as easily captured through some other admissions tools. We have undertaken several important projects to look at the impact of these tools, including, supporting a McMaster-led, longitudinal study looking at admissions tools as predictors of important medical education outcomes; and support of two projects focused on applicants from low resource backgrounds: (1) looking at the medical school admissions experiences of these applicants, and (2) the impact of each of our admissions tools for applicants of low resource background.

We continue to admit students from a wide breadth of academic backgrounds due to our lack of any course or program pre-requisites for application to our program. This approach has provided students with a broader variety of less traditional academic backgrounds and pathways to enter a career in medicine.

McMaster's facilitated Indigenous admissions process continues to support enhanced numbers of Indigenous medical students in our medical program. The facilitated process was reviewed recently and has been revised to be more inclusive in terms of Indigenous identity and to be more stringent with respect to having connections to Indigenous community and/or personal identity. McMaster's Indigenous Health Initiative and the development of an Indigenous Learning Lodge will provide additional supports for Indigenous learners once they are in the MD Program, expanding on supports provided by our Indigenous Students Health Sciences Office.

University of Toronto

[Community of Support](#) (CoS) is a collaborative initiative developed to increase the number of students from underrepresented groups in the health professions. Established at the U of T in March 2015, CoS has expanded to 11 Canadian universities and has grown to over 1,400 students. Specific CoS opportunities include a free MCAT prep course for low-income students and an application mentorship program. Over 100 CoS students have been admitted to medical school.

The MD Program introduced a Black Student Application Program (BSAP) in 2018. Members of the Black community were involved in the development of BSAP and take part in the admissions process. In its first year (2018 entry), 14 students were admitted through BSAP, which increased to 15 students in 2019. There are no fixed BSAP seats or quotas, and the academic standards required for admission are identical to the general admission stream.

To effectively evaluate applicants on non-academic attributes, we are piloting an asynchronous online video interview tool. This customizable tool will allow us to expand our use of multiple independent sampling, horizontal assessment and relative rating methodologies and collect larger data points per applicant. In turn, the tool will improve the reliability of the Program's non-academic assessment by reducing the adverse effects of 'dove' and 'hawk' evaluators, as well as 'halo' effects, while offering flexibility to assign diverse groups of raters. If this two-year pilot is successful, full implementation will take place for students entering medical school in August 2021.

Queen's University

Admissions Processes remain one of the key challenges facing all medical schools in Canada.

We continue to strive to refine a selection process to find people who will thrive in medicine and want to stay in the profession and best serve the medical needs of the Canadian population in the mid-21st Century.

At Queen's, we now have:

- Multiple Admissions streams (traditional, Indigenous, MD/PhD, QuARMS, DND)
- Expanded GPA/MCAT cut-offs to encompasses more diversity in applicant pool for file review (e.g. SES, rural), as part of ensuring our admissions processes are aligned with our social accountability focus
- We have made progress in attracting applicants from key target populations (Indigenous candidates and candidates from lower SES)
- While recruiting Indigenous students to study in Kingston is a challenge, overall we have had a positive response
- We have revised the QuARMS admission process to better address socioeconomic and cultural barriers to medical school

Suggestion:

Canada needs a national database of applicants with unique identifiers to understand those who apply and don't get offers to learn from that to help eliminate selection bias.

University of Ottawa

The mandate of our Admissions Committee is to select academically sound, accomplished students who represents Canada's three cultures; Aboriginal, Francophone and Anglophone. Additionally, in the spirit of social accountability and responsibility, in order to address the current socioeconomic disparity in medical school admissions, new for 2020, we have created two low socioeconomic status (LSES) reserved seats (part of our larger LSES program which offers full tuition for pre-med studies and mentorship of LSES students who wish to pursue medicine as well as community outreach programs targeted towards high school students) as a first step in an attempt to decrease barriers, to offer fairness, and to provide all candidates with equal access opportunity.

Cognitive abilities are assessed with wGPA ranking (uOttawa does not require the MCAT as it is an English only tool) and candidates must also have prerequisite science and humanities courses. Non-Cognitive attributes are assessed using the Casper test. All other activities are assessed using the Autobiographical sketch using a predetermined grid. The highest ranked candidates are then invited to a 40 minute semi structured panel interview (1 faculty member, 1 community member and 1 fourth year medical student) wherein seven key values and personal characteristics are assessed.

We consider that our admission process is an excellent example of a mission based, socially accountable consideration of candidates and one which includes all stakeholders from faculty, to students to members of the community all coming from a diverse and unique background.

We continue to hold our outreach program with Mini Medical School sessions, called 'Come Walk in our Moccasins' which inspires Indigenous student candidates with the medical education system. Francophone Affairs similarly has Mini Medical School sessions for the francophone Canadian population.

McGill University

McGill continues to welcome candidates from all backgrounds through an open, inclusive and bilingual system, using a standardized, rigorous selection process. The Faculty monitors the diversity of medical students by way of a demographic survey. In 2016, the Faculty underlined the importance of diversity with the creation of its new Social Accountability and Community Engagement Office which collaborates with Admissions, and, along with the Widening Participation Committee, identifies which populations should be the focus for outreach activities. The Office provides anti-bias training for multiple mini-interviews (MMI) raters for MDCM admissions.

Inclusion of non-academic competencies as a first step in our file review process is key to addressing this recommendation. Via the CV and CASPer (adopted 2017), worth 30% towards invitation to the MMI, we are able to assess competencies targeted in the CanMEDS roles and go beyond academic abilities alone.

McGill continues to participate with the other three Faculties of medicine in Quebec in the Quebec First Nations and Inuit Faculties of Medicine Program; the government of Quebec grants six supernumerary seats for eligible Quebec students. The Admissions committee is currently working with the Faculty's Indigenous Health Professions Program to explore additional concrete ways to increase access for Indigenous students.

Beginning in 2019, a pathway for Quebec residents who completed high school in a rural or small Quebec community was launched, to recognize the excellence these candidates bring to the profession. As of 2020, our new medical campus located in the Outaouais region will allow us to offer medical education in French to 24 students. Additionally, the Office of Admissions provides financial support for interview attendance to candidates for whom travel costs are a barrier, and offers interview accommodations for applicants with a disability.

Université de Montréal

Collaboration between the three francophone medical schools in Quebec for the integrated francophone mini-multi-interviews (MEMFI) continues. Each interview station focuses on one or more specific aspects of the candidate profile being sought. Some stations attempt to better assess applicants' collaborative skills, in addition to human and ethical values.

Admission practices and research at UdeM also include a situational judgment test, thus diversifying the tools used to assess "non-academic" skills.

A research project involving the four Quebec Faculties of medicine is measuring the relationships between the socio-demographic characteristics of candidates and their performance in the selection process. This project aims to ensure the equity of this process and to assist the Faculties in achieving their diversity objectives.

The Awareness of Study, University and Research (SEUR) project is continuing its activities, the results of which can be seen within our institution. In addition, the SEUR project has designed surveys to study students' perceptions of health studies and to evaluate the impact of its activities. The data collected is used to improve and better target the activities offered by the program.

Two spots reserved for students from disadvantaged socio-economic backgrounds have been created in 2018, and this number increases to three this year. These spots come with tuition grants to help students succeed.

We are looking at best practices in terms of admissions for Aboriginal students. In Quebec, six spaces are reserved for this quota.

In addition, the diversity survey administered to students admitted to the medical program has an excellent response rate of over 95%. The results collected by a committee dedicated to equity and diversity in the program allow us to better identify under-represented groups in medicine and to measure the impact of the special quotas, the Access to Medicine program and the changes made to the selection process.

Université Laval

In an effort to broaden access to the MD degree to a greater number of candidates who are qualified to become physicians, the Faculty recently adopted a new selection process that places greater emphasis on the assessment of personal competencies. As of admissions in 2021, candidates invited to the Mini-Multiple Interviews (MMIs) will be those who, among the candidates meeting predefined academic performance criteria (less restrictive than at present), will have obtained the best results on a Situational Judgment Test (SJT). The offer of admission will then be based entirely on the performance of MMI candidates. In addition, in keeping with its social responsibility towards the Eastern Quebec regions it

serves, the Faculty will further improve the academic performance rating of candidates from designated regions of Quebec so that a higher proportion of them can qualify for the SJT.

Since 2015, the Faculty has made other changes to the admissions process to promote diversity of students admitted and equity of process, including eliminating the need to repeat prerequisite courses completed more than eight years ago, ensuring that the same number of credits is required of all university applicants, regardless of their university of origin, and reserving up to 16 positions for university applicants with particular profiles. As well, the number of provincial positions for First Nations and Inuit candidates from Quebec has been increased from four to six in 2019.

Université de Sherbrooke

The FMHS continues to improve its admission process to the medical program with the goal of broadening its applicant pool, fostering diversity of those admitted, and fostering relational attitudes by the following means:

- continued collaboration with Quebec's francophone Faculties to offer a greater number of places for MMI and to improve their validity;
- the addition of a situational judgement test (Casper) for certain admission quotas;
- the addition of a contingent of special profiles (humanities and social sciences, labour market, research doctorate);
- the withdrawal of certain pre-admission courses to promote accessibility and diversity;
- the increase in the number of positions offered in the Programs for First Nations and Inuit (PFNI) offered in Quebec;
- the addition of admission bursaries for applicants from remote regions;
- maintaining the financial assistance bursary program;
- the implementation of pipeline projects in less advantaged schools.

In addition, changes are currently being made to further broaden the pool of applicants and to encourage the admission of people from a greater number of backgrounds, particularly in the regions.

Dalhousie University

Customize admissions criteria to align them more closely with each faculty's social accountability mandate: Dalhousie Medicine Admissions continues to employ affirmative action/education equity with respect to regional populations of interest, specifically Indigenous peoples and African Canadians of the Maritimes. In the current student body (across four years/classes), there are 13 Indigenous students and 17 African Canadian students.

Develop and research new admissions tool kits that have meaningful predictive value for desired future medical practice attributes: Medicine Admissions requirements are reviewed annually by the Admissions Committee. In 2016, an external review of Medicine Admissions was completed with a summary report and 12 recommendations. In 2017, a situational judgment testing tool (CASPer) was approved as a new admissions requirement. The CASPer (computer-based assessment for sampling personal characteristics) is used for interview selection. Applicants must meet a minimum CASPer threshold to be considered eligible for interview.

Recognizing that standardized tests such as the MCAT have shown to have bias towards marginalized groups, Dalhousie has amended MCAT thresholds in recent years.

Value and profile diverse academic faculty members as leaders and mentors in order to attract a more diverse applicant base: Establishment of the new position of Assistant Dean for Serving and Engaging Society has demonstrated the value of community relations and addressing needs of communities. The Global Health Office is integral in community relations and recruitment efforts in Indigenous and African Nova Scotian populations. In the Department of Community Health and Epidemiology, Dr. OmiSoore Dryden is the James R. Johnston Research Chair in Black Canadian Studies. In addition, Dalhousie University is part of a federal contractor program relating to employment equity.

Create policies that encourage a broad range of applicants: With the August 2019 expansion of first year medical seats, Dalhousie was able to offer admission to four additional qualified Nova Scotia applicants. In the current application cycle, we will be able to offer 16 additional seats to qualified Nova Scotia applicants. The Admissions Committee is currently developing a supplementary questionnaire for the 2020-2021 application cycle to identify applicants for a widening accessibility stream, based on geography and socioeconomic status/history.

Work with the provincial/federal governments to monitor student debt-management and create policies that encourage a broad range of applicants: Medical students are facing increased pressures as the result of student debt. The Faculty of Medicine has made it a fundraising priority to minimize these pressures and allow our students to focus on becoming excellent physicians and researchers. Established in 2019, the Dalhousie Medical Student Bursary was created to relieve some of the financial burdens our students are facing. The Faculty of Medicine is also working with the provincial government on bursary support.

Memorial University

Memorial has developed pathway programs that connect students from underrepresented communities of Newfoundland and Labrador. Future physicians ought to reflect the diverse populations we serve and we need to ensure that we select future physicians who have the aptitude to succeed. To achieve this, we have expanded our assessment tools beyond academics into critical reasoning and judgment.

This process continues to evolve and currently utilizes a standardized exam to assess situational judgment. The goal is to look beyond grades and ensure we find candidates with a broad range of interests and experiences, and possess the requisite communication abilities. In essence, the faculty of medicine undergoes a rigorous and holistic approach to admissions.

In line with the mission of the Faculty of Medicine, our three priority areas continue to include the aboriginal people of Newfoundland and Labrador, those from rural areas, and economically disadvantaged learners. We value both work and volunteer experiences that support the applicant's rural home communities and highlighted these contributions during admissions committee meetings. A strength of our Interview and Admission Committees is the diversity with representatives from many communities. We have a dedicated aboriginal pathway, which reserves spots in the class for suitable candidates.

With additional metrics we assess our candidates objectively. We are long-standing contributors to the multi-centered research with the MCAT validity study and we are in the fourth year of using a situational judgment test. Research is ongoing to determine validity and appropriate weighting.

Recommendation 3: Build on the Scientific Basis of Medicine

Promoting a healthy Canadian population requires a multifaceted approach that engages the full continuum of health and health care. Faculties of Medicine have a critical role to play in enabling this requirement and must be rooted in fundamental scientific principles, both human and biological sciences must be learned in relevant and immediate clinical contexts throughout the MD education experience. In addition, as scientific inquiry provides the basis for advancing health care, research interests and skills must be developed to foster a new generation of health researchers.

University of British Columbia

The MDUP curriculum is competency-based and designed around the principles of horizontal integration and vertical integration (i.e. spiraled). Integration occurs through a “body systems and themes” framework with a strong scientific basis. Themes of Medical Sciences, Diagnostic Sciences, Treatment, Populations and Diversity, Care of Patients, Evidence-based Medicine, and Scholarship are integrated into relevant body system weeks across all courses. Systems and themes are revisited throughout all four years of the curriculum with increasing levels of difficulty.

The Flexible and Enhanced Learning (FLEX) course is a required curricular and scientific component that spans all four years and emphasizes a broad understanding and application of scholarship, engagement, and social accountability. Students are prepared through a Foundations of Scholarship component and engaged in community and/or research activities. Goals include fostering innovation, creativity, critical thinking as well as preparing graduates as scholars, life-long learners, and health leaders.

Based on self-reported data from Years 2 and 4 students in 2018/19, FLEX activities yielded 1,628 scholarly manuscripts, workshops, training modules, and video/podcasts. Of the over 400 manuscripts written by Year 2 and 4 students, 130 were published. In addition, these students delivered over 500 presentations at local, national, and international conferences.

The MD-PhD Program, part of the MDUP, provides qualified students the opportunity to combine medical school learning with intensive scientific training for careers as clinician-scientists. Students usually complete the program in 7 years, with 3 years of full-time PhD training occurring between pre-clerkship and clerkship.

University of Calgary

We offer intro sessions to basic science concepts in July for first year students.

There is a renewed emphasis on anatomy with a new anatomy course.

Essential to supporting the success of our faculty and to meeting the university's Eyes High mandate, is a commitment to develop the scientific platforms, facilities, cores and information technology (IT) necessary for the conduct of transformative research. The full breadth of our research enterprise is supported and expressed through seven research institutes. Our research priorities—brain and mental health, inflammation and chronic diseases, and cardiovascular health—reflect both the central role of the CSM in the University of Calgary's current strategic plan and the recognized leadership position the school occupies in these research areas. Each year the CSM breaks new ground in research and knowledge translation, delivering excellence in education, and striving for improved and progressive patient care. Despite being one of the country's youngest medical schools, the school is currently ranked within the 51-100 category of the QS World University Rankings by Subject.

University of Alberta

To build on and fully integrate the scientific basis of medicine, we have Basic Science faculty included on our key Curriculum committees. The Foundations course builds the "biological sciences" foundation including anatomy, biochemistry, embryology, genetics, pharmacology, physiology, microbiology and infectious disease. Our Physicianship course, includes approximately 21 threads primarily focused on the "human sciences". Learning occurs in relevant and immediate clinical contexts and in small groups.

We offer a very flexible approach to research through our "Research Community of Learning" recognizing that students have a range of interest in research from informal research projects, to those who want to complete the STIR program, a Master's, or a PhD. We increased the number of MD/PhD students in our program from 3 in 2015 to 13 in 2019. New in 2019-2020, we have a cohort of 6 learners in the first-year class in an "MD/PhD" group concurrently completing their PhDs, while completing their MD Program. Sixteen students are taking a graduate course in Translational Research. Our graduating classes of approximately 162 students have between 370-420 confirmed peer reviewed works.

An *Excellence in Medical Student Research* event celebrates the research contributions of our students and to provide an opportunity for new students to meet research teams and talk about potential projects. In 2019, 72 posters were displayed by students, with their research teams.

MD students collaborate with graduate students in our faculty in a new "Bench to Bedside Students Association" which pairs medical students with graduate students with similar research interests.

University of Saskatchewan

Current Status

In our current 2+2 curriculum, students undertake a 'Principles in Biomedical Sciences' course in their first term in the medical program. This course provides opportunity for common grounding in the biomedical sciences for all medical students irrespective of their pre-medical educational focus. In the subsequent three pre-clerkship terms the 'Foundations of Clinical Medicine I-III' course series integrate relevant biomedical perspectives in the context of systems based clinical medicine.

A research/evidence-based medicine vertical theme incorporates content around principles of medical research, quality assurance/quality improvement, knowledge translation and evidence-based medicine throughout courses in the four-year program. A focus is placed on the student developing critical

appraisal skills to appropriately interpret and apply medical research literature. There is a faculty lead for the research/evidence-based medicine vertical curricular theme.

Experiences in research are supported through the research vertical theme curriculum, together with opportunities for Dean’s summer research projects and research electives for undergraduate students.

Students have the opportunity to participate in graduate research projects (either MSc or PhD) either through deferral of admission to the MD Program (typically for 1 year and for students completing an MSc) or through taking an educational leave of absence between years 2 and 3.

University of Manitoba

- Med I summer research added.
- Unlimited number of students now able to enroll.

Northern Ontario School of Medicine

Human sciences are primarily in Themes 1, 2, and 3, and biomedical sciences in Theme 4, all of which run from the start to the end of the 4-year undergraduate medical program. In 2016 clinical reasoning sessions were introduced which include a combination of whole group case and problem based learning and small group sessions using a team-based format. The whole group sessions focus on applying clinical reasoning to clinical scenarios, while the small group sessions will explore higher level concepts of the “behind the scenes” steps in clinical reasoning. Concepts explored and discussed include the process of diagnosis, cognitive error and the effects of bias in physician decision-making.

Schulich School of Medicine and Dentistry, Western University

Our School commits to our strategic direction: “Advancing patient care across the life span” and “Partnering with communities while leading in scholarship”. Our learners graduate as Master Adaptive Learners striving to improve on individual, community and population health care outcomes while providing quality health care. We collaborate with School and university partners to advance critical scientific inquiry, including research, that reflects Canadian patient care needs.

Basic Sciences are integrated into the longitudinal curriculum across the four years to ensure the foundational sciences underlying health and health care are aligned with staged competencies and achieved by graduation. Basic Science faculty contribute to curriculum leadership, teaching and scholarship at all campuses. MD/PhD students often undertake their doctoral studies in Basic Sciences.

To equip our students to succeed and where appropriate excel in the highly competitive research environment, the Program has introduced and is supporting a mandatory research experience. Students engage in small teams to complete a project under faculty mentorship. Additional research experiences are supported with student programs, funding and awards which has led to peer-reviewed publications, presentations, advocacy and scholarly education innovation. Along with Western and the University of Windsor, the School partners with the Centre for Education Research and Innovation and Lawson Research Institute to offer various options. We are expanding our MD / PhD program and developing a wide selection of Western and Windsor joint Masters/MD dual degrees.

McMaster University

McMaster's MD Program has long taken the view that basic and applied sciences are best learned in the context of how they will be used in future practice. To this end, basic science learning is highly integrated with clinical science learning within the problem-based learning (PBL) case objectives. To further support the importance of these domains, our blueprinting assessment includes several basic and applied science disciplines and assessments are carefully designed to meet the blueprint.

We have also increased our support of students who wish to do research. Students in our Regional Campuses have always been robustly supported by local research leads who provide opportunities and guidance to students about participation in research. With the addition of a similar lead in the Hamilton Campus, students are now supported at all three campuses to engage in broader research activities. Additionally, programming was added to improve students' understanding of project design and some methodological support courses, particularly in areas where students are more likely to be leaders of research projects, such as systematic reviews.

McMaster has also been keen to develop better mapping of the learning objectives throughout our educational program with respect to the basic and applied sciences; however, this rubric has continued to be elusive. Nonetheless, we will continue to look for rubrics that are informative to understanding appropriate coverage of the scientific foundations of medicine throughout the medical school curriculum. The blueprint that we currently use for assessments is being considered for this purpose.

Finally, we have several students who take advantage of more extensive opportunities to develop careers with a research focus. Three MD/PhD's are enrolled in each year of the MD/PhD Program and a number of other students take time away from our three-year MD program to participate in an Enrichment Program which invariably has a strong research component.

University of Toronto

The introduction of our renewed pre-clinical curriculum – now known as Foundations – in 2016 is one of the most significant changes we have made to the way we deliver medical education. A feature of our Foundations curriculum is the integration of basic science, psycho-social concepts and clinical concepts. Based on a robust evidence base that identifies integration as an active cognitive process, our Foundations curriculum evolved from its previous course-based organizational structure to a series of spiraled blocks that build upon each other conceptually, with each block comprised of a sequence of scaffolded cases with progressive introduction of complexity. This evolution involved a shift from lecture-heavy learning to case-based learning (CBL), with each case acting as the core for the week's learning. These cases enable our students to contextualize their learning and integrate foundational and basic science knowledge within the structures of the curriculum.

The introduction of our Foundations curriculum included the reconfiguration of our Health Sciences Research (HSR) course as a two-year integrated component. HSR in year 1 focuses on foundational research knowledge, with the opportunity to build upon this knowledge and apply research skills in year 2 through various activities and a practicum exercise. The HSR foundational topics and activities are integrated into the Foundations CBL cases.

We introduced a Graduate Diploma in Health Research (GDipHR) in January 2019 that provides selected first year medical students with the opportunity to participate in a 20-month longitudinal research program under the supervision of a Principal Investigator.

Queen’s University

We have integrated separate histology, anatomy and physiology courses into two “Human Structure and Function” courses to parallel “system” based instruction in subsequent courses. Online modules developed in collaboration with basic science instructors provide some core content. Clinicians and basic science instructors use labs and active learning cases to promote concept application. Genetics has a stronger presence in first year.

First-year modules provide an accessible foundation for instructors and students to build on in clinical system-based courses. Pathology is better represented through development of on-line modules and multi-disciplinary case discussions (e.g. oncology-related topics e.g. lung cancer and renal labs). Some system-based courses identified and addressed “top 10 medications” in their disciplines to improve students’ familiarity with prescribing and applied pharmacology. Multi-disciplinary “case of the month” illustrate applications of microbiology, pathology and anatomy applied to relevant imaging.

Three clerkship classroom courses permit advances in basic science to be discussed: e.g. immunotherapies and genetics.

The Critical Appraisal and Research course provides a strong foundation in the skills needed for independent, evidence-based learning. The Critical Enquiry course allows every student to develop a research concept and in many cases, to execute it.

Going forward, we need to:

- provide foundations for emerging medicine e.g. personalized medicine, immunotherapy, and the role of “big data”
- engage PGME to include instruction in discipline-specific basic science
- encourage clinicians to illustrate basic science concepts in clinical settings
- leverage skills of students entering medicine with advanced degrees in the sciences
- improve instruction in infectious diseases and prescribing throughout the curriculum.

University of Ottawa

We have been renewing our longitudinal Society, the Individual and Medicine (SIM) curriculum which covers epidemiology, prevention and public health issues. Significant evidence-based medicine (EBM) curricular changes have recently been made.

We have established a new collaboration with the School of Epidemiology and Public Health (SEPH) which will help with ongoing renewal of this curriculum.

The 2019 AFMC GQ results have demonstrated significant improvement in how education in nutrition, genetics, biochemistry, epidemiology and biostatistics (among others) are preparing our students for their clinical experience during Clerkship.

In preclerkship, our Case-Based Learning and Team Based Learning sessions ensure that basic sciences are being taught in the context of clinical scenarios. We have recently been working on a way to enhance the transition from preclerkship to clerkship to allow our students to more effectively bring to and to add to their basic science knowledge while in clerkship.

The MD/PhD program continues to offer exceptional students the opportunity to pursue 2 degrees. There are 4 positions reserved each year for eligible applicants who will graduate with both an MD and a PhD degree at the end of seven years. Applicants choose their language stream of choice upon completing their application.

The Department of Innovation in Medical Education is being invited to discuss the creation of a UGME Medical Education Research Program that would support and promote research and scholarship initiative as part of a broader curriculum renewal strategy.

The MD program has created a longitudinal clinician investigator program (articulated in recommendation 9).

The implementation of the national EPAs for the class of 2025 will provide a unique opportunity to revise the structure and focus for both education and assessment across the pre-clerkship and clerkship stages of our curriculum.

The annual summer studentship program continues to fund research projects each year. Ongoing funding issues faced by the University and affiliated hospitals may limit further expansion of this program.

McGill University

In addition to the teaching of the basic scientific disciplines comprising the basis of the practice of medicine, students are also enrolled in Research Fundamentals courses in the first 18 months of their training. These courses link students with a basic science researcher-mentor and focus on the bidirectional aspects of knowledge translation. The Basic Science, Critical Thinking and Knowledge Translation theme ensures that key scientific principles are disseminated throughout the MDCM curriculum, including a longitudinal journal club pairing a basic science advance with its clinical translation that begins in the first month of the curriculum and continues to the end of UGME. Faculty members from basic biomedical sciences are members of the MDCM Program Committee as well as some of the Component Subcommittees. At the end of clerkship, the Putting It All Together (PIAT) course consolidates knowledge of scientific concepts and students participate in discussions about the translation of cutting-edge scientific knowledge.

Université de Montréal

The preparatory year for the medical course, completed by students coming from CEGEP or a non-medical bachelor's degree, was completely redesigned and introduced in the Fall of 2019. The relevance of the objectives in the humanities and basic sciences was reviewed at the discussion tables.

The teaching of social sciences has been improved, particularly in the PBL course, "Growth, Development and Aging. For each of the problem-based learning (PBL) course blocks, the teaching aims at integrating basic human and biological sciences in the understanding of clinical situations illustrated in the problems submitted for study in PBL.

The number of students interested in research projects increases from year to year. More external students are also attending scientific conferences and, for a large number of them, presenting their work. Our students also have the opportunity to enroll in M.Sc. or Ph.D. programs or in Summer Research Internships supported by scholarships from the Medical Excellence Program for Research Initiation (PREMIER). These fellowships are a success with our students; close to 200 medical school students apply annually, for a total of 84 fellowships in 2019, with a growth rate of 55% in 10 years.

Université Laval

Since 2015, the promotion of research training for students in the MD program has been the subject of sustained efforts by the Faculty. These efforts have resulted in a substantial increase in the participation of students in Summer research internships. In fact, the annual Summer Research Internship Symposium held in the Fall of 2019 welcomed a record number of oral and poster presentations (116 in all). To meet the increased demand for research internships, the Faculty has been offering a micro internship program since 2018 that allows students to accumulate several research internships (up to 12 credits) during their Undergraduate training.

The basic concepts of epidemiology and critical analysis of the medical literature are covered in the Epidemiology and Critical Reading I and II courses, which are offered in consecutive sessions. These courses have been reviewed in depth in 2014 in order to improve the distribution and continuity of learning. Since 2015, several lectures have been replaced by online modules that students can easily refer to in the subsequent stages of their training. The Integration course series specifically addresses evidence-based medical practice.

Université de Sherbrooke

Since the implementation of the new program, the FMHS has opted for a decompartmentalized curriculum integrating basic and clinical sciences and promoting interdisciplinary teaching. The program approach adopted ensures a global vision of the curriculum and the integration of biomedical sciences (BS).

- The organization of teaching activities (courses) is based on relevant clinical situations of increasing complexity rather than by organ-systems resulting in :
 - the distribution of objectives and contents related to BS in the different clinical situations of the curriculum (just-in-time concept);
 - the teaching offered by a duo of professors (clinical and biomedical sciences) during the team learning sessions;
 - the development of evaluation modalities including the BS component.
- The development and implementation of five pedagogical activities dedicated to the acquisition of essential knowledge and the implementation of basic elements of health research, addressing the following themes:
 - biostatistics and epidemiology, literature search and critical reading;
 - research specifications, data collection and analysis of research results;
 - presentation and argumentation of research results.

In addition, the following actions have been pursued :

- Promotion of Summer research internships with an increase in student interest in Summer internships.
- Increase in the research grant programme for Summer internships.
- Promotion of the MD/MSc and MD/PhD training path and increase in registrations.
- Growing research interest groups and optional activities offered outside the program.

Dalhousie University

Involve basic scientists, clinical faculty and medical educators in the collaborative design, development, and implementation of the MD education curriculum: Basic scientists, clinical faculty, and medical educators continue to be valued members of the undergraduate curriculum committee and many are tutors and unit directors in the preclerkship years. Longitudinal theme heads in the basic sciences actively participate in curriculum development and evaluation.

Support existing and new programs that integrate research training with medical education: Research in Medicine involves all medical students to complete a research project over the course of their training. Research in Medicine continues to be a vibrant, mandatory component of the curriculum and was the focus of the undergraduate medical education retreat in summer of 2019. Students are able to pursue scholarly activity in a broad scope of areas, including research and care reports. Scientists and clinicians serve as mentors for this curriculum element.

Memorial University

The Physician Competencies Course runs throughout the MD Program and includes the research curriculum. This curriculum begins with the conception of a research question and culminates with knowledge translation in the final year of the program. Learners select a faculty supervisor with expertise in the learner's area of research interest and work closely with that supervisor throughout the 4-year program. Our learners research questions address pressing and emerging needs of regional, Indigenous and global populations through research in clinical sciences; biomedical sciences; population health; quality improvement; and social justice and equity in health and is aligned with the Strategic Plan, Destination Excellence 2018-2023, mandate to address pressing and emerging needs of regional, Indigenous and global populations.

Very early in the program, all learners are exposed to the theoretical foundations of research, including evidenced-based medicine, critical appraisal, research ethics and research methodologies. These concepts are reintroduced at strategic intervals throughout the remainder of the curriculum to best support the research process through the stages of literature review, research proposal, data collection, data analysis and knowledge translation. In line with the remainder of the theme-based curriculum, the learner builds upon the knowledge and skills specific to research as they progress through the MD Program.

The research curriculum continues to evolve and a working group is currently reviewing the content of the research curriculum.

Recommendation 4: Promote Prevention and Public Health

Promoting a healthy Canadian population requires a multifaceted approach that engages the full continuum of health and health care. Faculties of Medicine have a critical role to play in enabling this requirement and must therefore enhance the integration of prevention and public health competencies to a greater extent in the MD education curriculum.

University of British Columbia

Prevention and Public Health (PPH) teaching is included in the MDUP curriculum in each of Years 1 to 4.

PPH-themed teaching begins in the first month of classes and is spiraled throughout the curriculum. While early-stage PPH teaching focuses on foundational science, students rapidly integrate this with clinical practice during the Clinical Experiences sessions. For example, Year 1 students have a lecture “Vaccines and Immunity” (week 5), learn how to administer a vaccine in a simulation session (week 5), and have a Clinical Experiences session in a Family Medicine setting where they may give an actual injection (week 10).

PPH content is expanded throughout Years 2 to 3, both in terms of content and complexity. As members of care teams delivering health service, Year 3 students (Clinical Clerks) can be involved in a variety of PPH activities, such as smoking-cessation counselling, cervical cancer screening, to name a couple of examples.

In Year 4, students have the opportunity to engage in electives involving PPH activities, which can be population-based (e.g. electives at the BC Centre for Disease Control) or patient-focused (e.g. counselling patients on the health benefits of exercise and weight loss in a Diabetes Clinic).

Additionally, FLEX (described in the comment under Recommendation 3) enables students in Years 1, 2 and 4 to explore particular areas of interest, including PPH.

University of Calgary

We moved our population health course to the first course for medical students to emphasize the important of disease prevention and health promotion.

We have added a new community engagement project (piloted in 2019/20) which will inform the future directions for engagement with the local community.

University of Alberta

Topics of prevention and public health are integrated throughout our program in the longitudinal physicianship course, with a strong emphasis on the determinants of health. The curriculum also includes content on biostatistics, epidemiology, surveillance and reporting of communicable disease,

advocacy and communication, the impact of the environment on health and ethical challenges in public health.

In their first year, students spend time with community agencies as part of the service learning requirement of the program. Through these experiences, many students see the impact of the social determinants of health first hand.

We include primary and secondary prevention strategies including age specific screening strategies. Students learn communication skills including shared decision and motivational interviewing. Specific sessions on topics such as tobacco and other substance abuse are included. A dedicated geriatrics clerkship helps students focus on the health and health needs of an aging population. Students also spend time with community agencies and programs that support elderly members of our population with varying degrees of health support need.

In response to the opiate crisis, we have developed curricular content together with other health professionals, pharmacologists, members from community agencies and students. This content is integrated across all years of the program in the Physicianship course. Students also receive curriculum and support aimed at improving their own health and wellbeing.

We continue to work to further develop curricular threads on evidence-based nutrition and nutrition counselling and exercise to promote healthy lifestyles as well as on health systems and health policy.

University of Saskatchewan

Current status

- Medicine and Society courses (Years 1 and 2)
 - M&S I Introduction to Patients, Health and Medicine
 - Content: Indigenous Health, Cultural Safety and Competency, Indigenous People History and Intergenerational Trauma, Immigrant Health, LGBTQ2S
 - Experiential learning: Shadowing, Experience in the Community, Community Service Learning Program, Wanuskewin Experience, Patient-Family Centred Care
 - M&S II Public Health and Preventative Medicine
 - Content: Health Equity and Social Determinants of Health, Health Promotion, Orientation to Public Health, Prevention and Screening, Outbreaks & Communicable Disease Control, Introduction to Community Engagement and Work, Environmental Health, Epidemiology
 - Experiential learning: Shadowing, Experience in the Community, Patient-Family Centred Care, Health Innovation & Public Policy Conference
 - M&S III The Health Care System
 - Content: Community Care and Long Term Care, NIHB and Indigenous Health Issues, Physician Interactions with Patients and Society
 - Experiential Learning: Community & Workplace Centred Learning Experience, Patient Narratives
- Clerkship (Year 3)
 - Family Medicine Rural/remote rotations
- Selected Topics in Medicine (Year 3)
 - Cannabis and the Law, Indigenous Health

- Electives (Year 4)
 - Indigenous Health electives
 - Family Medicine rural/remote electives
- Extracurricular:
 - Making the Links, Global Health Certificate
- Other curricula:
 - Curriculum relating to vaccination within the Immunology module of the Principles course in Term 1 Year 1 as well as within the pediatrics component of Clinical Skills II in Term 2 Year 1 and in the Year 3 STIM course.
 - Curriculum relating to screening guidelines and practice which is included within most modules of the Foundations courses in Years 1 and 2 as well as within Year 3 Core Rotations and STIM.
 - The Integrative Medicine (Complementary Alternative Medicine) Curriculum within Principles/Foundations and STIM as well as a Year 4 Elective
 - Public Health Elective in Year 4 (replacing the CH&E elective as of the 2020-21 AY).
 - Nutrition vertical theme as a health promotion vehicle includes sessions throughout Years 1,2, and 3.

Barriers:

- Capacity for experiential learning
- Ensuring cultural safety; not promoting voyeurism
- Having a curriculum which is nimble enough to allow incorporation of evolving crises/issues

University of Manitoba

- The prevention and public health aspects of our current curriculum is robust.

Northern Ontario School of Medicine

Social and population health continues to be a strong focus at NOSM throughout the 4 years of the MD program and are defined in the Medical education Program Outcomes: “Apply knowledge of the determinants of health to promote health and wellness within a population and the individuals it comprises; and Apply knowledge of the health care and public health systems in Canada to achieve maximum health benefits for all patients”

The social determinants of health are integrated into all Case Based Modules as part of the Northern Ontario context of each module. The four-week Indigenous community immersion experience in first year allows students to experience first-hand the influence of cultural, historical, social and political realities on the health and health care of Indigenous communities and Peoples. In addition, students experience the importance of population health during two four-week blocks in a rural community in second year and 8 months in a medium sized community during their 3rd year clerkship.

Schulich School of Medicine and Dentistry, Western University

Knowledge, skills and attitudes that promote prevention and public health are key competencies in our renewed curriculum with required learning on the current and future state of Canadian health systems.

Project and small group case-based learning delivers on this recommendation, integrated within courses.

We believe prevention and health system education is a goal learned in an experiential process. Moving beyond small group learning in Year 1, students participate in Year 2 faculty-mentored Quality Improvement projects - conceived and completed within the clinical learning and working environments of affiliated hospitals and communities.

Accessing faculty leaders and educators dedicated to delivering public health education has been a challenge for the Program. The Hidden Curriculum which often de-emphasizes the importance of public health requires continual management and nuanced integrated curriculum for students.

Our School Accredited Masters in Public Health Program is modelled on case based and experiential learning, drawing students from Canada and other international universities. Graduates have been impactful and effective in advancing care and scholarship in the region they enter. The 2020-2021 academic year brings the launch of a dual degree MD-MPH program in partnership with the Public Health program. Students undertaking this joint degree will be future change agents that will be better equipped to advance health care regardless of chosen career path.

McMaster University

McMaster's MD Program has long had a strong focus on preventative and public health aspects of care. From the school's inception, a broad-based focus on population, behavioural, and biomedical perspectives have been incorporated in all healthcare problems students encountered.

With the inception of the COMPASS curriculum in 2005, the MD Program introduced our Professional Competencies course which includes the Public & Preventative Health Domain as one of seven domains. Preventative health topics are also covered throughout a number of the clerkship rotations. McMaster students consistently express a high level of satisfaction with coverage of public and preventative health topics throughout the curriculum; and performance in this domain on high stakes examinations exceeds national benchmarks.

Reflecting this focus throughout our curriculum, we have a higher than national average number of students entering public health and family medicine specialties with many alumni implementing important public health initiatives. Students also find many alumni mentors and engage in important local and provincial public health projects during their time in the MD Program.

Finally, new programming will be focusing on inclusive clinical skills and inclusive problem-based learning. Concepts of behaviour modification in the context of preventative health practices will be further understood for many marginalized patient groups in the contexts of historical and structural systems that reinforce maladaptive health behaviours. Furthermore, disease distribution will be better understood in these contexts as well.

University of Toronto

The development of or new pre-clinical curriculum – Foundations – included a renewal of our public health curriculum, including the identification of learning objectives grounded in the following core areas: data-related actions (surveillance, epidemiology, population health assessment); health protection (including following up on communicable disease and environmental health concerns); health

promotion; disease and injury prevention; and emergency preparedness and response. Teaching and assessments to support achievement of these public health learning objectives are integrated into relevant course sections and CBL cases throughout the Foundations curriculum, including cases that highlight population-level interventions. For example, the content in the Endocrinology block complements the corresponding CBL case such that students explore the concepts of health, wellness, illness, sickness and disease, including how individual and sociocultural values can influence understandings and perceptions of these concepts. Through this integrated approach, students are also required to consider how the social determinants of health contribute to the health status of individuals and populations, and to health inequities among groups.

Queen’s University

Curriculum Focus: The Population and Global Health course was introduced successfully in first year and after feedback from students and faculty, it has undergone helpful revisions, and is currently two courses with more clearly defined foci: “Health Determinants” and “Population Health”. The new course director is a Public Health and Preventative Medicine Specialist in addition to being a practicing Family Physician. The Department of Public Health Sciences is very engaged in assisting the School of Medicine with ongoing curricular reform. Following a recent mini retreat planning is now underway to restructure the course into three distinct themes: Health Determinants, Health Systems and Policy, Public Health: Theory, Application & Methods. Prior to this retreat several gaps were identified and emerging topics such as environmental health, occupational health, chronic disease prevention and Health Promotion will be integrated more fully in the curriculum. These changes will be reviewed for areas that will still require attention.

Curriculum Integration: A process was instituted this year to identify where prevention and public health topics are included in other courses (e.g. falls prevention in geriatrics, role of screening in oncology) in order to map where these topics are included in the curriculum. This will be used to conduct a gap analysis to guide enhanced teaching across the curriculum. Additional teaching is provided in clerkship, particularly in the back-to-class curriculum, including preparation for MCCQE part I.

University of Ottawa

The Society, the Individual and Medicine (SIM) curriculum includes content on epidemiology, evidence-based medicine, population health, public health, social determinants of health, health promotion and disease prevention. Since the retirement of the epidemiologist who spearheaded this program, the direction of SIM has been assumed by a team of epidemiology and public health trained clinicians, who work closely with the leadership, faculty and learners from the School of Epidemiology and Public Health (SEPH) to integrate quality content into the SIM curriculum. The issues in the FMEC’s “the way forward” continue to be addressed in SIM sessions within the context of the theme of the week. Students are still encouraged to apply epidemiological principles and critical appraisal of evidence to individual patient care. The leadership of SEPH and SIM are conducting a review of these content areas and how they are taught during the winter of 2020. In addition, new content has been added to SIM over the past few years (some at the behest of students) and includes such issues as Quality Improvement, Human Trafficking and Climate Change and Health.

McGill University

Health promotion and public health remain an important theme in the MDCM program. Students are exposed to the principles of public health, including the social determinants of health and population and community health, during their first month of medical training as part of the first-year course *Molecules to Global Health*. Relevant concepts and evidence-based medicine related to public health and social accountability are integrated throughout the curriculum in both pre-clinical and clinical courses. The Social Accountability, Public Health and Health Advocacy theme advises the MDCM Program Committee on the current and more pressing issues related to public health and vulnerable populations and is responsible for ensuring horizontal integration of these issues into the curriculum. Students also complete a service-learning experience in community organizations working with various marginalized populations during the CHAP course. Finally, the Public Health and Preventive Medicine course brings together the concepts learnt throughout the first years and applies examples witnessed during clinical experience, in addition to focusing on other important topics such as environmental hazards and disease surveillance. Students appreciate the chance to participate in a debate about health care policy during this course, in addition to other teaching methods used.

Université de Montréal

The Preventive Medicine and Public Health clerkship was completely renewed in 2018. Based on a specific competency framework, the training is structured around six areas of knowledge: prevention and health promotion, health surveillance and epidemiology, protection of infectious diseases, occupational medicine, environmental health and health administration.

It empowers externs to:

- link certain health issues to the major individual and social determinants of health;
- get to know the population approach and public health interventions;
- assume the preventive aspects of care;
- fulfill their social responsibility to the population they serve.

AFMC's Entrustable Professional Activities (EPAs) are introduced in the clerkship program. In particular EPA 12: "Educate patients on disease management, health promotion and preventive medicine" allows for direct observation and feedback to the student in the contexts of smoking cessation, cancer screening, immunization promotion, and promotion of healthy nutrition and physical activity.

We have added the teaching of the impacts of climate change on physical and mental health and on the migration of populations.

Université Laval

Starting in the Fall of 2020, the clerkship in Public Health and Preventive Medicine (formerly the clerkship in Social and Preventive Medicine) will last four weeks and will take place in the public health facilities attached to the Faculty's teaching network, including those located in the regions. Previously,

this essentially theoretical three-week clerkship took place at the Faculty of Medicine. These changes are intended to increase students' exposure to public health through an immersive practical internship.

Université de Sherbrooke

Since the implementation of the new program, the FMHS offers more opportunities to integrate prevention and health promotion concepts, notably through :

- the development and implementation of longitudinal educational activities dedicated to the prevention and health promotion of populations using :
 - the case study method that promotes interactive learning and knowledge translation in situations that are representative of the practice of physicians working in public health;
 - several case studies related to Aboriginal health, child development, healthy lifestyle environments, social inequalities, cancer and injury prevention, STBI and outbreak prevention, occupational and environmental health;
 - the integration of essential knowledge related to the determinants of health, prevention and promotion of the health of individuals in clinical situations, where relevant, during the first 2 years of the curriculum.
- the redesign of the population health internship allowing for team projects on prevention and health promotion in communities.
- enhancement of mandatory community service-learning activities to facilitate learning about the determinants of health in various settings.

Dalhousie University

In partnership with a variety of communities, agencies, and health disciplines, enhance MD education curricula to include competencies, skills, and expected outcomes in relation to population health, prevention, promotion, and the social determinants of health: Professional Competencies courses provide strong background to students in these important areas. Curriculum is adjusted to address new and emerging priorities such as cannabis, opioids, medical assistance in dying, Indigenous health. Current focus is on development of curriculum around climate change.

Promote a culture of innovation and scholarship in the teaching of population health (including prevention and public health): The RIM program requires strong direction and support for interested students wishing to pursue research in these areas. Professional competencies course covers an array of population health topics and pursuits.

Provide encouragement and support to learners and faculty in advocating for population-level interventions: This topic is covered in our Professional Competencies course.

Teach learners how to look at individuals in the context of their environments, think about both patient-doctor and population-doctor relationship, and identify patients who are part of “at-risk” populations: These areas are covered in our Professional Competencies course. In addition, through service learning, clerkship and elective opportunities, students experience working with at risk populations.

Teach learners to apply epidemiological principles and critical appraisal of evidence to individual patient care. Encourage faculty to incorporate such principles into every part of the medical

curriculum: In the pre-clerkship program, students are provided with these opportunities during the Professional Competencies program, the Research in Medicine program, and during the first curricular unit of the program – Foundations of Medicine. These programs help to establish the foundation for students to practice the application of epidemiological principles and critical appraisal of evidence to individual patient care.

Utilize existing resources, such as the AFMC Best Practices in Public Health Undergraduate Medical Education report and established national networks of public health educators: Our curriculum includes cases concerning public health related issues in the Professional Competencies program. The learning objectives for these cases coincide with the overarching theme of social determinants of health, which runs through the entire two-year program. Many of the best practices discussed in the AFMC report are ones that are used. For example, we use case-based discussion related to topics such as physician responsibilities and roles during an infectious disease outbreak and draw upon literature from the Public Health Agency of Canada, the World Health Organization, Canadian Public Health Association, and the National Advisory Committee on Immunization. The students also have an opportunity to engage in a structured debate regarding the duty to care or treat in emergency and non-emergency medical situations. The lecture delivered in conjunction with the case on infectious outbreaks is always delivered by a Public Health Officer from either New Brunswick or Nova Scotia.

Memorial University

In line with *Destination Excellence*, Memorial aims to put the needs of our learners and communities at the forefront of everything we do, providing learners with active, engaged, empowering and authentic community-based experiences. Population health and public health has been well integrated into the curriculum.

Community Engagement I introduces the knowledge and skills necessary for understanding contemporary issues in community health, and the integration of population health principles into clinical practice settings through academic work and a community placement. Learners complete community placements at local urban community settings, as well as in rural Newfoundland and Labrador, New Brunswick, Prince Edward Island, and the Yukon.

Community Engagement II allows learners to build on population health principles during a two-week rural placement within which learners acquaint themselves with the social determinants of health in rural communities and identify health promotion and disease prevention organizations in the communities.

Community Engagement III is devoted to the administration and health systems, health illness beliefs, aboriginal health, and obesity, placing learners in physicians' practices for two weeks to further experience interactions among patients presenting with new or chronic conditions, their family physician and the health care system and further developing the learner's concepts of population health.

Memorial also has an optional service learning program built around the Social Accountability mandate which ensures a community-engaged and equity-driven approach and emphasizes the social determinants of health. Faculty and learners at all levels are supported in advocacy and social engagement as they learn about and address health inequities which exist at the community level.

Memorial’s curriculum also provides opportunities for discussion on power and privilege as well as justice and systemic challenges to health equity locally, nationally and internationally.

Recommendation 5: Address the Hidden Curriculum

The hidden curriculum is a “set of influences that function at the level of organizational structure and culture,” affecting the nature of learning, professional interactions, and clinical practice. Faculties of Medicine must therefore ensure that the hidden curriculum is regularly identified and addressed by students, educators, and faculty throughout all stages of learning.

University of British Columbia

The MDUP has developed a learner-centered approach to the hidden curriculum, involving four iterative steps:

- 1) prime students that there is a hidden curriculum and that all students are prone to incidental adoption of the values transmitted from their learning environment;
- 2) notice these moments of enculturation as something to be reflected on;
- 3) reflect on experiences in a safe, guided, and group setting; and
- 4) choose future strategies that best reflect each student’s own internal values.

Based on this model, we have implemented a reflection–based Portfolio program for students transitioning to clerkship, with the following 3 goals:

- 1) sensitize students to the hidden curriculum;
- 2) provide a safe and confidential forum to discuss their experiences; and
- 3) co-construct strategies to deal with the pressures in the clinical environment.

Clerkship students found the group setting helpful and commented on the importance of sharing their experiences and gaining feedback from others.

The Portfolio program has subsequently been implemented across all four years of the MDUP at all four regional sites. This creates a safe and confidential forum whereby groups of 8 medical students meet regularly with a Portfolio Coach to explore socialization and the hidden curriculum, grounded in clinical experiences. In Years 1 and 2, the sessions are more structured. In Year 3, as students’ clinical experiences dramatically increase, the sessions become more flexible to allow students space to discuss and process these experiences.

University of Calgary

The CSM is sensitive to ensuring that the hidden curriculum is not supported in formal learning experiences. An audit was performed of our small group cases to ensure that any negative references to Family Physicians or Allied Health Professionals are removed.

University of Alberta

The hidden curriculum is a powerful socialization force in medical education going beyond what is taught in the formal curriculum to include mixed messages students perceive when they step outside the classroom. We have sessions on professionalism and the hidden curriculum to expose it. “Physicianship Discussion Groups” bring together small groups of students and a faculty regularly during each year of the program to discuss topics, including the hidden curriculum.

To help students better balance curricular requirements and para-curricular interests, students have a half day of protected time in most weeks to pursue work with formalized communities of learning (e.g. Social Justice, Research, or Arts & Humanities). A full day each week is also protected for students to pursue para-curricular interests, to study, to shadow and to look after their own physical and mental health. Our student affairs office has introduced activities during mental health week to support students and to reduce the stigma around mental health issues.

We have a system for confidential or anonymous reporting student mistreatment and professionalism lapses reviewed by an Associate Dean Professionalism and a triage committee.

The strongest disconnect in the hidden curriculum is about Physician Health. Students are encouraged to look after their own mental health, but work with faculty who may not be looking after their own health. Despite having a “26-hour rule”, some clerkship students still perceive that working long hours is favorably regarded by staff.

Our faculty recently appointed an Assistant Dean for Faculty Wellbeing to support faculty members.

University of Saskatchewan

Current Status:

Acknowledging that the hidden curriculum may be protean and difficult to define, we have focused to date on several specific attitudinal areas within our undergraduate program.

- Overlapping with Recommendation 7, we have intentionally addressed the sometimes evident sense of intra-professional hierarchy or perceived value of the different medical disciplines by ensuring diversity of perspective in our Curriculum Committee and the working Sub-committees of Curriculum Committee. We have acknowledged a shared understanding of the goal to prepare students to succeed in any post-graduate career path. Teachers in the medical program are drawn from all streams of medical study and practice.
- Inter-professional relationships and collaborations are a second area which may be adversely impacted by a hidden curriculum. From a perspective of interactive engagement to establish foundational collaborative context, In our program we facilitate undergraduate student interaction with students from other health science or related colleges through inter-professional case based sessions and patient narratives within curriculum and curricular time/support for first year student attendance at IPASS an annual inter-professional conference organized by student members of the Health Sciences Students Association. Additionally, extra-curricular IPE activity opportunities are shared with health science students from various U of S Colleges through a new IPECT app recently introduced this year.
- Recognizing the potential for conscious or unconscious bias to impact ideal engagement with the role and responsibilities of a health care provider, our Medicine and Society I course

intentionally highlights the nature and hazards of bias particularly with reference to vulnerable populations. Populations specifically focused on in this course include indigenous peoples, new immigrants, people who identify as LGBTQ2S, and those with mental health concerns.

University of Manitoba

The curriculum material is stable.

Northern Ontario School of Medicine

Over the past two years there has been an increasing focus at NOSM on student well-being and addressing the long-standing medical culture which has ignored the well-being of physicians. The Student Wellness Committee and the recently constituted School-wide Task Force on Wellness have as goals creating a fully integrated culture of respect, kindness, professional collegiality and civility in which students, faculty and staff can speak up and give appropriate feedback without fear of reprisal or negative outcomes.

The other common “hidden curriculum” is a devaluing of Family Medicine as a discipline and a career choice. NOSM students experience eight months in third year based in Family Medicine and historically NOSM has had the highest percentage of graduates choosing Family Medicine in Canada

A key element in this area requires a commitment to the professional support of staff, faculty and learners. At NOSM our work-life culture has approaches for all stakeholders including our staff and faculty. We strive for a healthy working and learning environment through addressing harassment, discrimination and racism. In Northern Ontario addressing the issues of racism as a result of a legacy of oppression and colonialism are front and center in our policies, procedures and the curriculum. We believe the concept of the ‘hidden curriculum’ should be interpreted in a more inclusive way – the FMEC definition fails to acknowledge the issues raised by the TRC and the RMWG.

Schulich School of Medicine and Dentistry, Western University

Schulich leaders, faculty, staff and students are committed to “a destination of choice for exceptional education and learning.” The Program competency-based curriculum addresses this key outcome via:

- A Longitudinal four-year course supporting student professional identity: “*Professionalism, Career and Wellness*”, delivered using active class learning and small group sessions. Objectives include better understanding and empowering skills to address the Hidden Curriculum and evolving professional and personal competency for a healthy career.
- Monitoring and improving learning outcomes using data from the learning environment surveys, courses and student experience.
- Reflective practice incorporated into the curriculum addressing the Hidden Curriculum
- Career and personal counselling through our Learner, Equity & Wellness (LEW) Office and Program Mentorship Program.
- Students are assigned to a single faculty Academic Coach for the first three years. The Coaching role is not mentorship, but to clarify academic goals and work to address issues impacting the student’s academic success.

- Our School, working in partnership with our clinical affiliates, mirroring processes in health care, has launched a process with students, staff and faculty to understand and continually improve the learning environment through an outcome driven process.

McMaster University

McMaster has sought to address the hidden curriculum using multiple approaches:

- As problem-based learning (PBL) is a mainstay of the McMaster medical program, we are looking at how the use of PBL to illustrate the epidemiological distribution of disease contributes to implicit bias with respect to specific patient populations. We are examining how the distribution of disease should be reframed within the structural, historical, political, and other systemic influencers of the social determinants of health.
- We have had a sustained effort within the PBL curriculum to have cases be more broadly representative with respect to patient demographics and identities. Additionally, cases are carefully considered to intentionally provide examples of where generalist physicians make challenging diagnoses and begin care before involving specialists where cases had previously often followed the pattern of the specialist solving the missed diagnosis of the generalist.
- McMaster has been collaborating with researchers at University of Toronto to examine how non-intrinsic CANMEDS roles are taught and assessed in medical education. This project has led to the addition of explicit sessions on epistemology and world views among others to help students understand the varied means by which knowledge is generated, prioritized, and used. While the scientific method is essential to the practice of medicine, physicians also need to understand the generation of knowledge more broadly to address the health needs of their patients who have a breadth of epistemological perspectives. The hidden curriculum of prioritizing scientific over other perspectives is harmful to patients and this project is beginning to make this more evident to students.
- We have also been increasing the number of large group sessions that originate in our Regional Campuses to challenge the hidden curriculum that ‘experts’ work in larger centres and that there is less expertise in community centres. We have a minimum number of sessions that we aim to deliver from our Regional Campuses in each course.

University of Toronto

- The Faculty of Medicine launched an ongoing series of “Voice of” surveys in which learners from across the continuum of medical education as well as faculty are asked demographic and experiential questions, including with respect to medical school and clinical organizational structures and cultures. This survey data informed the identification of several priorities for action, including “optimize our learning environments to deepen the integration of wellness, respect and resilience”, in the Faculty of Medicine [Academic Strategic Plan 2018-2023](#).
- Over the 2019-2020 academic year, the Vice Dean, MD Program met with every academic department to present and discuss mistreatment data relevant to their clinical discipline.
- Informed by “Voice of” and other survey data as well as education scholarship, a Faculty of Medicine Optimizing Our Learning Environments Working Group developed recommendations intended to address barriers that impact both the reporting of mistreatment by learners and the ability of education leaders to address concerns brought forward by learners. One recommendation was for the establishment centralized Faculty of Medicine leadership to address learner mistreatment (see next).

- Two new mutually-related Faculty-level leadership positions have been created to promote a culture of professionalism across the Faculty of Medicine and address learner mistreatment: Director, Professional Values Program (filled in July 2019) and Director, Learner Experience (filled in May 2020).
- Under the leadership of the Director, Professional Values Program, the development of an e-module for medical clinical faculty on professional values is well underway, with an anticipated completion date of April 2020.

Queen’s University

Much of our progress on hidden curriculum has been in relation to the mistreatment/unprofessional behaviours students either witness or experience as this is one way the learning environment may not reflect the values and behaviours in our formal curriculum. Although not “curriculum”, it speaks to our efforts to increase students’ trust in our processes: when they report things, we listen. We have developed a specific process for addressing student disclosures about negative learning experiences with faculty and this process has been shared with students, as well as a summary of outcomes so students are aware something is being done. This reinforces formal curriculum and exposes the hidden curriculum for what it is.

Other highlights:

- Learning Environment survey extended to preclerkship and adapted by PGME so messaging in the LE is consistent
- Family Medicine Working Group, looking at the extent and impact of hidden curriculum around specialty choice for career
- Addressing ongoing challenge of attitudes embedded in hospital cultures through the Hospital Liaison Committee. The committee brings hospital and UGME leadership together to discuss and address issues of hidden curriculum related to student mistreatment; also looks at quality of resources, e.g. call rooms, wifi access etc.
- New AS “professional reps” positions, whose role to dialog with leadership about unprofessional behaviours seen/experienced in the clerkship. They meet with the Assistant Dean Academic Affairs and the Professionalism Lead
- Distribution of wallet cards to all students with information on how to report positive and negative learning experiences in the curriculum in all 4 years.

University of Ottawa

In addition to 2015 responses the following have been implemented:

- Faculty of Medicine Professionalism website (under Professional Affairs) which outlines the explicit professionalism policies and procedures for faculty, postgraduate and undergraduate trainees, along with description of the professionalism program and curriculum -under revision for updates currently
- Incident report will have alongside a new Kudos report- to celebrate exemplary professionalism
- In clerkship there are now 4 mandatory professionalism Self Learning modules including a module on mistreatment and on boundaries
- Boundaries remediation module for faculty supervisors – under construction
- Yearly professionalism workshops offered to faculty through the Faculty Development Office

- The 4-year reflective eportfolio program for students whereby coaches provide support and opportunity for debriefing on all core competencies, including professionalism
- UGME Professionalism Committee with student class representatives and faculty which meets three times yearly to review and provide feedback on the professionalism curriculum

McGill University

The Faculty has taken a proactive approach to encouraging and teaching professionalism in order to enhance positive elements of the learning environment, as identified through student feedback. Formal training for faculty in professionalism skills is available through two routes: faculty development open to all faculty members and the targeted Faculty Development Program for Osler Fellows. Skills related to professionalism, such as role modelling, are developed through faculty development workshops open to all faculty members. These programs are often attended by faculty who are education leaders in their own units, who in turn serve as role models and resources for their peers, contributing to a local culture of high standards of professionalism in the learning environment. In addition, a select group of faculty members are Osler Fellows. Osler Fellows lead a small group of six students through the Physician Apprenticeship program in the MDCM curriculum. Small group discussions about professionalism and professional identity formation give our medical students tools to critically evaluate behaviours they observe in the clinical learning environment and address the hidden curriculum in a non-threatening experience. This is an important pedagogical approach that equips learners to benefit from positive role models, and to minimize the negative impact of unprofessional behaviours they may witness. A Wellness curriculum supported by the Assistant Dean, Student Affairs, also helps address the hidden curriculum and related effects that students could be experiencing, such as ethical erosion and a decline in empathy.

The Faculty of Medicine Code of Conduct underwent a major revision in June 2019. It applies to all learners, teachers and other members of the Faculty of Medicine. It is introduced on the first day of medical school and is a focus of discussion at multiple junctures in the formal curriculum. The UGME Policy on Student Professional Behaviours holds students accountable to these standards (<https://www.mcgill.ca/ugme/policies-procedures/professional-behaviours>), as does the University's Code of Student Conduct and Disciplinary Procedures (https://www.mcgill.ca/secretariat/files/secretariat/code_-student_-conduct-discipline-procedures_april_2013_final_revised_1.pdf). Academic Affairs follows up on disciplinary measures or unprofessional behaviours regarding teachers.

Université de Montréal

Students have joined the Faculty executive to promote family medicine as a rewarding discipline, as a medical specialty in its own right, and as a career choice. Many of our students choose family medicine as their first choice for residency training.

We support our students in their career choices with many opportunities for group and individual meetings. We inform students of the risks associated with unauthorized electives (rogue electives) as well as identify alternate ways to enhance the residency match.

The Faculty advocates respect for all people and the promotion of well-being. We aim to minimize undue pressure on learners regarding the internship workload. As such, we have developed policies to guide expectations, such as the policy on hours worked in the clerkship, and on accommodating pregnant students. Student time off, such as the day before exams and from noon on the day of the

residency match, are examples of the support offered by the Faculty to students. Adherence to the hours-work policy is monitored in the evaluation of each placement setting. The student records any excess hours worked.

If a negative influence is exerted during a placement, the student can report it without risk of reprisal through the evaluation of the placement, or through the "red button" directly linked to the University of Montreal's Office of Intervention in Harassment Matters.

Université Laval

At Laval University, the negative aspects of the hidden curriculum are explored formally in the Physician, Medicine and Society courses (I to IV) and informally in the interest groups. The Faculty of Medicine has adopted codes of conduct and policies that govern medical students and faculty members: code of professionalism for medical students; code of faculty professionalism; code of conduct for teachers; policy against harassment, intimidation and violence; policies on relations with industry and private companies; policy on the management of residency program funds, etc. A reference framework on social accountability and professionalism was also adopted by the Faculty of Medicine Council in June 2013. A plan to disseminate these codes and policies to students and teachers has been implemented in all settings. The Faculty has ensured that clear mechanisms for remediation and response to potential adverse events are in place.

Université de Sherbrooke

Since the implementation of the new program, the FMHS offers 4 new pedagogical activities dedicated to learning reflective practice and developing professional identity, deployed over the 4 years of the program, including :

- interactive workshops in small groups on a variety of themes including the hidden curriculum, prejudice, stress management, social responsibility of physicians, vulnerability, resilience, complexity and uncertainty, and medical error;
- the use of reflective portfolios to support identity development;
- coaching by a teacher-mentor throughout the four years of the program to facilitate the progression of professional identity in a favourable climate.

In addition, the new curriculum proposes the integration of the professionalism and ethics dimension within the pedagogical activities when relevant and according to the most frequent issues encountered in practice. In addition, to counter the impact of the hidden curriculum, the FMHS opts for an approach that promotes exemplary behaviour through:

- dissemination and promotion of the FMHS-Respect site and the FMHS Code of Conduct;
- multiple ways to report breaches of the code of conduct;
- several opportunities to highlight the presence of inspiring role models;
- optional recognition of exemplary behaviour (e.g., the "Coup de cœur respect" award);
- meetings between the program management and representatives of the Student Association of the 3 training sites to discuss the student experience and their concerns in relation to the learning environment.

Dalhousie University

Create culturally safe ways for students and faculty to make the hidden curriculum explicit and relevant to the formal curriculum: The Faculty of Medicine involves students at all stages of curriculum design, development and implementation. Students are encouraged to explore aspects of the hidden curriculum and provide suggestions to the faculty for inclusion in the formal curriculum. In addition, faculty development offers sessions entitled the “Hidden Curriculum” and “Role Modeling” on an annual basis for faculty, staff, and residents.

All clerks and their clinical faculty, at the beginning of clerkship, are required to sign a contract which outlines the roles and responsibilities each party has to each other on matters dealing with professional behavior. The hidden curriculum is explicit in this document. Over the past two years, the curriculum has focused on increasing the positive aspects of family medicine. This has included a review of cases and remove inappropriate or negative comments about family physicians, with the goal to increase the engagement and profile of family medicine through all aspects of our undergraduate training.

Encourage ongoing mentorship programs to provide guidance for learners in such activities as choosing electives, engaging in research, getting involved in the community and making career choices: Through student affairs, considerable effort has been made to guide elective setting, engagement in research, and residency and career choices. Students get community experiences through the Rural week program, clerkship electives and LIC experiences.

Engage students and faculty from different schools in discussing the challenges of the hidden curriculum and in share in ways to address it constructively: Students from a variety of health professions backgrounds are invited each year to enroll in the MEd program offered jointly by Dalhousie Faculty of Medicine and Acadia University. Topics dealing with the hidden curriculum are presented to learners. Through student feedback and accreditation planning, there is opportunity to learn from other institutions about how they are managing these important issues.

Expose students and faculty to the effects of the hidden curriculum on learners by using data and research: All students are introduced to the concept of hidden curriculum through the Research in Medicine (RIM) curricular sessions. Here, the hidden curriculum is explored as a potential area of research. We have also performed an explicit review of our preclerkship curriculum cases to quantify and eliminate areas of “hidden curriculum” context by one of our family medicine faculty.

Memorial University

As stated in the Strategic Plan, the Faculty of Medicine is committed to fostering an environment that encourages wellness for all, employing a number of initiatives to address the hidden curriculum in the MD Program.

The Dean of Medicine has committed to a working and learning environment which is free of bullying, intimidation, harassment, sexual harassment and sexual assault. A number of strategies have been implemented to optimize the learning and working environment, including policy development, website development, communication, education and supports. This is a high priority of *Destination Excellence*, and is managed through a culture of excellence project team and a wellness project team.

To help address the hidden curriculum, Memorial has also introduced large-group sessions and Integrated Learning Sessions which are co-taught by College of Family Physician of Canada certified physicians and Royal College of Physicians and Surgeons of Canada certified physicians. Both groups of physicians demonstrate their medical expert competency and impart their particular medical expert knowledge and experience on our learners.

Memorial prioritizes continuous quality improvement, offering regular quality improvement sessions to learners, holding responsive focus groups about the curriculum and its delivery, and including learner representation on all curriculum oversight and management committees. Memorial has also implemented regular meetings between learner leadership and Undergraduate Medical Education (UGME) leadership and a parallel arrangement with the Office of Student Affairs.

Learners have the opportunity to evaluate courses and faculty members who deliver curriculum content. Data from learners' evaluations of faculty performance are aggregated and sent to academic heads semi-annually and to the faculty, themselves, annually. In the event of an egregious complaint or concern the academic head receives a "Red Flag" notification and formal intervention is required. The "Red Flag" notification system has been recently reviewed and revised.

Recommendation 6: Diversify Learning Contexts

Canadian physicians practise in a wide range of institutional and community settings while providing the continuum of medical care. In order to prepare physicians for these realities, Faculties of Medicine must provide learning experiences throughout MD education for all students in a variety of settings, ranging from small rural communities to complex tertiary health care centres.

University of British Columbia

The province-wide distributed medical education platform is fundamental to the UBC Faculty of Medicine's structure and culture. MDUP students are exposed to a diverse range of communities and patient populations, and they are taught in underserved areas, including remote and rural areas and deprived urban communities.

Clinical education takes place in urban, regional, and rural/remote settings across BC. Year 3 core clerkships and Year 4 clinical electives are offered across the province at clinical academic campuses (larger, often highly specialized hospitals) and affiliated regional centres (medium sized hospitals in urban or non-urban settings) that incorporate rotation-based clerkships and integrated community clerkships (ICCs).

ICCs are currently delivered longitudinally at 6 sites with 24 students in total, located in rural and remote communities. Year 2 students apply to ICCs for their third-year clerkships. Students are selected on the basis of merit and in accordance with regional quotas. For their entire clerkship year, ICC learners are assigned to a primary preceptor in family medicine and work with patients whom they follow through various specialty clinics and other aspects of their care in the local community hospitals.

24 weeks of clinical electives are offered in Year 4, during which students can complete two or four-week rotations in a variety of disciplines, in-province, out-of-province and/or out-of-country.

University of Calgary

All CSM MD students will spend time in a wide variety of clinical environments.

In pre-clerkship, students have experiences in Family Physician offices (combination of urban and rural) through the Family Medicine Clinical Experience courses in year one and two. Students will spend time in inpatient and outpatient experiences in each of Courses I-VII during clinical correlation in settings ranging from primary to tertiary care. Similarly, in the Pre-clerkship electives course, in the career development program clinical block and in the clinical portion of AEBM, students will work in clinical environments that range from rural primary care to metropolitan tertiary care – and everything in between.

In clerkship, students will all complete both an urban and a rural family medicine mandatory rotation. Other clerkship rotations will span the breadth of clinical care from primary care to tertiary care centers. All of the four adult hospitals in Calgary and the Alberta Childrens' Hospital provide care that would be considered tertiary (and in some cases, quaternary) care. All students will spend time in one or all of these centers during clerkship.

The clerkship change for FM is having two four-week blocks, every student does one block rural, one block urban (starting with class 2021).

University of Alberta

Our curriculum takes place in many different settings including in the community with agencies that support diverse populations in first year and later as part of the Geriatric clerkship.

All students learn in hospital based in/out-patient settings and in community clinics. Students begin their clinical learning in Family Physician offices and can complete their Gastrointestinal health course embedded in a rural community. Required electives and informal shadowing are completed in any setting. The patient immersion experience pairs students with community members living with chronic conditions. Learning about living with chronic illness comes from their patient mentors.

All students do a minimum of 4 weeks of rural family medicine as part of their 8-week Family Medicine clerkship. The Surgery and Obstetrics/Gynecology clerkships are both structured so that each student spends time in both community hospitals, as well as in tertiary or quaternary centers.

Third year students have the option to complete their year in a rural community through a parallel longitudinal integrated community clerkship (ICC) in a family practice and follow patients through the multiple venues for care including the family medicine clinic, the hospital and the home. Communities chosen for the Rural ICC are located in northern and central Alberta and range in population size from 6,000 to 17,000. ICC students also work with a local community organization to develop and implement an initiative that meets a need in the community. New in 2019/20, students can request to complete their core 4th year clerkship rotations in Grand Prairie.

University of Saskatchewan

Current Status

In Year One of the pre-clerkship program, students participate in either an in-term community-based service learning project or a summer rural community experience. In Year Two of the pre-clerkship program, students engage in community agency-based service learning. For both pre-clerkship years, students are required and encouraged to participate in Shadowing of physicians and other health care providers in various clinical environments. The discipline specific clinical skills components also provide pre-clerkship students with exposure to different clinical environments within hospitals and other health care delivery settings.

In the Clerkship Year Three, students may be located in the Saskatoon campus, the Regina campus, the Prince Albert distributed site, or either of the two Longitudinal Integrated Clerkships located in smaller provincial centers. Students within the block rotation streams also participate in rural family medicine rotations. During all these Year Three options, students have opportunities for learning experiences within hospital-based settings and in outpatient clinics.

In Year Four, students have opportunities for Selectives primarily in the medical and surgical subspecialties, involving both in-patient and out-patient environments. Year Four also includes the Electives course, which includes a variety of generalist and specialty focused rotations, including indigenous health electives, urban and rural clinical rotations, palliative care, rehabilitative medicine, research, public health and others.

University of Manitoba

There are currently three students doing a longitudinal integrated clerkship in Brandon. Plans are in the works for expansion to Dauphin and Boundary Trails.

Northern Ontario School of Medicine

We offer very diverse settings and opportunities for clinical learning include more current issues such as racism, climate change and rural and remote health which are priorities. As well we provide exposure to the critical issues of mental health and addictions, end of life care, generalism and especially Indigenous health.

NOSM students continue to experience diverse communities and clinical settings across Northern Ontario from small remote rural and Indigenous communities to the large tertiary referral centres in Sudbury and Thunder Bay.

Schulich School of Medicine and Dentistry, Western University

Our vision “*Strengthen and develop sustainable regional and international partnerships and networks*” is based on twenty years of distributed education including the Windsor Campus, now a destination of choice for learners. Outcomes include increased numbers of Western graduates contributing to the Program in regional communities.

The Rural Admission stream attracts students aspiring to learn and practice in regional centres. Student voices visibly seek rural and regional learning experiences aligning with career choices and societal health care needs.

All Year 1 students complete a clinical *Discovery Week* in rural communities - often the initial stimulus to explore smaller communities. *Clerkship* learners complete a minimum 4-week rotation in a distributed site. Feedback from student evaluations speak to the value these learning experiences afford.

Our renewed Program curriculum protects one weekday for clinical and self-directed learning in Years 1 and 2. Students are encouraged to explore regional sites during the Year 1 *Longitudinal Clinical Experiences* - each paired with a Family Medicine preceptor. Team-based project learning in *Service Learning* and *Quality Improvement* include regional options. Regional summer learning is encouraged, highly valued and supported with funding by the School.

A priority will be to engage, retain and sustain regional faculty with support from Clinical Departments and the School. We are aware that this requires balancing teaching with growing clinical loads. The School currently supports DE regional academies with designated faculty leads. To recruit and retain distributed faculty requires tackling burnout, rewarding faculty contributions and developing skills as educators.

McMaster University

McMaster has a long history of encouraging students to practice in a wide variety of settings based on level of acuity/chronicity, access to resources, and comprehensiveness of care provision. We have also provided students with many opportunities to explore this variety.

Our distributed medical education network has continued to grow over the past five years. Additional community-based clinical sites have been added to this network, providing more opportunities for students to participate in core rotations in a broader variety of healthcare settings.

The addition of more community-based, CaRMS-entry residency position also provides students with opportunities to continue training in settings that align with their practice aspirations beyond medical school. This is a vital aspect of diversifying learning contexts. It signals to learners both that advanced training can be provided from centres outside of Academic Health Science Centres (AHSC); and that student practice interests beyond AHSC's is sustainable beyond medical school and valued.

Finally, McMaster has long encouraged students to seek out early clinical learning experiences, including in rural, small and large community settings, in generalist and specialist care. Students use these opportunities to explore healthcare delivery across our entire healthcare system. McMaster's medical students have also participated extensively in community-based delivery of healthcare services working closely with community health centres, within the shelter network, with newcomers, and with our vulnerably-housed population.

University of Toronto

The development of our new pre-clinical curriculum – Foundations – included a renewal of our Health in Community curriculum. In Year 2, our Community-Based Service-Learning (CBSL) curriculum and Enriching Educational Experiences (EEE) career-engaged curriculum provides students with the

opportunity to explore clinical intersections within their community-engaged learning placements. As part of their career exploration (EEE) shadowing experiences, students are required to seek out a clinician who serves the population(s)/communities that they work with for their service-learning placements. For example, if a student is placed in a community organization that serves clients with HIV/AIDS for CBSL, they will spend time shadowing a physician who treats patients with HIV/AIDS in EEE. Students are required to present a reflection on this experience, drawing on concepts in community health, social determinants of health, community development, career exploration and critical theory.

In its urban context, the U of T MD Program understands “diverse learning contexts” to include vulnerable patient populations that are embedded within the many geographic communities in the Greater Toronto Area. All clinical sites used by our Family and Community Medicine core Clerkship rotation have identified one or more vulnerable populations as priorities for their practice in the local community, and students assigned to those sites interact with the identified vulnerable populations as part of their required clinical learning activities.

Queen’s University

Pre-Clerkship Learning Contexts: We have added interprofessional observerships and new sessions for shared learning for nursing, medicine and rehabilitation students. Learning sessions have been reclassified to incorporate a variety of other teaching strategies, such as patient contact experiences and educational games. There has been expansion of simulation lab sessions, technical skills lab sessions and use of point of care technology (IE: POCUS).

Clerkship Learning Contexts: Clerkship now includes seven integrated sites encompassing south eastern and south central Ontario. Approximately 20-25% of the class participates in an integrated experience. In addition to this, students in block clerkship rotations are placed at a variety of regional partner sites and are away for at least 12 but up to 18 weeks. Student will experience at least three, but up to five different communities during the core clerkship experience. There has been expansion in to communities based on student interest (e.g. Akwesasane for Indigenous students).

University of Ottawa

The Faculty has many varied settings for clinical learning throughout their Distributed Medical Education (DME) network. These range from remote Indigenous communities to small rural towns to community hospitals to tertiary care centres. Students are exposed to these settings in each of their years of medical training and these exposures are mandatory and elective.

Barriers – There are ongoing challenges in finding housing for learners in rural areas. Travel to and from the sites is difficult as well as travel within the communities. Also, maintaining our physician - teacher resources is a constant challenge in rural areas.

McGill University

At the Faculty of Medicine of McGill University we seek to be relevant to the society we serve and the greater global context through excellence in our missions of education, research and service. Within our health professions programs and scholarly degree programs in health we provide training and educational opportunities that address the needs of the society we serve. We promote diversity within the Faculty, as defined in our diversity statement, understanding that promoting our internal diversity will better serve our diverse communities. We deliberately build environments of inclusion in order that

all individuals within our Faculty can be welcomed and respected, and can participate freely and to the best of their ability in our missions of excellence in discovery, learning, and service. We address concerns of Faculty equity through programs aimed at increasing the participation of historically marginalized persons in Faculty life and programs. We commit to equity in health through service to our communities, in full partnership with them, and with special attention to the impact of our activities in education, research and service on vulnerable and marginalized populations. Through engagement with the communities we serve, we listen to their identified key health priorities, and commit to incorporating this community voice into the educational, research, and service goals of our Faculty.

The strategic plan for the new undergraduate medical curriculum entitled *Think Dangerously: Toward a New Curriculum* recognized the societal need to increase the number of medical graduates who choose family medicine as a residency. Therefore, family medicine exposure in the new curriculum (which graduated its first class in May 2017) is longitudinal in order to allow for early, repeated, and varied exposure to the expertise of family doctors. In their first year of the medical program, students attend a family medicine clinic every two weeks as part of the Longitudinal Family Medicine Experience (LFME) course. In second year, Family Medicine is part of the Comprehensive and Consultative Health Block of Transition to Clinical Practice (TCP). Students are exposed to primary care settings including long-term care settings, with emphasis on interprofessional practice and common medical issues addressed in primary care. During third year, students complete an eight-week family medicine clerkship course. In the four-week urban segment of the course, students work both in follow-up clinics and walk-in clinics and often in an academic family medicine milieu. During the four-week rural family medicine segment, they witness and take on the various roles of a rural family physician, often including inpatient, obstetrical and/or emergency department care in addition to outpatient clinics. Family medicine electives are also available to students in third and fourth year clerkship. Students completing their third year of clerkship in Gatineau do family medicine clinics longitudinally during the 48 weeks of third year clerkship and have weeks of inpatient medicine on the family medicine unit. Most clerkship clinical courses also include exposure to ambulatory settings.

Specific Marginalized Populations: There is an Indigenous Health Professions Program (IHPP), led by Dr. Kent Saylor, a Mohawk pediatrician. This program is advised by the Indigenous Health Professions Program Advisory Board, which includes community leadership from Indigenous communities within the RUIS. The identified needs are recruitment and training of Indigenous health professionals, as well as curricular content. There is a public health stream to the UGME MDCM curriculum, led by Dr. Anne Andermann, which specifically targets required curricular content and educational opportunities within the social determinants of health, based upon identified priorities from public health data. Students are also exposed to vulnerable populations in the second-year service learning course in which they are placed in approximately 70 non-governmental organizations within the city of Montreal.

Université de Montréal

Students are showing an ever-increasing interest in joining the integrated longitudinal clerkship (ELC) in the Mauricie region. However, these clerkships are very time-consuming for family physicians, forcing us to limit the number of participants to 14 out of 40 students annually at the Mauricie Campus.

Our goal is to raise early awareness of medical education in remote areas, for example, through a PBL session on transporting Inuit children requiring specialized care and a parent. In addition, we offer

electives in Aboriginal settings.

All students complete a week of palliative care internship, most of which are in small palliative care homes.

During the Commitment to Social Medicine Week, students visit community settings caring for vulnerable people, such as prisoners, substance abusers or sex trade workers, in the company of community workers. The external participants are invited to share their experiences at the end of the week during a plenary session.

Urban family medicine clerkship settings in medically underserved areas are being added to those already in place. This will allow students to be in contact with populations in urban areas, but living in disadvantaged contexts and further away from major tertiary and quaternary centres.

In addition to our 18 CUMFs (University Family Medicine Centres) distributed throughout the territory of Quebec for exposure to primary care, our students benefit from extensive exposure to complex tertiary environments, such as the new Centre hospitalier de l'Université de Montréal, the Centre hospitalier universitaire mère-enfant (CHU Sainte-Justine), the Montreal Heart Institute and the Institut national de psychiatrie légale Philippe-Pinel, not to mention five CIUSSS (Integrated University Health and Social Services Centres).

Université Laval

Laval University is constantly improving students' exposure to the diverse realities of medical practice through internships in urban, semi-urban, rural, intermediate and remote areas. Students are also exposed to community settings, routine intra-hospital and ambulatory care, as well as tertiary and quaternary care. A longitudinal integrated clerkship site in Baie-Comeau has recently been added to the Joliette, Rimouski and Lévis sites, and other sites are under development. The mandatory family medicine clerkship is carried out in regional settings. In addition, Laval University offers clerkships with vulnerable populations, Aboriginal communities, emerging countries, etc. Since 2012, the clinic's introductory activities have been raising students' awareness of patients' experiences in various care contexts. They include observation blocks on the work of physicians and other professionals in different contexts: outpatient clinics, acute care units, palliative care units, rehabilitation units, home visits, minor and major emergencies, private clinics, university teaching clinics (GMF-U), etc. Students must also participate in community activities in community organizations. Finally, the program relocation project will promote learning that encourages clinical exposure, and the Faculty is currently working on developing a patient partner office to involve citizens more in the training of medical students.

Université de Sherbrooke

In order to diversify learning contexts, the program management offers :

- varied opportunities for clinical exposure, including:
 - half-days of clinical immersion and accompaniment of various health care workers in various settings at the various training sites;
 - an integration internship (2 weeks) in multiple and varied clinical settings in Quebec and New Brunswick, starting in the second year of the program;

- the obligation for all externs to spend at least 8/48 weeks in a setting other than their basic training site and 20/48 weeks and a maximum of 8 weeks of elective training in the same discipline;
- an integrated longitudinal clerkship in remote and urban areas;
- recognition of internships in Indigenous health, global health in different settings at the provincial, national and international levels;
- opportunities for exposure to a variety of community settings:
 - community Service-Learning activities;
 - community-based project management.

Dalhousie University

Create opportunities for early and extensive learning in a variety of community settings, including longitudinal and integrated clerkships: Longitudinal Integrated Clerkships have now been established in five communities across two provinces, with a sixth, in the South Shore of Nova Scotia, due to start in 2020, for a total of 25 students, and with a goal of continuing expansion. Rural week takes place at the end of first year exposing all students to rural practice in the Maritimes.

Develop specific objectives for learning in community contexts throughout MD education: A new LIC curriculum and assessment process that more appropriately aligns with the LIC learning experience was launched in 2019, with the first comprehensive summative exam will be in the fall of 2020.

Develop specific objectives for learning in community contexts throughout MD education: The Dalhousie program is founded on four overarching objectives; Life-long Learner, Professional, Skilled Clinician, and Community Contributor. As such, the program has specific objectives and opportunities relating to learning in community contexts throughout the four-year program.

Promote an organizational culture that positively reinforces the value of multiple learning sites in MD education: Teaching and learning opportunities throughout the four-year program extend across 100 learning sites. Dalhousie is considered the “Medical School of the Maritimes” spanning three provinces – unique to other Canadian medical schools.

In line with *Destination Excellence*, learners have active, engaged, empowering and authentic community-based experiences that include longitudinal learning activities.

Memorial University

In Phases 1 through 3 learners complete the Community Engagement course, during which they participate in clinical and community service opportunities to experience the integration of primary health care and the community. Learners begin these Community Engagement experiences at urban family medicine clinics. In each of Phases 2 and 3, learners complete two-week rural clinical and community experiences.

The Core Experiences course in the third year of the MD Program is delivered within urban and rural hospital and clinical settings within Newfoundland and Labrador, New Brunswick, Prince Edward Island and the Yukon. The eight-week Family Medicine core experience is delivered in a rural setting. The Core Experience course may also be completed at one site in New Brunswick as a 48-week Longitudinal Integrated Clerkship which runs in parallel to the block-based rotations. Similarly, through the Advanced

Practice Integration Course, learners have the opportunity to complete Progression To Postgraduate, a twelve-week selective opportunity in a rural setting, during which learners follow patients as they interact with the health care system.

The Global Health Office continues to provide a well-scaffolded learning context for international experiential learning with pre-departure training and de-briefing. Our International Summer Institute for Global Health Training (InSIGHT) program is in its eighth year and has led to a robust collaboration with a medical school in Nepal. The global health office has also established partnerships with other medical schools in South Africa, Australia and Uganda, facilitating opportunities for diversified learning. In addition, our Service Learning program offers clinical experiences in inner city clinics and a Refugee health clinic.

Recommendation 7: Value Generalism

Recognizing that generalism is foundational for all physicians, MD education must focus on broadly based generalist content, including comprehensive family medicine. Moreover, family physicians and other generalists must be integral participants in all stages of MD education.

University of British Columbia

The MDUP values generalism, including comprehensive family medicine. Students in the MDUP have scheduled office visits (approximately 28) with urban family physicians in Years 1 and 2. They have 4 weeks of rural family medicine in Year 3, and options for Year 4 electives across the province with family physicians in a wide variety of practice styles, ranging from solo clinic practice to team-based care.

Family physicians have made significant contributions to the MDUP curriculum, such as in case development for case-based learning (CBL), and delivery of lectures that support CBL. Family physicians also form the basis of the Longitudinal Integrated Clinical Clerkship program for 24 of the Year 3 students.

Physicians in generalist specialties are integral participants in all years of the MDUP. They participate in CBL development and instruction, lecture delivery, and clerkship preceptorship in internal medicine, psychiatry, pediatrics, and general surgery.

MDUP graduates entering Family Medicine residency has increased from 34% (2003) to 40% (2011) and further to 45% (2014)*. For those entering generalist specialties, the proportion remained stable: 28% (2003), 28% (2011) and 29% (2014)*.

*based on MDUP entry year.

University of Calgary

We have a very strong emphasis on family medicine and generalism in our curriculum.

Family physicians and other generalists make up a significant proportion of UME leaders. The UME Associate Dean is both a Family Physician and a General Pathologist.

Family physicians specifically provide the majority of the teaching in our flagship longitudinal course, Medical Skills.

In both year one and two, students complete the Family Medicine Experience course. In these courses, students are paired up with a family physician preceptor and spend a series of three or four half-days with that preceptor in his or her clinic.

Within the clerkship, family medicine is emphasized as an important rotation. Beginning with the class of 2021, we have adjusted our clerkship schedule. Students will complete an eight-week mandatory family medicine clerkship (increased from six weeks).

University of Alberta

As a socially accountable medical school, we strive to train physicians, including clinician scientists, educators, and leaders, to serve and be accountable to the populations we serve. Generalism is considered throughout program development starting with medical student selection. We incorporate generalism as a core value that all physicians should understand and incorporate in practice.

Our program has broad generalist representation in the faculty guiding learning. Our MD Curriculum and Program Committee, has designated positions for both generalist family and specialty trained physicians. Approximately 30 different working groups review the curriculum as part of a continuous quality improvement process and each working group includes generalist physicians from a variety of disciplines. All course objectives and content are reviewed periodically from a generalist perspective. We continue to deliberately increase the amount of teaching and mentorship provided by generalists, recognizing the importance of role models whose practice incorporates these important values as a strong and important influence on identity formation.

Our curriculum is designed to develop health care providers who better understand the community context, the patient's total health status, and are able to respond to patient and community needs. We partner students with people living with chronic disease and community agencies serving diverse populations to help students understand health needs and the importance of a broad approach. Students learn the generalist role within the health care system in community based and tertiary care contexts to appreciate that a physician can be a specialist while still considered a generalist who delivers a broad scope of practice.

University of Saskatchewan

Current Status

Generalist clinicians are extensively involved in undergraduate curriculum. The majority of our Year Chairs/site Chairs and Course Chairs are generalists, as are the majority of our pre-clerkship course

directors and many of the faculty engaged in administering and teaching throughout the undergraduate program.

A generalist perspective is embraced in the program curriculum focus and delivery for all pre-clerkship courses. Students have opportunities for clinical experiences in generalist environments in the pre-clerkship clinical skills courses as well as throughout clerkship. Clerkship years include required experiences in generalist contexts for internal medicine, paediatrics, comprehensive family medicine, psychiatry, surgery, and emergency medicine. Additional elective opportunities are available in generalist medical fields for students in Year Four of clerkship.

As part of our cyclic course review quality assurance/improvement process, course objectives and content are reviewed in the context of the 10 FMEC recommendations including value generalism. The reports generated from this peer-review process are provided to the course leadership and the curriculum committee solicits the course director's actions in response to these reports after an appropriate time period.

University of Manitoba

- We now have 35 students per year doing the Home for the summer program.
- All clinical reasoning instructors in Med I and Med II are generalists.

Northern Ontario School of Medicine

NOSM continues to have strong focus on generalism and Family Medicine as outlined in our previous response. Family physicians are involved in teaching medical students from the first year when they act as small group facilitators, through the second year when students spend two four-week blocks in a rural family practice, through third year where students are based in Family Medicine. In addition one of the co-chairs of the UME Curriculum Committee is a Family Physician and many family physicians contribute on the various Theme committees that drive and oversee the curriculum. The Dean and Vice Dean at NOSM are family physicians as are a majority of faculty.

Schulich School of Medicine and Dentistry, Western University

The vision of School Program curriculum development, delivery and improvement is education experiences with and from generalists. "Generalism" is a competency of care demonstrated by specialist and primary care clinicians. Our school is proud of consistent annual residency match outcomes with over 45% Family Medicine and 30% other general entry level disciplines.

Learner data supports early and longitudinal generalist exposure. Year 1 students have mandatory clinical learning with Family Physicians (*Discovery Week* and *Longitudinal Clinical Experience*). Other learning supports generalist educators in various sessions and student opportunities for self-directed generalist learning and mentorship. Scholarship and team-based projects are delivered with generalists. Students in Year 3 *Clerkship* complete a mandatory clinical learning rotation in regional sites.

A strategic goal of the renewed Program curriculum is supporting generalism as an outcome through engaging generalists as essential educators, leaders and mentors for learners across the four-year program.

The key to success is having visible and valued generalist leaders and educators. This has been a challenge. The role of generalists in many academic departments must be prioritized for recruitment to mitigate competing education and clinical care specialty demands. This is critical to ameliorate hidden curriculum influences that may turn students away from generalism. We will prioritize graduating generalists across identified specialties, including Family Medicine. Identifying and supporting clinicians who demonstrate generalism becoming education leaders is essential.

McMaster University

McMaster has a long history of valuing generalism throughout our program and curriculum. Our Department of Family Medicine (DFM) has long had a high degree of respect in the community and institution. Their leadership has been important throughout the MD Program's history of valuing generalism.

The DFM worked very early on with the MD Program to develop an early clinical exposure to family medicine practice. Every medical student participates in this program within the first year of medical school. This opportunity is combined with McMaster's belief that even early medical students can take their learning to date and apply it to real patient care, even in the first year of the program. This exposure gives students an early appreciation of the role of Family Medicine and primary care within the healthcare system, an important opportunity to begin practicing and applying knowledge and skills that they are learning in the rest of the medical program, and provides exposure of all learners to the possibility of a career in Family Medicine. As a result, McMaster has regularly had a strong representation of students matching to Family Medicine in the residency match and choosing Family Medicine as their career.

Within the Medical Foundations curriculum, an increasing number of problem-based learning (PBL) cases have been re-oriented to 'value generalism'. Very often, the natural course of PBL cases has the patient assessed by generalists who do not make a diagnosis and then referring the patient (or even failing to refer the patient) to a specialist who makes the diagnosis. In practice, this is very much the opposite of what commonly happens. Far more often, the generalist makes the diagnosis, begins optimal treatment, and refers appropriately for complex cases or assistance with treatment management. A number of our PBL cases have been re-oriented to reflect this reality.

University of Toronto

Generalist principles informed the renewal of our pre-clinical curriculum, Foundations. The Undergraduate Education Committee in the Department of Family and Community Medicine (DFCM) reviewed the mid-level design of the entire Foundations curriculum. In order to complete this review, the committee developed an evidence-informed approach to ensuring generalist principles informed curricular development. The Toronto Generalism Assessment Tool (T-GAT) was deployed to review all case-based learning (CBL) modules in the Foundations curriculum.

All new Family Medicine preceptors must complete a DFCM Undergraduate New Preceptor Practice Profile. The Practice Profile captures information that ensures that community-based sites for our required year 2 Family Medicine Longitudinal Experience (FMLE) are focused on general Family Medicine practice, rather than specialty clinics.

Queen's University

Our approach is based on The Royal College report of the Generalism and Generalist Task Force, from the Canadian Consensus Conference on Generalism 2012 *which* provides the following guidelines:

“Generalists are able to provide broad-based medical care, cutting across disease pathologies or systems within the body. Using this understanding, they excel at differential diagnosis, particularly for complex or undifferentiated patients. The generalist, aware of a patient’s social circumstances, is able to understand the patient in the context of their world and can therefore effectively intervene to prioritize care.”

Changes since 2015:

1. New course in 2nd year features case studies of patients with undifferentiated presentations that explicitly connect with their social circumstances. Taught by generalist physicians (emergency and family doctors) and highlights important physician skills like professionalism and advanced concepts in communication. Student evaluations have been very positive.
2. This case study format has also been added into the C-courses with new weekly structured cases using the same format and with a focus on generalist teachers in MEDS 471.
3. Enhanced opportunities for integrated clerkships allow students to embed into a smaller community for a prolonged period. This provides students with real life connection to practicing generalists and longitudinal exposure to patients and their unique social circumstances

Areas of renewed focus:

1. Core curriculum still primarily taught from a specialist point of view with majority of pre-clerkship clinical foundations course content delivered to students via a discipline-specific specialist lens

University of Ottawa

Generalism has always been valued at the Faculty of Medicine of the University of Ottawa. Many family physicians have been important leaders at the school. In 2020, we still have important input from leaders in family medicine in regards to the curriculum completed by our students. At both the pre-clerkship and clerkship levels, numerous family physicians are teaching our students through CBL, the community preceptor program and the different lectures offered to students. We also have many family physicians who coach students through the ePortfolio program and others who are part of our admissions’ committee.

We will also introduce a family medicine bootcamp in 2020 offered to all incoming first year students in order to promote generalism and family medicine. Some of the challenges we have faced include the limited number of lectures offered in pre-clerkship by family physicians in certain units. Some of the units have very strong representation from family physicians, but some fields of medicine are taught mainly by specialists with little content presented by generalist physicians. However, the Faculty ensures that even when specialists are teaching medical students, they present generalist content to the students. Another challenge resides in providing similar comprehensive views of family medicine to all our family medicine clerks. During their rotation, the students are paired with physicians in rural, urban and semi-rural settings. Ensuring that all students receive a similar experience proves to be challenging, but most students are very pleased with their learning opportunities. The MD program continues to ensure generalism principles in student electives and is more rigorous in ensuring students have broad ranging electives than would be permitted by the AFMC electives diversification guidelines alone.

McGill University

In addition to the LFME course, family physician-led clinically-oriented lectures were added to the different courses of the first component of the MDCM program, Fundamentals of Medicine and Dentistry (FMD), to address this issue. The aim of these newly-added interactive lectures is to demystify the role of a family physician in the care of patients with specific and yet complex issues, while bringing an evidence-based approach to the practice of family medicine.

Other principles of generalism are imbedded in the MDCM curriculum. The importance of the doctor-patient relationship is addressed in the Physicianship curriculum. Students learn about and experience during their clinical exposure concepts such as patient-centred care, recognition of a patient's illness and suffering, and healing. Interprofessional care is valued in the program and medical students participate in interprofessional courses with the other health care profession students of the Faculty of Medicine.

Université de Montréal

Quotas of patients monitored were assigned to family physicians by the Ministry of Health so that they increase their clinical load. This new load has decreased the time spent teaching first and second year medical students. Nevertheless, the proportion of family physicians among our teachers and professors is gradually increasing. A family physician is co-responsible for the Breathing and Oxygenation course in second year, and the Assistant Director of the clerkship is also a family physician.

We encourage students to remain open in their career choices and to diversify their interests. We participate in the national initiative to diversify electives and educate our students about the importance of generalist training.

We consolidate our students' generalist learning, for example, in the monitoring of chronic diseases, or through themes such as gender identity.

In the 2019 residency match, 55% of Montreal students and 74% of students from the Mauricie region have matched in Family Medicine, for an average of 58% at the University of Montreal.

Université Laval

The Laval University training curriculum is closely associated with pedagogical objectives of generalism and the field of study is circumscribed by a series of clinical situations directly related to the objectives of the Medical Council of Canada. The generalist disciplines are very much present in the leadership of the program and in the various committees. In addition, the mandatory clerkship rotations are structured around the basic specialties, known as generalists: internal medicine, family medicine, pediatrics, general surgery, obstetrics and gynecology, geriatrics, emergency and psychiatry. The development of the integrated longitudinal clerkship also promotes an integrative and generalist view of medical disciplines and practice. Also, the majority of teachers involved in the preclerkship are attached to the Department of Family Medicine and Emergency Medicine. Finally, since 2017, in cooperation with the Department of Family Medicine, strategies have been implemented to promote primary care medicine in teaching, as well as student activities to demonstrate to students the value of this type of practice.

Univeristé de Sherbrooke

Since the implementation of the new program, we have opted for :

- the integration of Generalism as the main orientation of the program;
- the choice of clinical situations and themes to be covered in the pedagogical activities, taking into account their frequency and relevance;
- the systematic involvement of core discipline teachers in the design and revision of all pedagogical activities;
- the active involvement of core subject teachers in the teaching of all pedagogical activities; and
- the establishment of a centralized teacher recruitment process to ensure interdisciplinarity and adequate representation of family medicine and other core disciplines in the delivery of teaching;
- the integration of the comprehensive approach in partnership with the patient in all clinical situations in the curriculum;
- the continuation of the mandatory clerkship in family medicine (7 weeks), anesthesiology (1 week), general internal medicine (4 weeks), general pediatrics (4 weeks), general psychiatry (4 weeks), general surgery (4 weeks), obstetrics and gynecology (4 weeks), and community health (4 weeks) as a clerkship.

Dalhousie University

Ensure that the health human resource planning process customized the mix of generalists and specialists in the physician workforce with the needs of populations: Currently, the human resource planning processes for Nova Scotia does take into account the need for the mix of generalists and specialists in the physician workforce with the needs of populations in a collaborative process involving both faculty of medicine and government Health HR planners. The Faculty of Medicine is committed to have 50% of its graduates seek careers in family medicine by 2022. In 2019, 40% of graduates pursued Family Medicine residencies.

Identify and address elements of the hidden curriculum that devalue generalism and family medicine: A Family Medicine Charter was developed to address real and perceived barriers to student selecting Family Medicine as a career. Cases were reviewed and audited for bias against family medicine. With LIC expansion, the focus on generalism is increasing in clerkship education.

Provide learning opportunities for students to experience undifferentiated patients and early presentation of illness in natural contexts: A mandatory five-week Family Medicine experience was introduced into Med 1 and more family medicine tutors were recruited for preclerkship units. Starting in academic year 2020, there will be nine additional family medicine tutors in the Med 1 & 2. Focus on LIC and community-based rotations increases student exposure to early presentation of illness in the natural context.

Memorial University

The curriculum of the four-year Doctor of Medicine (MD) Program is guided by the principles of a generalist and holistic approach to medical education and practice. The curriculum is organized into themes which integrate basic and clinical sciences as they relate to common clinical encounters and patient symptoms. The curriculum is also integrated longitudinally via courses which run throughout all four phases (i.e. the Physician Competencies course, the Clinical Skills course etc.). For each theme, learners are immersed in foundational content which is assembled and delivered by physicians who are

certified by the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) from multiple specialties. This allows learners to experience and develop a generalist approach to common clinical encounters.

The individual session objectives, which are covered in each theme, are developed from and linked directly to the Medical Council of Canada objectives which detail the expectations for knowledge and skills of a generalist physician. Learners are exposed to a variety of teaching and learning methods throughout the curriculum including didactic sessions, tutorials, clinical skills and integrated learning sessions which are co-taught by a family physician and a specialist and highlight the importance of the role of family physicians and generalists in health care settings.

Learners also complete clinical placements with family physicians in the Community Engagement course, through weekly early clinical experiences and two two-week community placements over the first two years of the MD Program

In line with *Destination Excellence*, Memorial aims to graduate learners who are prepared to respond to population needs and to be tomorrow's scientific and clinical leaders.

Recommendation 8: Advance Inter- and Intra-Professional Practice

To improve collaborative, patient-centred care, MD education must reflect ongoing changes in scopes of practice and health care delivery. Faculties of Medicine must equip MD education learners with the competencies that will enable them to function effectively as part of inter- and intra-professional teams.

University of British Columbia

Inter-professional collaboration is a prominent theme in the MDUP curriculum. Early in their training, students participate in the UBC Health Inter-professional curriculum through online modules and face-to-face workshops with other health discipline learners. For instance, there are numerous inter-professional learning sessions with other health professional students in occupational therapy, physical therapy and dentistry. In the clinical years, students are assessed on their inter-professional and collaborative team skills through mandatory workplace-based assessments.

The UGME Committee continues to explore further opportunities to transform the clinical placement model and experience in collaborative learning. The goal is to support practical, team-based and lifelong learning.

University of Calgary

We have a Director of Interprofessional Education (Dr. Ian Wishart) and have introduced interprofessional learning opportunities in a variety of contexts.

We are currently developing a new program which will offer interprofessional advanced training opportunities for medical students in education, business and personalized medicine.

University of Alberta

The University of Alberta has a longstanding program to promote inter- and intra-professional practice. The Health Sciences Council, an association of nine health related Faculties, facilitates an inter-professional education program that our students participate in.

All first-year medical students participate in the INTD Pathway Launch within the first month of starting medical school. At the Interprofessional Pathway Launch, students from different health science programs are placed on interdisciplinary teams of 6-7 students for a 3-hour session that focuses on developing skills and relationships that will support learners through their education and into the practice setting. Student teams explore collaborative practice through experiential learning components: working through clinical case studies, engaging in discussions with professional organizations and patient/family mentors.

First year students also complete INT D 403, Foundations of Collaborative Practice, which offers students from other health care programs (including Nursing, Rehabilitation Medicine, Dietetics/Nutrition, Kinesiology, etc) the opportunity to further develop the interprofessional team skills that will prepare them to meet the challenges of their future work environments. INT D 403 enables students to develop competency in areas such as Interprofessional Communication, Team Functioning, Interprofessional Conflict Resolution, and Role Clarification.

Our program level objectives mandate that collaborative learning occurs in our program. A variety of team-based learning and problem-based learning opportunities reinforce the importance of team practice within the profession. Also, peer and inter-professional assessments are integrated into learning experiences throughout the program.

University of Saskatchewan

Current Status

Interprofessional Education is a vertical theme within our four-year program. There is a faculty vertical theme lead for this component of curriculum. Undergraduate students are supported in development of inter-professional and intra-professional collaborative competencies through numerous curricular opportunities including:

- Required shadowing of physicians and non-physician health care providers in pre-clerkship
- Patient and Family Centered Care curriculum and patient narrative experiences in Year One
- Students are provided with release time in Year One for a student-driven annual IPASS conference.
- Community agency service learning experiences in Year Two of pre-clerkship
- Students participate in quality improvement/quality assurance/ patient safety related activities within Year Two which are relevant to inter and intra-professional collaborative practice.
- Interprofessional group case based learning opportunities in each term of pre-clerkship in conjunction with students from other health sciences Colleges.
- Dispute resolution exercise in collaboration with College of Law students in Year Two of pre-clerkship
- Advanced communication skills modules in Clinical Skills II-IV courses

- Interprofessional team teaching in i) Physical Medicine and Rehabilitation and ii) Geriatrics Skills days in pre-clerkship

University of Manitoba

UGME does not have a seat the interprofessional collaborative table. The curriculum is poorly received by students. Scheduling has been complex.

Northern Ontario School of Medicine

An Interprofessional Working Group of the UME Committee was established in 2019 and is exploring new strategies to enhance IPE at NOSM. There will shortly be an expanded whole school IPE working group to establish IPE goals, principles and expectations for all education programs at NOSM

One is a four-day simulation-based experience where NOSM medical students and first year nursing students work together in teams to address patient scenarios. Team function, communication, collaboration are explored in a safe environment

Another initiative is the Culinary Medicine Labs (offered as an elective 11 times per year) where medical students and dietetic interns spend three hours together focused on a specific nutrition topic (e.g. diabetes) during which time they cook a meal, have a formal seminar and eat together.

Schulich School of Medicine and Dentistry, Western University

Interprofessional and interfaculty education is a strategic vision for Western University and our School. Program students learn and are assessed within rich interprofessional learning opportunities in all clinical learning experiences. Students are exposed to learning from and with other health professions in a variety of learning modules and their QI and Research projects.

Our School partners in supporting large group co-learning events annually with health professional learners including 1) Interprofessional Education (IPE) Day with the Health Sciences and Social Sciences Faculties at Western, Windsor and Waterloo universities and 2) discrete large and small group sessions with Western Law and Social Sciences. There are designated IPE Leaders at each campus, working collaboratively with other university and health system partners on developing a renewed IPE vision at Western.

Lessons can be learned from the success of IPE at the Windsor Campus Medical Sciences where nursing and medicine occupy the same building and some facilities. Co-creating curricular learning with students is challenged by academic calendars that are difficult to reconcile. Planning for IPE learning with other university faculty senior leaders has been positive and collaborative. We are planning to offer increasingly integrated clinical and simulated IPE learning as our renewed curriculum rolls out.

McMaster University

McMaster's medical school is one of many schools within a Faculty of Health Sciences that includes Rehabilitation Sciences (physiotherapy, occupational therapy, and speech language pathology), Nursing (undergraduate and graduate nursing programs in a consortium with two Ontario colleges), and additional programs in Medicine (including midwifery and physician assistant programs). The health

professions programs, in addition to other health sciences programs collaborating with both Business and Engineering, makes for an exciting inter-professional milieu.

Programming is supported by our Program for Interprofessional Practice, Education and Research (PIPER) which ensures that there are structured opportunities for students from different health professions and health sciences program to learn with, from, and about one another.

PIPER further complements a formal stream within our Program focusing on Interprofessional Practice. This is one of the core domains of our Professional Competencies curriculum with a focus on professional role identification; identifying how various professionals contribute to specific patient/client care needs; and resolving differences or conflicts between professionals. This domain of the curriculum is introduced in the pre-clinical period but also has an extensive assessed component throughout the clerkship which includes assessments of students' interprofessional orientation by professionals in other professions outside of medicine.

Students also establish self-directed opportunities to further explore interprofessional practice. These have taken on the form of interprofessional conferences and workshops such as the International Women's and Children's Health Conference. They have also worked on the development of several community engagement opportunities such as immunization clinics.

University of Toronto

- With growth in the number of available Interprofessional Education (IPE) activities available to our students, the MD Program increased its IPE elective requirement from four to six credits in 2015-16.
- The MD Program Competency Framework underwent significant revisions in 2016, with changes to our key and enabling competencies informed by CanMEDS 2015, adapted for an undergraduate medical education context. The MD Program IPE Theme Lead was chair of the Collaborator Role working group, which helped ensure alignment between our IPE curriculum and Collaborator competencies.

Queen's University

- Interprofessional Observerships and mandatory IP learning events, across all 4 years, as previously described, have continued
- Allied health professionals teaching and/or co-teaching sessions, including but not limited to: Nurses in multiple roles, lawyer engaged in medico-legal practice, policy analyst, pharmacist, social worker, dieticians, occupational therapist, physiotherapist, audiologist, genetic counselor
- New since 2015: Interprofessional Symposium on Leadership involving all 3 schools in the Faculty of Health Sciences (spring 2019, again spring 2020: Year 2)
- New since 2015: Formation of the FHS Interprofessional Education Committee (replaces the Office of Interprofessional Education Curriculum Advisory Group), with representatives from all 3 schools: mission to identify current IP educational curricular components/assessments, including opportunities to enhance IP educational (learning with, learning from, and learning about).
- New since 2015: formal teaching assessment of Handover has been implemented in Clerkship.
- New since 2015: Interprofessional Education mini-lecture series: endorsed by Curriculum Committee. Monthly co-curricular event targeting students in all 3 schools.

University of Ottawa

Since 2015, we have had many new initiatives and experiences during which medical students learn alongside students from allied health professions. Multiple lectures are given by allied healthcare providers. Some of the new initiatives put in place include a research project at the Montfort Hospital, an Interdisciplinary Student Research Conference on Healthcare, a grant to create six modules on interprofessional competencies, an inter-professional clinic focusing on social determinants of health and an upcoming MSK interprofessional day regrouping students from various professions and programs from Ontario and Québec.

While creating these new opportunities for students, we have faced different challenges. One of the main one resides in coordinating events based on the different programs' schedules. While it is important for our undergraduate students to be taught by different healthcare providers, we feel it is even more crucial for them to learn and collaborate with students from other professions.

Another challenge is to incorporate a curriculum based on the Canadian Interprofessional Health Collaborative (CIHC) framework's six competency domains. We have created interactive modules for students, but ensuring that students learn theoretical information regarding IP collaboration throughout their four years of undergraduate education has been challenging. We however have the support from the undergraduate curriculum content committee and are currently reviewing how to best incorporate the learning sessions.

McGill University

As part of its new strategic planning, the Faculty has proposed a strategic framework entitled Physicians of Tomorrow for UGME and PGME learners

(https://www.mcgill.ca/medicine/files/medicine/project_renaissance_physicians_of_tomorrow.pdf).

Physicians of Tomorrow has the following major goals: 1) To promote a student-centred approach that engages learners across the continuum of the Faculty's medical educational programs; 2) To continuously improve the undergraduate medical education learning environment and experience; 3) To promote interprofessionalism and interdisciplinarity to prepare students for collaboration and teamwork; 4) To grow the provincial impact of our educational programs.

To support these goals, the Office of Interprofessional Education (OIPE) was created in 2016 and includes faculty members from all health profession schools within the Faculty of Medicine. The OIPE supports the interprofessional education curriculum, a compulsory curriculum for all undergraduate health profession students across the Faculty, including medical students. Students need to complete three interprofessional courses during their first two years of training.

Université de Montréal

Collaborative Health Sciences Courses (CHSCs) involve up to 1200 students of 14 health and social service professions, plus patient partners. The equivalent course in Mauricie is Interprofessional Collaboration in Health Care.

Students are introduced to patient-centred collaboration at the back-to-school symposium, with the testimony of a patient-doctor duo. Patients affiliated with the Collaboration and Patient Partnership Directorate (DCPP) have multiple opportunities to intervene with students in order to share their

experiences, through testimonials in different courses and in particular in the ethics workshops that students attend in each year of the curriculum.

AFMC's Entrustable Professional Activities (EPA) are introduced at the clerkship level. In particular, EPA 5: "Formulate, communicate and implement management plans", is observed in the interdisciplinary meetings and students receive feedback on their ability to communicate and collaborate.

Increasingly, in placements, students are working with specialized nurse practitioners. Collaboration with pharmacists, social workers and other health professionals is widespread in the settings. Encounters with other professionals in palliative care and social medicine clerkships provide students with very enriching perspectives.

We are adding to the second-year students' curriculum encounters with patients whose health has been improved through digital health to reinforce the notion of communication in a context of partnership between the treating team and the patient. Indeed, this partnership relationship is gradually changing, not only because of digital technologies to support the patient, but also because of the increasingly precise digital information available to patients. Students will be better equipped to adapt to the rapidly changing reality.

Université Laval

Intra- and inter-professional collaboration is at the heart of patient-centred care. This competency is taught throughout undergraduate education, in Interprofessional Collaboration courses (I-III), integrative courses, and in clerkship placements.

The MD delocalization project, discussed in Recommendation 1, includes a component focused on developing models of collaboration between medical students and primary care nurse practitioners.

In addition, the program is delivered in an integrated health sciences training complex (CIFSS) that includes the Faculties of medicine, pharmacy and nursing. This proximity is conducive to bringing the professions closer together and to carrying out trifaculty activities such as sociability week, social responsibility week and a day of reflection on professionalism. The CIFSS Simulation Centre used by students now has a trifaculty governance model that also promotes interprofessionalism.

Université de Sherbrooke

Over the past few years, the FMHS has supported :

- the development of a repository of professional collaboration skills in its various programs;
- the implementation of interprofessional collaboration workshops involving stakeholders and students from different health and social work programs (early workshop, selective activities, simulation of emergency situations and an advanced workshop in end-of-life care);

For its part, the program management proposed :

- the integration of the professional collaboration dimension into several educational and applied activities in various care, training, management, health promotion or research contexts;
- the integration of professional collaboration learning through interactive workshops in small groups;

- coaching health care providers in clinical immersion activities during the first two years of training;
- learning and mobilizing collaboration and communication skills in management and research projects and in all pedagogical activities involving active small-group methods;
- the integration of peer evaluation and multi-source evaluation that promotes the development of collaborative skills in a number of educational activities carried out in small groups (training, management, research).

Dalhousie University

Acknowledge and address the traditional power relationships and hierarchies that undermine the implementation of effective inter- and intra-professional education and practice:

Students are exposed to interprofessional learning opportunities throughout medical school beginning early in the first year with DalAmazing. Medical students learn about the skills and ambitions of other health professional students and train in a team environment through multiple experiences. Students have interprofessional case-based sessions in the PIER units (Med 3) where they work through communication issues in inter and intraprofessional groups with IP faculty. Students learn about communication, shared leadership, conflict resolution, and role clarification in these sessions.

Collect and share exemplary practices in inter- and intra-professional education: The Dalhousie Faculties of Medicine, Health and Dentistry collaborate in a forum called the Interprofessional Education Collaborative Committee (IPECC). This meets monthly and has subcommittees that work together to identify IP curricular opportunities, scholarly activity and IP events. In designing IP curriculum, the champions on this committee use best evidence and best practices in curriculum development.

In Med 1, DalAmazing Parts 1.0 and 2.0 are empiric IPE experiences given to all 1000 health professions students at Dalhousie, in addition our five-part IP Indigenous Health and Wellness program, which brings medical, dentistry and nursing students together. In Med 2, all students are embedded in IPE simulations, and participate in the multi-award-winning Collaborative Stroke IPE Part 1 and 2 sessions. In the Med 3 year, students attend three IPE simulations embedded in the clerkships and IP sessions throughout the PIER units. In Med 4, all students must participate in a three-week IP elective to round out the required experiences.

Foster further research and knowledge translation to help shape medical education policies that support inter- and intra- professional learning: Over the past four years, the Faculty of Medicine, partnering with the Faculties of Health and Dentistry, have produced much scholarly activity presented and published locally, nationally and internationally. This educational scholarship has been focused on innovative programs, and curricular development, in addition to looking at changes in student attitudes and knowledge around interprofessional competencies. With the cooperation of The Simulation Education Network, the Simulation Leader Interprofessional Instructor Course, the first IP course of this type in Canada has trained over 200 faculty and staff in IP debriefing techniques to benefit student and faculty IP learning over the last four years.

Review existing faculty and departmental structures with support for inter- and intra-professional learning in mind: The IPE longitudinal curriculum is implemented at Dalhousie Medical School, as outlined above. We are now administering the validated ICAAS tool the first week of Med 1, at end of

clerkship, and end of Med 4 to look for changes in student IP competencies over the course of medical school.

Teach and assess team-based and collaborative competencies in all learning environments: In the Skilled Clinician Program that runs from Med 1-4, and includes the longitudinal theme of IPE, there are multiple opportunities for students to perform in team-based environments, with specific feedback from faculty on IP competencies during these sessions. These occur in IPE simulations in Med 2, clerkship, and PIER units. The sessions are co-briefed by IP faculty, which emulates best standards of practice. These facets of care are so well integrated as to no longer require explicit definition in the curriculum. Collaboration is high in all clinical settings and particularly evident in mental healthcare and addictions, emergency medicine, family medicine and cancer care.

Memorial University

Memorial Curriculum

Since 2005, the MD program has had a strong educational component in inter-professional practice through the Centre of Collaborative Health Profession Education (CCHPE). This centre brings together faculty and educational leaders from the Faculty of Medicine, Nursing, and Education; the Schools of Pharmacy, Social Work, and Human Kinetics and Recreation; the Doctor of Psychology program and the Memorial Student Wellness and Counselling Center. In 2013, the Faculty of Medicine introduced a shifted approach from primarily disease-based interprofessional education (IPE) modules to longitudinal collaborative competency development in consistent interprofessional learner groups. Current topics include team functioning, communication, conflict resolution and enhanced collaboration for patient-centred care, aligning with the Canadian Interprofessional Health Collective's competency framework. Since its introduction in 2013, IPE skills training has steadily evolved to include more structured team-based simulations using standardized patients, which are assessed formatively and summatively.

Recommendation 9: Adopt a Competency-Based and Flexible Approach

Physicians must be able to put knowledge, skills, and professional values into practice. Therefore, in this first phase of the medical education continuum, MD education must be based primarily on the development of core foundational competencies and complementary broad experiential learning. In addition to pre-defined curriculum requirements, MD education must provide flexible opportunities for students to pursue individual scholarly interests in medicine.

University of British Columbia

The MDUP has adopted the CanMEDS competency framework that focuses on both the process and outcomes of learning. The same framework is used in postgraduate medical education and continuing professional development, thereby allowing for continuity of learning experiences. There are specific objectives, learning outcomes and milestones mapped to CanMEDS competencies in each course of the curriculum, with Entrustable Professional Activities that are well defined and objectively assessed via direct observations in workplace-based assessments during clinical experiences.

The MDUP deploys a programmatic assessment approach that includes 4 assessment modalities, with each designed to assess specific content and competencies. These modalities include written tests (multiple choice question exams), portfolios, objective structured clinical examinations (OSCE), and workplace-based assessments. All assessments are designed to measure achievement of specific objectives, learning outcomes or milestones mapped to CanMEDS competencies in each course. The goal is to provide longitudinal and competency-based assessment that enables regular feedback and opportunities for coaching.

A significant innovation is the Flexible and Enhanced Learning (FLEX) course which is described in the comment under Recommendation 3. FLEX allows students to apply their knowledge, skills, and professional values to practice, starting in Year 1 of the MDUP and continuing over the duration of their undergraduate medical education.

University of Calgary

We have incorporated competency-based language and concepts into our ITERs.

We have begun to incorporate global ratings in OSCEs.

Students have the opportunity to pursue scholarly activity in summer electives and in AEBM electives.

University of Alberta

Our curricular schedule allows flexible time for students to engage in scholarly areas of interest. The research community of learning provides a continuum of research options for students. The students in the Social Justice Learning Community create scholarly work for their final projects completed in a community engaged manner.

We are implementing a competency-based approach to education with a process that is inclusive of a broad base of stakeholders. The approach begins with outcomes-based program level objectives and a programmatic approach to assessment. We are working to align our curricular objectives with the Entrustable Professional Activities (EPA's) accepted by AFMC.

The physicianship course extending across all four years of the program has been fully competency based for the past 5 years. We have instituted changes in clerkships to allow for earlier identification of learning deficits and remediation and have an academic mentoring coordinator to establish personal learning plans for students requiring remediation.

One of the great challenges in moving toward a competency-based system of assessment is the need for a record keeping and management system to track the tens of thousands of data points per learner. Critical to our success, we have custom built, an electronic learning management system uniquely capable of presenting all formative and summative assessments in a multidimensional portfolio. This system has been modified and implemented in a highly successful manner in several of our post-graduate programs demonstrating its sound development, utility and broad relevance to learners along a continuum of medical education.

University of Saskatchewan

Current status

- Incorporation of CanMEDS roles in all student assessments
- Alignment of session learning objectives with module/course learning objectives, program learning objectives and CanMEDS roles
- Linking of assessments to the session/module learning objectives
- Individualized feedback to students as to specific session/module objectives which were not met on examinations
- Initial implementation of AFMC EPAs
- Approximately 30% independent learning time per week.

Barriers:

- Faculty engagement to ensure accuracy of session/module learning objectives
- Technology to ensure further personalization of student knowledge gaps

University of Manitoba

- Three additional weeks of electives were added for the class of 2021.
- All clerkship rotations have reviewed their competency profile.

Northern Ontario School of Medicine

With the recently developed Medical Education Program Outcomes (MEPOs) and the focus on CanMEDS for the Phase 3 (Year 4) clerkship and the mandatory Entrustable Professional Activities established by AFMC, NOSM has made progress in CBME. As the residency programs transition to CBME and integration across the educational continuum evolves at NOSM, so will CBME.

Students have some flexibility in their education through elective blocks and Special Elective Experiences (which are non-mandatory short elective experiences).

Schulich School of Medicine and Dentistry, Western University

The Program has moved to an integrated competency-based education model aligning with PGME, to support learners developing competencies that will serve them throughout their careers. Curriculum outcomes, achieved in Stages, align Key and Enabling Competencies derived from CanMEDS 2015 and achievement of stage appropriate AFMC Entrustable Professional Activities milestones integrated across all years. There is an emphasis on formative assessment for learning, with progression decisions made by the Program Competence Committee based on completion, summative knowledge assessments and demonstration of appropriate knowledge, skills and professional behaviours.

Students in our renewed curriculum meet monthly with their Academic Coach who support career success and coach for academic excellence. There will be opportunities for students demonstrating excellence or achieving competence early to elect to pursue parallel degrees or certificates. The fourth-year capstone course will allow for flexibility with options aligned with student interests and career paths.

The transition to a CMBE model concurrent with the Royal College launching CBD has allowed for a common learning platform and similar assessment tools. Change of this magnitude requires transparent communication alongside faculty and student development. The perception of novel or increased

demands on clinical faculty who teach and assess medical students and residents can lead to uncertainty on the part of learners.

The Hidden Curriculum remains a factor, particularly around support for clinical teachers within an environment of multiple competing demands.

McMaster University

As described in the FMEC 2015 report, many of McMaster’s pedagogical approaches espouse and promote the concepts of recommendation number 9. These include our signature problem-based learning, grounded in development of self-directed and lifelong learning skills. Students are also encouraged to have very early interaction with real patients in “horizontal electives”, clinical skills, and early family medicine experiences.

We are pleased to see that these foundational pedagogical pillars of our medical school are being adopted in an increasing number of medical schools globally, including variations on problem-based learning and an increasing number of opportunities for medical students to have early patient encounters in most medical schools in Canada.

McMaster recently made revisions to our pre-clinical programming and we are currently making revisions to our clinical Clerkship. We have maintained our commitment to our problem-based learning pedagogy, as well as early patient encounters. We have also added more structural components to ensure spiraling through our 3-year curriculum, which is often more challenging to achieve than in the traditional 4-year program. Both the pre-clerkship and clerkship components have major sections of repetition which enable the building of complexity and competency throughout the 3-year program. This is in addition to extended orientation and transition periods. Finally, this will include adopting the AFMC EPA’s by building on our existing Mac-DOT (McMaster Direct Observation Tool).

University of Toronto

- The MD Program’s Education Goals, refreshed in 2017-18, articulate our aspiration to prepare graduates who are:
 - clinically competent and prepared for life-long learning through the phases of their career;
 - ethical decision-makers dedicated to acting in accordance with the highest standards of professionalism;
 - adaptive in response to the needs of patients and communities from diverse and varied populations;
 - engaged in integrated, team-based care in which patient needs are addressed in an equitable, individualized and holistic manner;
 - reflective and able to act in the face of novelty, ambiguity and complexity;
 - resilient and mindful of their well-being and that of their colleagues; and
 - capable of and committed to evidence-informed practices and scholarship, and a culture of continuous performance improvement.
- In order to support achievement of our Education Goals, the MD Program curriculum is governed by a Competency Framework (CF), which includes key and enabling competencies. Approved in 2016, with subsequent minor revisions, development of our key and enabling competencies was informed by CanMEDS 2015, adapted for an undergraduate medical

education context, as well as MCC objectives and the AFMC Entrustable Professional Activities. Our CF provided the basis for the development of an Elentra-based Curriculum Map that is used to inform student assessment, program evaluation and curriculum change.

- With the introduction of the Foundations curriculum in 2016, students in years 1 and 2 have the equivalent of a full-day of unscheduled time every week, which provides protected time for self-study and other activities such as early clinical exposure.

Queen's University

Building on our competency-based curriculum, a system of assessment based on Entrustable Professional Activities (EPAs) has been introduced in the two clerkship years. These are mapped to our existing competency framework.

Our back-to-the-classroom sessions during clerkship (“C courses”) have flexibility within the curriculum to address topics which emerge during the students’ time at medical school.

Scholar assignments throughout clerkship encourage students to study topics of interest in more depth. Students are also supported in developing individualized electives such as ones at NASA. We also provide flexibility in scheduling for students to participate in the US Match to support their career goals.

Student-led interest groups continue to expand and an Academic Enrichment Program (AEP) focused on research is now available.

Support and schedule accommodation is provided to students to be able to present or attend at conferences of interest to their career development.

University of Ottawa

- This enrichment program has increasing uptake by students. Barriers include student desire to graduate as soon as possible.
- Diverse elective opportunities in non-clinical areas continue to supplement offerings in non-clinical activities including research electives and uptake of these opportunities increases every year.
- A newly created optional longitudinal clinician investigator program pairs students with clinician investigators along the continuum of grant submission, ethics board submission, patient recruitment, data review and publication. Wide range of elective opportunities, both in pre-clerkship and clerkship
- Core selective opportunities build-in to 4th year curriculum
- International clinical opportunities via International and Global Health Office
- Summer studentships
- Special interest groups and summer school programs continue to expand in scope and diversity of offerings
- Distributed Core rotations to provide opportunities for students to train and develop their competencies in community-based environments increase in offering and in student uptake

McGill University

The MDCM program objectives are based on the CanMEDS roles developed by the Royal College of Physicians and Surgeons of Canada and form the basis for our course learning objectives. The Medical

Council of Canada clinical presentations have also been incorporated throughout the curriculum as additional learning objectives. Integrated assessments now occur throughout the four-year program through Reflection and Evaluation (R&E) weeks and integrated assessment courses in second to fourth year. R&E weeks feature a mixture of written and practical evaluations aimed at encouraging ongoing integration of material to which students have been exposed to that point. Progress testing and Objective Structured Clinical Examination (OSCE) are used in the integrated assessment courses to promote life-long learning. In both Transition to Clinical Practice and Clerkship components, student assessment is based on a specific rubric developed to address specific competencies and objectives pertinent at each stage of these experiential learnings. Finally, Entrustable Professional Activities (EPAs) are being rolled out in the curriculum over the upcoming years. EPA 1, on history taking and physical examination skills, has been implemented with improvement in the quality and quantity of feedback given to our learners for these skills.

Université de Montréal

The "Learning Methods and Competency-Based Approach" committee is responsible for adapting the learning methods and to introduce AFMC's Entrustable Professional Activities (EPA) into clerkships. A Clerkship Skills Committee has also been struck to monitor student skills development.

We have added a mandatory OSCE at the end of a student's clerkship to assess their overall competency in a variety of contexts.

The adoption of the pass/fail assessment method respects the principles of the competency-based approach. In addition, since its adoption, students can more easily find the time they need to engage in projects, whether they are with the student association, various interest groups such as environmental health or Aboriginal health, or research projects.

Students benefit from 20 weeks of electives, part of which can be used to complete a research project. Students may also request periods of suspension from medical school to undertake or complete a master's or doctoral degree, or to carry out a personal project, for example an international project.

Progressive performance tests during the clerkship allow students to self-assess their progress and identify areas where they should enhance their learning.

Teaching is being modernized. Several lectures are energized by testimonials from partner patients or replaced by self-study modules.

Université Laval

The MD program at Laval University is based on the development of seven CanMEDS competencies. A longitudinal and personalized follow-up of the development of students' competencies throughout the program, from the beginning of the preclerkship to the end of the clerkship, has been developed (series of courses Follow-up of Competency Development (I to V)). This is a strength of the MD program that includes pairing each student with a physician-supervisor who accompanies him or her in the initiation of reflective practice and the development of specific development plans for his or her competencies; that integrates the continuous evaluation of competencies carried out in the integrator courses and

internships; that monitors exposure to clinical situations and the demonstration of clinical skills during internships; and that is supported by specifically developed computer platforms (SDC Platform and Clinifolio). In 2019, the Faculty began the implementation of Entrustable Professional Activities (EPA). Furthermore, Laval University stands out by offering great flexibility in the academic path to pre-clerkship (2 years, 2.5 years, 3 years). This allows students to complete a joint program in research (MD-MSc) or health services management (MD-MBA), a profile (international, entrepreneurial, sustainable development, research, distinction), a certificate or other activities. There is also flexibility in accommodating leaves of absence for study, sports excellence and other leaves, in accordance with university rules.

Université de Sherbrooke

Since the redesign of the curriculum, based on a competency-based approach and updated by a professionalization process based on typical professional situations (TPS) representative of practice (situations of care, promotion, management, training and health research), the program offers :

- the integration of CanMEDS roles in all TPS and objectives consistent with those of the Medical Council of Canada;
- several educational activities dedicated to the mobilization of competent action in situations of care, training, management, promotion and research, as well as in community projects;
- new evaluation modalities including numerous feedback, practice moments in support of skill development, low-stakes and high-stakes evaluation modalities;
- a success support program (academic/pedagogical support), including special mentoring;
- a pass/fail rating system;
- coaching by a mentor over the four years, facilitating the identification of needs and actions to ensure optimal skills development.

More specifically, in terms of flexibility, the program offers :

- pedagogical activities allowing students to choose subjects and projects according to their personal and professional interests at all levels of training;
- a professional development activity at the end of the course enabling students to complete additional training in a chosen field.
- the possibility of taking breaks from studies for a joint MD/MSc, MD/PhD program, personal projects or in case of academic or personal difficulties.

Dalhousie University

Develop a competency-based assessment system supported by appropriate faculty development that includes continuous assessment: The assessment system has undergone changes to ensure the objectives defined in the curriculum are appropriately assessed. This has been achieved through the process of standard setting and blueprinting of the examinations including the OSCE examinations.

Identify MD education level competencies: This work by the PGME and UME leadership nationally is ongoing.

Link more closely with postgraduate education to create a learning continuum: The Faculty of Medicine Education Council has provided opportunity to look at curricular and assessment elements across the UG/PG continuum and develop tools across the levels of learning. The use of field notes in family medicine experiences in the LIC and in Family medicine residency are examples of best practice in this area.

Tighten the integration of accreditation standards for MD education into those for postgraduate medical education: The Education Pillar of the Dalhousie Faculty of Medicine focusses on the collaboration across the continuum. Through this process, commonalities around accreditation standards have been reviewed and areas such as student and resident learning environments have been approached with a broad lens.

Memorial University

The MD program competencies directly reflect the CanMEDS competencies and have been fully adopted by the Undergraduate Medical Studies Committee. All course and phase goals and session objectives have been derived from and mapped to the program competencies and to the Medical Council of Canada Objectives. In the final two years of the program the course goals are achieved through competency-based clinical learning using Entrustable Professional Activities (EPAs) as an assessment tool. The use of EPAs facilitates monitoring of competency development over time and in multiple contexts. This framework provides opportunities for coaching, intervention and competency demonstration during the Core Experiences course, and through selective experiences to ensure competency prior to graduation. The introduction of Comprehensive Clinical Science exams, which are delivered in the form of progress tests, allow learners to monitor their own progress and focus on improving areas of weakness.

The Undergraduate Medical Studies (UGMS) committee and its sub-committees endorse protected time for self-directed or independent learning and utilize an in-house curriculum mapping software to track and monitor competencies, learning objectives, linkages to the Medical Council of Canada objectives, inventories of teaching and learning materials, as well as associated resources. Memorial University has also implemented Integrated Learning Sessions (ILS) which provide an opportunity for undergraduate medical students to integrate their recent learning in the context of patients, their families, their communities, and the CanMEDS competencies. In line with the objectives of *Destination Excellence*, Memorial has incorporated competency-based learning and programmatic assessment in its MD program.

Recommendation 10: Foster Medical Leadership

Medical leadership is essential to both patient care and the broader health system. Faculties of Medicine must foster medical leadership in faculty and students, including how to manage, navigate, and help transform medical practice and the health care system in collaboration with others.

University of British Columbia

Medical leadership is an exit competency of the MDUP and a theme in the curriculum. Leadership encompasses the spectrum from being the leader of a team of health professionals caring for individual patients, to leadership roles at provincial, national and global levels.

Students learn about medical leadership from the beginning of their education. CBL cases are discussed weekly throughout Years 1 and 2, and many include opportunities to discuss leadership of care teams, how systemic factors affect health outcomes, and physicians' roles in health advocacy. Lectures focus on how physicians provide leadership in many different contexts.

In Clinical Clerkship (Year 3), students become members of care teams and have opportunities to begin taking on leadership roles in supervised clinical environments.

In Year 4, interested students have the opportunity to explore leadership through appropriate electives. In addition, the MEDD 448 course, which prepares Year 4 students for the transition into residency training, devotes several sessions to leadership-related topics.

In addition to didactic and clinical teaching, the MDUP encourages leadership in medical students through para-curricular activities. Student representatives are embedded in most Faculty of Medicine committees and working groups. This enables students to provide leadership that contributes to positive systemic change in a real-life setting.

Student-led initiatives also provide many leadership opportunities. Examples include the Wellness Initiative Network that advocates for systemic change to enhance student wellness, and the Emerging Topics in Medicine Symposium that examines the impact of climate change on human health.

University of Calgary

We recognize leadership as a key competency of future physicians. We are developing a new Precision Health Professions Program (including advanced training opportunities in education, business and precision health) which will further foster leadership training amongst medical trainees.

We developed a collaborative practice unit in our med skills course. This gives trainees an opportunity to develop leadership skills.

University of Alberta

We have multiple opportunities for students to participate in and demonstrate leadership and followership throughout the program. These are embedded in day to day activities including in team-based learning and discovery learning sessions in the core curriculum. There are other flexible or optional opportunities.

Each year students explore leadership through the MD/MBA program; the MD/PhD program; and the established communities of learning. We are currently working with internal and external stakeholders to develop a Leadership and Entrepreneurship Community of Learning. Recently, some students have completed the Peter Lougheed Leadership program at the University of Alberta. The Peter Lougheed Leadership College teaches students who are enrolled in the program the skills that will allow them to fulfill a compelling vision, make decisions based on critical thinking and sound evidence, understand diverse perspectives, resolve conflict, take risks, learn from failure, and act on values firmly anchored in ethical and social responsibility.

We support learners to attend local and national medical association meetings including supporting four students a year to attend the CMA annual general meeting.

Our students are involved in Quality Improvement initiatives in local hospitals and with Primary Care Networks. The MD Program supports 4 summer studentships in QA/QI in collaboration with the Department of Medicine. Students have presented work based on these initiatives at international meetings.

Developing leadership in other areas of scholarly work, we provide financial support for approximately 75 students per year to present research at international meetings.

University of Saskatchewan

Current Status

With the implementation of a new undergraduate curriculum in 2014, there was the addition of learning objectives on the CanMEDS Physician as Leader role. Within the context of a longitudinal curriculum on Medicine & Society, the course MED222: Medicine & Society IV occurs in Year 2 Term 2.

The course, MED222: Medicine & Society IV focuses on the Physician Leadership Roles, and is the fourth of four courses in the Medicine and Society series (following Introduction to Medicine and Society in Canada, Public Health and Community Medicine, and Canada's Health Care System).

Topics in the MED222: Medicine & Society IV includes physician leadership, debate, knowledge translation, global health and occupational health. This course explores the context for the practice of medicine involving many of the non-medical expert CanMEDs roles.

University of Manitoba

This recommendation maps to many of our existing courses.

- Professionalism
- Patient Safety
- Indigenous Health

Northern Ontario School of Medicine

Leadership is integral to NOSM’s social accountability with a specific curriculum outcome of: “Increasing the number of physicians and health professionals with the leadership, knowledge and skills to practice in Northern Ontario”

Since 2015 NOSM has developed a strong focus on professionalism for students which includes leadership among the exemplary professionalism expectations. A Committee in Support of Student Professionalism was established in 2015 and oversees and assesses students’ professionalism throughout the entire 4 years.

The curriculum objectives for Phase 3 (Year 4) clerkship are based on the CanMEDS Roles including “Leader”. NOSM graduates become faculty usually immediately after completing residency and a number of them have undertaken leadership roles soon after graduation. We have had an obvious impact in developing leadership for Indigenous physicians as we graduate the largest number of Indigenous doctors in Canada.

Leadership development is also supported through the annual faculty development conference “Northern Constellations” which includes a mentoring session by current faculty leaders for student leaders and the annual “Northern Health Research Conference” which sponsors local education groups and northern research.

Schulich School of Medicine and Dentistry, Western University

The vision and priorities for our Program, School and Western University include developing leadership competency. Developing and graduating the next generation of physician leaders for Canadian health care is a key outcome for our School. The transition to a CBME model will facilitate meeting Program leadership competencies. Key leadership skills and attributes are introduced early and built upon throughout the curriculum. Assessment of defined competencies is done in small and large group active learning integrated in the longitudinal four-year course shaping professional identity – *Professionalism, Career and Wellness*.

Leadership is best understood and demonstrated by experiential learning. This principle gave rise to the team-based project course *Experiential Learning*. There are several modules with expectations for the creation and delivery on projects – for example, *Quality Improvement* in the health system. Additional leadership development is envisioned in completing the mandatory *Research and Service Learning Projects*.

Students are supported with school funding for self-directed leadership experiences in student government, provincial and/or national leadership roles. Student leaders are a valued contributor, integrated into School processes, committees and governance.

With curricular renewal and the changing Canadian health care systems, opportunities arise to engage students in leadership and change management as an essential aspect of medical education in the future of health care. Strong local and national voices are essential to mitigate student’s apprehension that leadership learning displaces medical expert in the curriculum.

McMaster University

McMaster learners have had a strong presence in a variety of initiatives and projects to advance change in the healthcare system over many years. This is strongly facilitated by a medical program that admits a number of applicants from a variety of disciplinary backgrounds and who have prior experience with the healthcare system; a program that has less scheduled time than most medical programs; and a program that encourages early interaction with patients. These factors, combined with a cadre of faculty change leaders, create optimal conditions to foster future medical leaders.

Our medical program introduces learners to a variety of factors within the healthcare system that contribute to the maldistribution of health within Canada, as well as patient demographics and identities which are further affected by historical, political, social and other factors which act upon and through the social determinants of health. This positions learners well to identify a number of areas to focus their advocacy.

Several medical student interest groups related to social justice and advocacy are further supported by the McMaster Medical Student Council and the medical program to advance advocacy initiatives. McMaster medical learners participate through political lobby days, conference and workshop organization, and community engagement work. Our program supports students across these many activities by promoting time off for participation, providing funding to interest groups, supporting connections with faculty leaders, and a variety of in-kind supports.

University of Toronto

We appointed a new MD Program Faculty Lead, Leader Theme in June 2018. Since then, our Leader curriculum has been redesigned to provide students with a four-year longitudinal experience, including learning activities that provide topic-specific integration among our Leader, Health Advocate, Collaborator/Interprofessional Education, and Quality and Patient Safety themes. An example of this integration is the use of the film [Falling Through the Cracks: Greg's Story](#), including interactive exercises delivered in collaboration with the University of Calgary.

Our Leadership Education and Development (LEAD) Program was reconfigured as a System Leadership and Innovation (SLI) concentration in the MSc in Health Policy, Management and Evaluation in 2016-17. Although successful, the LEAD program had limited capacity and no separate credential. The SLI concentration allows learners to obtain a non-thesis MSc with a focus on the key aspects of physician leadership for system innovation. The part-time format allows learners to complete the program and receive a separate MSc credential without having to step away from medical school.

Offered by the Institute of Biomaterials and Biomedical Engineering (IBBME), the MEng in Biomedical Engineering is a professional graduate degree program that focuses on the design, development and commercialization of biomedical devices. IBBME offers a MD-oriented version of this program, which can be completed on a part-time basis. The MEng curriculum consists of courses structured into three pillars (biomedical engineering technology, biomedical sciences, and commercialization & entrepreneurship) and an internship, which provides the opportunity to take on design challenges and meet industry demands.

Queen's University

- A Leadership curriculum has been developed and embedded across four years.

- Specific themes have been developed and promoted through the leadership curriculum, including: Self-awareness; Service-based Leadership; Change Management; Decision Making; Managing Adversity
- Promotion of Interprofessional education with development of a standing committee to oversee development and implementation of IP educational objectives and content
- Development of a day-long interprofessional Leadership Symposium held in the community and involving schools of Medicine, Nursing and Rehabilitation
- A Quality Improvement curriculum has been developed and implemented QI assignments during the Clerkship
- Further curricular content has been developed regarding the role of the physician within the health care system.

University of Ottawa

There has been a successful implementation of the leadership curriculum into medical school. Students are beginning to gain insights into the importance of medical leadership throughout their careers. Some perceived barriers are the students tend to be more focused on basic medical knowledge rather than developing their own leadership skills.

McGill University

Medical leadership is promoted in the MDCM curriculum via two main avenues. Leadership is a theme addressed in the Physicianship component and students have a workshop on this topic. Health advocacy is also imbedded in the first course of the program. A student-led health advocacy workshop is now included in the course in addition to interactive lectures on this topic. Students also have the chance to meet role models who have been involved in health advocacy.

As part of the Medical Ethics and Health Law course in second year, students learn more concretely about our health care system and policies. The Public Health and Preventive Medicine course in fourth year gives students the opportunity to voice their points of view in health care policy debates.

Outside the MDCM curriculum, students are welcome to participate in student leadership within the McGill Medical Students' Society (MSS). Student representation is actually imbedded in all the MDCM program course committees.

Université de Montréal

Student representatives sit on all pedagogical committees, on the equity committee--diversity, in the various course committees and on the Faculty of Medicine Council.

The Faculty supports students involved in various projects, for example: the university student association, the Fédération médicale étudiante du Québec, the IFMSA, interest groups in various specialties, including family medicine, Choosing with Care, the environmental health group, the social responsibility group and several groups involved in charitable actions.

Student initiatives can be rewarded with university awards, scholarships from UdeM Student Services, or the Community Involvement Recognition Scholarships that reward social responsibility projects in the Mauricie region. In addition, the Faculty offers support to students applying for external awards or scholarships that reward student leadership and civic involvement.

The clerkship in preventive medicine and public health includes 16 hours of teaching on health administration, as well as group work for external students. During the Engaged Social Medicine clerkship, students see how physicians are making a real difference in the health and quality of life of vulnerable populations.

Leadership is about self-knowledge. The "Wellness and Life Balance" courses raise awareness of different determinants of physical and mental health.

Université Laval

Leadership begins with the importance of knowing oneself well and developing healthy lifestyle habits. In recent years, the Student Affairs Department has improved its services in this regard. In the curriculum, the leadership competency is addressed in the course entitled Follow-up on skills development and is concretized through community involvement and extracurricular involvement of students in the pre-clerkship program. Leadership is also reflected in a series of patient safety courses that begin in the pre-clerkship and are being developed at the clerkship level.

Université de Sherbrooke

In order to better prepare future graduates, the program management proposes :

- new pedagogical activities dedicated to leadership development throughout the curriculum, aiming at both study management, project management and clinical activity management, including :
 - workshops allowing the identification and development of leadership style, basic principles of time management and teamwork;
 - the use of knowledge gained from projects in the community;
 - interactive workshops on hospital management and the health care system at different levels, managing adverse events, improving quality of care, the use of ICTs in medical practice, and medico-legal aspects of practice.

In addition, the FMHS ensures student representation in an organizational and decision-making structure at the faculty and program levels and offers financial support to encourage :

- the participation of student representatives in various educational and research conferences;
- the implementation of projects in the community through the creation of the "Engage, Motivate, Inspire and Stimulate" (S'engager, motiver, inspirer et stimuler) (SEMIS) Fund.

For faculty members, several opportunities are offered including :

- major involvement in the design and implementation of the new curriculum, promoting the development and recognition of leadership in teaching activities;
- financial support for leadership training and development (e.g. CLIME, ASPIRE, etc.).

Dalhousie University

Enhance learners' understanding of the health care system and their responsibility as physicians to participate in the process of transforming the health care system: During the two-year longitudinal Professional Competencies program, students are introduced to the health care system(s) and through

case-based learning sessions, are able to explore their responsibilities as physicians to participate in the process of the transformation of these systems.

Cultivate collaborative leadership skills in learners through mentors and role models from multiple disciplines: Dalhousie medical students across all four years of the program are provided with numerous opportunities to develop their leadership skills through the following:

- Students are voting members of all curriculum committees and sub-committees
- The Dalhousie Medical Student Society (DMSS) provides a wide variety of leadership positions for students enrolled in all four years of the program – e.g. Leadership for student wellness, medical education, student leadership, etc.
- Through the DMSS, each class has struck a Class Council – student leadership is essential
- Each class has an elected class president
- Each Unit in the pre-clerkship curriculum has an elected “Unit representative” who is responsible to liaise with faculty leadership in that Unit
- The DMSS has facilitated the development of numerous “student interest groups” – the focus of which depends entirely on the interests of each group of students.

Memorial University

The Strategic Plan, *Destination Excellence 2018-20203*, identifies inspiring leadership as one of its pillars with a commitment to *encourage and support leadership development for current and future leaders*. In line with this commitment, a Leadership In Medicine certificate program has been developed by the Faculty of Medicine. Within the MD program eight leadership modules have been created to introduce medical learners to leadership and management skills and address the CanMEDS “Leader” role. Incorporating the latest research and educational practices, the program explores emerging leadership skills, issues and strategies and applies them to the specific requirements of the healthcare system. Learners complete two interactive Physician Competencies online modules in each of the four phases of the MD program, for a total of eight modules. Each module provides a 4-hour learning activity and includes learning objectives, relevant readings, a narrated PowerPoint presentation, case studies, pre- and post-test assessments and additional learning resources. The program has been designed so that learners may complete the modules asynchronously and submit the respective assignments online.

Upon completion of the eight Physician Competencies modules, the Office of Professional and Educational Development (OPED) at Memorial’s Faculty of Medicine offers undergraduate learners the opportunity to pursue a Leadership in Medicine Certificate through the completion of an additional online capstone learning module. In completing the capstone module, learners apply and integrate topics covered in the eight MD program Leadership in Medicine modules with real health care scenarios, and are introduced to new concepts relating to conflict resolution, continuing professional development, and physician wellness.

Suggested New FMEC MD Recommendations

At the end of each survey the Faculties of medicine were asked if any new FMEC MD recommendations should be added. The following were the verbatim responses from the Faculties.

- Climate change and impact on health; Equity and diversity
- Support population-based strategies to better meet health care needs.

- Adapt the curriculum to changing practices in medicine, taking into consideration the patient and changes to the Canadian population. Medical practice is in a constant evolution. Whether it be digital health, artificial intelligence, environmental health or the ethical allocation of resources, curriculums must adapt quickly. Learners should however maintain a focus on generalist training centred on patient needs.
 - Consider adding to either 1 or a new recommendation on increasing emphasis on responsible use of limited resources towards mission specific goals
 - Identifying and supporting people who will thrive in medicine
 - Diversity and inclusion as a priority for faculty and education leadership
 - Medical education as a safe and inclusive experience: this includes aspects of medical student safety and wellness; mistreatment; and learning and work environments which are inclusive and without intimidation or harassment.
 - Wellness and Personal Health; Health Systems and Innovation; Addressing the Impact of Technology and AI
 - Pilot New Models for MD programs go paperless, classroom free, using advanced technology and robotics, AI and digital health to address public health, climate change and integrated team care.; Implement Accreditation REFORM: Completely revamp the standards and process.
 - There should be a specific recommendation built into the FMEC recommendations specific to the Health of Indigenous peoples and each school's response to the TRC Calls to action and the AFMC Joint Commitment to action on Indigenous Health.
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FMEC PG

The AFMC prepared a survey for key FMEC PG stakeholders in which they were asked to indicate if each of the then FMEC PG recommendations were applicable to them. If the recommendation was applicable, they were asked to provide an update on the work their organization has completed, is in progress, and is planned relating to the recommendation. They were also given an opportunity to comment on any barriers experienced. Respondents were then asked to rate the importance and relevance of each FMEC PG recommendation on a five-point Likert scale (Not Important, Slightly Important, Moderately Important, Important, and Very Important) and invited to provide commentary on why the recommendation is important and relevant. Finally, respondents were given the opportunity to suggest if any new FMEC PG recommendations should be added and why. The survey was initially released to respondents on December 19, 2019 but remained available for response until June 26, 2020. This extended response period was used to account for the pandemic which started during the response period.

AFMC received feedback from the following stakeholders⁴:

⁴ AFMC invited the following key stakeholders to complete the FMEC PG survey: Canadian Association for Medical Education (CAME); Canadian Federation of Medical Students (CFMS); Canadian Medical Association (CMA); Collège des Médecins du Québec (CMQ); College of Family Physicians of Canada (CFPC); Fédération des médecins résidents du Québec (FMRQ); Fédération médicale étudiante du Québec (FMEQ); Federation of Medical Regulatory Authorities of Canada (FMRAC);

- Canadian Federation of Medical Students (CFMS)
- Collège des Médecins du Québec (CMQ)
- College of Family Physicians of Canada (CFPC)
- Federation of Medical Regulatory Authorities of Canada (FMRAC)
- Medical Council of Canada (MCC)
- Resident Doctors of Canada (RDoC)
- Royal College of Physicians and Surgeons of Canada (RCPSC)

A total of seven stakeholders provided responses to the PG survey. Five of those stakeholders ranked the importance of each recommendation on a five-point Likert scale. These responses were converted to numeric values with higher values representing a higher degree of importance (i.e., Not Important = 1, Slightly Important = 2, Moderately Important = 3, Important = 4, and Very Important = 5). These values were averaged to determine the relative importance of each FMEC PG recommendation (see Table 2).

Table 2: Average importance of the ten FMEC PG recommendations

Recommendation	Average Importance Rating
Ensure the Right Mix, Distribution, and Number of Physicians to Meet Societal Needs	4.8
Cultivate Social Accountability through Experience in Diverse Learning and Work Environments	4.7
Create Positive and Supportive Learning and Work Environments	4.5
Implement Effective Assessment Systems	4.5
Integrate Competency-Based Curricula in Postgraduate Programs	4.3
Align Accreditation Standards	4.2
Develop, Support, and Recognize Clinical Teachers	4.0
Ensure Effective Integration and Transitions along the Educational Continuum	3.8
Foster Leadership Development	3.7
Establish Effective Collaborative Governance in PGME	3.2

The responses below represent are from those stakeholders who responded to the survey.

HealthCareCAN; Medical Council of Canada (MCC); Resident Doctors of Canada (RDoC); Royal College of Physicians and Surgeons of Canada.

Recommendation 1: Ensure the Right Mix, Distribution, and Number of Physicians to Meet Societal Needs

In the context of an evolving healthcare system, the PGME system must continuously adjust its training programs to produce the right mix, distribution, and number of generalist and specialist physicians—including clinician scientists, educators, and leaders—to serve and be accountable to the Canadian population. Working in partnership with all healthcare providers and stakeholders, physicians must address the diverse health and wellness needs of individuals and communities throughout Canada.

This recommendation, and the concept that we must adjust our physician workforce for the future, is fundamental. We need physicians in all corners of our country who have the right skill sets; and we need a balance of generalists and specialists, including clinician scientists, educators, and leaders. In mapping the right mix, distribution, and number of physicians needed across the country against societal need, several key factors must be kept in mind. These include the increasing importance of team-based care, changing scopes of practice of physicians and other healthcare providers, and how the professions interact in generating and disseminating information.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
Canadian Federation of Medical Students (CFMS)	<p>This issue is one of the top priorities for our organization and for medical students. Uncertainty secondary to the match drives significant stress amongst medical students. There continue to be far too many unmatched Canadian medicalgraduates (uCMGs). This years match numbers were very similar to last year with up to 98 students being unmatched after the second iteration. The reasons for this and trends associated are complex, however, we should note that the ratio of medical school positions to residency positions remains well below the 1 : 1.2 ratio we have been advocating for.</p> <p>Our activities on unmatched graduates include providing comprehensive learner supports during the pre-interviews, interviews and post-interviews period. We have held 2 federal days of action on the issue of unmatched medical graduates with calls to action to:</p>	<p>While we have felt supported by national organizations in our work on unmatched CMGs there remain significant areas for continued work. While some residency positions were added last year we continue to remain at residency to medical school position ratios of less than even 1:1.05. Funding is a significant barrier. The national PRPAC group has not been effective in moving towards a comprehensive national physician resource plan and a number of organizations are taking this on more individually which we view as problematic. Stronger national leadership that is action-</p>	Very Important	<p>This issue spans the entire physician career and training spectrum. In order to best meet the needs of society and ensure alignment of our training programs to future job opportunities health human resource planning must continue to be a core focus and be done more effectively. We need national leadership to create a more focused action based plan to address the many components of the issue, including government advocacy for more funding and effective policies to address factors that contribute to this issue including entry routes, residency transfers, electives, etc.</p>

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>Commit to a pan-Canadian strategy for effective and socially-responsible physician and health workforce resource planning that is evidence-based and transparent to both medical trainees and the public. In addition we participate on PRPAC and have started a new HHR task force. Previous work by our atlantic students task force included creating a resource for students on physician planning in Atlantic provinces. The HHR task force has now put extensive efforts into expanding this by creating a digital platform that collates and summarizes various physician mix, number and distribution data nationwide as an effort to try and help provide students with as much information as possible to help them make career decisions.</p> <p>More recently we are launching our Unmatched Canadian Medical Graduates Think Tank. Please see appendix.</p>	<p>focused is required. In addition, learners require transparent information to help them make decisions. Currently data to see the mix, number and distribution of physicians in Canada is not easily accessible. In addition, there is not a widely used physician forecasting tool that can help learners see what communities or provinces may need in the future. While certain provinces and health authorities employ certain models to do this, the other barrier is that this information is not readily available to medical students. A concerted approach that considers timelines starting well before admission to medical school and the need for recruitment and support to be provided to rural, BIPOC and other underrepresented populations in medicine must be part of any “solution” we discuss.</p>		
<p>Collège des Médecins du Québec (CMQ)</p>	<p>The CMQ actively participates in the deliberations of the <i>Table de concertation sur la planification de l'effectif médical au Québec</i>, which has been in existence since 1988. This “issue table” brings together representatives of the Ministry of Health and Social Services (MHSS), the four Faculties of medicine in Quebec and the CMQ. Each year, a government decree determines the number of residency positions in each specialty according to society's needs:</p>			<p>This recommendation is already well established in Quebec.</p>

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>55% of residency positions are in family medicine and about 20% of the other positions are in so-called general specialties (internal medicine, general surgery, general pediatrics, etc.). The CMQ also participates in meetings of the Physician Resource Planning Advisory Committee (PRPAC - CCPEM).</p> <p>The CMQ also participates actively in the MHSS committee "Québec 2030: the future of medical specialties". This committee, established at the end of 2018, is mandated to make recommendations on the distribution of positions among medical specialties based on the needs of the population and the evolution of practices in 2030.</p>			
College of Family Physicians of Canada (CFPC)	<p>The CFPC in the midst of a transformative "Outcomes of Training" project aiming to clearly define the scope of training and to anticipate evolving training requirements for a dynamic and changing health care environment. This project aims to ensure that graduates are prepared to practice anywhere in Canada; to enable the goal of "comprehensive care close to home". This project culminates in educational recommendations in late 2020.</p>	<p>We have the shortest postgraduate training in FM in the world; training resources (time) is a main barrier. Currently we hear that "the curriculum is full" and so there is concern about the capacity for it to evolve to meet evolving community needs. Family medicine needs an educational system support to train the family physicians of the future with enhanced skills in underserved areas and areas of increasing need such as addiction/mental health; palliative care; and complex chronic illness care (to name a few).</p>	Very Important	The health of the public and health equity is at stake -- this is the highest priority of all
Federation of Medical Regulatory Authorities of Canada (FMRAC)	Only indirectly.	HHR planning is not an exact science. The vastness of Canada is a huge barrier, as is the unwillingness of	Very Important	But is proving to be a daunting task.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
		physicians to practice in some parts of this country.		
Medical Council of Canada (MCC)	Participation in the PGME Governance Council and Canadian Medical Forum; organizational approaches to diversity in medical education; linkages with indigenous health leaders; increasing focus on new and emerging skills needed for current and future physicians	A lack of a cohesive approach to physician HHR planning across the country; negative Provincial government approaches to funding for medical education, residency positions and physician mobility through limited billing numbers etc.; disconnect between residency entry positions and future needs; restricted approaches to hospital privileges which is driving further sub specialization; restricted options for physicians with more limited scope of practice to provide clinical services	Very Important	a highly functional model of care provision is needed to inform the funders of medical education and health care services and we should all contribute to this
Resident Doctors of Canada (RDoC)	In 2013, to build awareness of residents’ concerns with respect to physician health human resources and to effect change, RDoC brought residents together on a Health Human Resources (HHR) Standing Committee and developed the position paper entitled Resident Principles on Physician Health Human Resources to Better Serve Canadians . Since then, we have continued to focus on advocacy and participation in national HHR stakeholder initiatives. We continue to work to improve the pan-Canadian alignment of physician human resources, and to provide accurate information to support decision-making by those considering and currently pursuing medical education.		Important	Proper management of physician health human resources is an essential component of quality health care. In a publicly funded system, it is critically important to achieve value, effectiveness, and efficiency in the utilization and expenditure of health care resources. The fact that Canadian residency graduates, from many specialty groups, experience difficulty in finding full-time employment, continues to be a major concern to governments, hospitals, students contemplating a career in medicine, and residents close to or currently looking for independent practice opportunities.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>Additionally, RDoC advocates for national licensure which would allow physicians to provide care across provinces and territories. This would ensure standardization, increased physician mobility, and improved response to patient-care needs in various geographical regions. RDoC’s advocacy in this area also includes the following :</p> <ul style="list-style-type: none"> • That any physician mobility agreements must not exclude physicians who have held an independent license for less than three years. • Portability of educational licensing and standardized requirements across jurisdictions (electives and educational license). <p>RDoC’s Collaborative Statement on Canadian Portable Locum Licensure has received the formal endorsement of the Canadian Federation of MEdical Students, the College of Family Physicians of Canada, Canadian Medical Association and the Society of Rural Physicians of Canada. We look forward to building on this statement to incorporate our position on full national licensure in the near future.</p> <p>Our involvement with such stakeholder-run groups as the Physician Resource Planning Advisory Committee, the Royal College Health and Public Policy Committee, the Choosing Wisely Canada project, and the AFMC Resident Matching Committee (ARM-C) is also, in part, a response to our commitment to ensuring the right mix, distribution and number of physicians to meet societal needs.</p> <p>Link: National Licensure Area of Focus</p>			

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	Link: Resident Principles on Physician Health Human Resources to Better Serve Canadians			
Royal College of Physicians and Surgeons of Canada	<ul style="list-style-type: none"> - development of a workforce knowledge hub available on Royal College website - hosted summit on creating and supporting the development of clinician Scientists (published in Academic Medicine) - through CBME removed required rotations and liberalized ability to do distributed and longitudinal training 	- service needs and academic requirements of academic centres and social aspects may contribute to less uptake on distributed training	Very Important	This is our role

Recommendation 2: Cultivate Social Accountability through Experience in Diverse Learning and Work Environments

Responding to the diverse and developing healthcare needs of Canadians requires both individual and collective commitment to social accountability. PGME programs should provide learning and work experience in diverse environments to cultivate social accountability in residents and guide their choice of future practice.

Health care is becoming more ambulatory and community-based. During their training, residents need to experience different types and contexts of practice, including and extending beyond Academic Health Science Centres. These different settings will help inform career decisions.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
Canadian Federation of Medical Students (CFMS)	While this recommendation focuses on postgrad training, it is relevant to undergraduate medical education as well. The CFMS views social accountability as a core value of medical training and as our patient population continues to become more diverse we must train our future physicians to be able to provide the highest standard of care for all of our patient populations.	This has, admittedly, not been a main priority of the organization in the last few years, and we would be interested in further exploring how to improve these opportunities for learners in collaboration.	Very Important	This recommendation aligns with the first recommendation. In order to ensure the right mix, distribution and number of physician, our trainees must be exposed to different learning environments

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>Learners also need to continually develop their understanding of what good social accountability means in clinical practice and our responsibilities as health professionals to be advocates for our patients and society.</p> <p>The CFMS supports students in working with their UGMEs to increase diversity of learning experiences and improve clinical rotations to ensure adequate exposure to rural, lower resource and other settings outside of academic hospitals and urban community clinics. The CFMS recently joined RRMIC to represent medical student perspectives and continues to work through our EDI Task Force and collaborations with underrepresented medical students to advocate for educational exposure to disadvantaged populations and their unique health needs.</p>	<p>Definition of social accountability is quite variable amongst health professions education. Capacity of educators who have strong knowledge and background in social accountability as well as capacity of the diverse learning environments can sometimes be barriers to ensuring more broad exposures and learning. Our Faculties need to take leadership in being allies to BIPOC individuals and communities to ensure our Faculties have the right skillsets to cultivate social accountability amongst our learners. This includes working to increase the representation of underserved populations in faculty and leadership positions.</p>		<p>and develop skillsets to provide effective care to all Canadians. Our Faculties need to “step up to the plate” to ensure that we are leaders in cultivating social accountability. We need to partner with BIPOC, rural and other underrepresented communities in medicine to ensure adequate learning opportunities and true allyship in addressing unacceptable health disparities.</p>
<p>Collège des Médecins du Québec (CMQ)</p>	<p>Postgraduate training in Quebec is decentralized with diverse learning environments in all regions of the province. The CMQ has been mandated to accredit training environments in Quebec. The list of accredited environments by program and by university is easily accessible on the CMQ's website, in a drop-down menu. The accreditation standards for residency programs established by the CanRAC (consortium comprised of the Royal College, CFPC and CMQ) have specific requirements regarding the diversity of learning environments.</p>			<p>This recommendation is already well established in Quebec.</p>
<p>College of Family Physicians of Canada (CFPC)</p>	<p>The CFPC has residency accreditation requirements for training in rural, indigenous and underserved communities; as well as newer CanMEDs FM (2018) competencies defined for cultural safety. The FM PG Program Directors have initiated a 'Selection</p>	<p>Again, the short length of training limits the diversity of experiences available. It is critical to invest in the recruitment and development of a diverse faculty with skills to promote health equity and</p>	<p>Very Important</p>	<p>It is a strategy to support #1.</p>

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	into FM' working group that is looking at selecting diversity/capability to address health equity.	anti-racism approaches within medical education. Selection into medicine, in terms of equity and diversity is starting to receive attention and may require investment to support.		
Federation of Medical Regulatory Authorities of Canada (FMRAC)	<i>Recommendation not applicable</i>	<i>Recommendation not applicable</i>	Very Important	Canada's physicians must understand that they work in the best interests of their patients and must take into their cultural realities. The social determinants of health are an important facet of health.
Medical Council of Canada (MCC)	organizational approaches to diversity in medical education; linkages with indigenous health leaders; increasing focus on new and emerging skills needed for current and future physicians		Very Important	speaks to item 1 on distribution: select from and train in the environments where individuals are needed for health services
Resident Doctors of Canada (RDoC)	<p>In 2017, RDoC developed a social accountability tool, identifying four metrics that, when considered together, build the foundation for a socially accountable initiative, position, or direction. With this evaluative tool that asks practical questions using four metrics (equity, transparency, sustainability and relevance), physicians can assess whether a given project is upholding the principle of social accountability. Our intent is to promote social accountability within medical education and the broader healthcare system and to support RDoC's leadership role in realizing these objectives.</p> <p>In our efforts to build a more economically sustainable, cost-conscious healthcare system, in 2017 RDoC also partnered with Choosing Wisely Canada to develop a list of 5 things residents and patients should question on the use of tests, treatments, or procedures.</p>		Important	RDoC recognizes the social contract that exists between its members and Canadian society. As members of the medical profession, we strive to meet the health needs of the communities we serve – locally, nationally, and globally.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>Link: Social Accountability Tool</p> <p>Link: Five Things Residents and Patients Should Question</p>			
Royal College of Physicians and Surgeons of Canada	- CBD has removed confining restrictions on where training may take place, individual programs/Faculties may tap into distributed sites	<ul style="list-style-type: none"> - no replacements available for residents pursuing distributed learning experiences - funding for living and transportation - desire of trainees to study/learn with peer group 	Important	this will be the key to obtaining the right competencies for practice

Recommendation 3: Create Positive and Supportive Learning and Work Environments

Learning must occur in collaborative and supportive environments centred on the patient and based on the principle of providing the highest quality of care in the context of teaching and learning the necessary competencies.

There needs to be a focus on professionalism and team-based care. Both the privilege of being a physician and the responsibilities that accompany it need to be emphasized. A careful balance is required to ensure that our future physicians combine the best of scientific knowledge and its application with exemplary, patient-centred care.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
Canadian Federation of Medical Students (CFMS)	Learner wellbeing and creating positive learning environments throughout the learning journey has become a central part of our work. In recent years the CFMS has adopted the terminology "health promoting learning environments" based on work from Canadian and International universities on the concept of the health promoting university. Much of this is outlined in the <i>Okanagan Charter</i> , which notes the following vision :	Lack of overarching leadership group to coordinate activities in medical education on wellbeing mean that there is often duplication. Further we have not yet come together to define a set of benchmarks, measurables and goals to work towards. Health promotion is lacking from the strategic plans of our Faculties of medicine. We need dedicated leadership roles and funding in each institution to truly create positive change. The	Very Important	This is a critical recommendation that we must make more significant progress on moving forward in both postgrad and undergrad. While there continues to be increased awareness about the importance of creating health promoting learning and working environments, medical culture is difficult to change and this is a long term goal which we have to take more concrete steps to address. The "Hidden curriculum" in

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>‘Health promoting universities and colleges infuse health into everyday operations, business practices and academic mandates. By doing so, health promoting universities and colleges enhance the success of our institutions; create campus cultures of compassion, well-being, equity and social justice; improve the health of the people who live, learn, work, play and love on our campuses; and strengthen the ecological, social and economic sustainability of our communities and wider society.’</p> <p>It also has two main calls to action, which our Faculties of medicine should lead within medicine and beyond :</p> <ol style="list-style-type: none"> 1. Embed health into all aspects of campus culture, across the administration, operations and academic mandates. 2. Lead health promotion action and collaboration locally and globally <p>We have a comprehensive national wellness program with pillars of advocacy, awareness, resilience and personal development and programming. We are working on updating our organizational position papers/charter documents on learner wellbeing to lay out more concrete steps required to create a more supportive environment for faculty, students and staff. We have ongoing projects on creating wellness curricula, addressing</p>	<p>irony of failing to properly address this recommendation is that wellbeing amongst a faculty should be one of the core foundations which enable overall success. By focusing on wellbeing of our Faculties, we empower ourselves to achieve new heights in everything else we pursue.</p> <p>While learner and physician wellbeing are now being discussed more openly, due in part because of the "hidden curriculum" in medicine, concrete action has still been lacking. Wellness is still often considered "another category" instead of a core principle that is actively integrated to how we evaluate new curricula, school policies etc. Education on what entails mistreatment and how to report has improved, however, there continues to unacceptable instances of mistreatment in our learning environments and students continue to voice concerns over the lack of action taken to address cases/individuals that are reported. As EDI is further emphasized, these perspectives need to be further integrated into our concept of positive learning environments.</p>		<p>medicine is very much alive and well and creates an less than optimal training environment for learners and all others involved in medical education. We need a dedicated governance group to ensure coordinated action, with objectives goals and consistent measurement. As noted in the 2020 CCME learner forum presentation, health promoting environments must be intergrated into faculty strategic plans in order to truly be actioned.</p>

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	<p>learner mistreatment and creating culture change in medicine We participate nationally on all wellness related working groups and collaborate closely with RDoC and CMA on many initiatives.</p>			
<p>Collège des Médecins du Québec (CMQ)</p>	<p>Quebec offers residents many opportunities to learn and work in environments that encourage respect between and within professions and that promote a collaborative and patient-centred approach. The CMQ participates with CanRAC in the accreditation of postgraduate training programs and ensures that the CanMEDS 2015 accreditation standards and competencies are applied, including those on the learning environment. The CMQ is also involved with the four Faculties of medicine in Quebec in various training programs dealing with ethics and the CanMEDS competencies.</p>			<p>This recommendation is already well established in Quebec.</p>
<p>College of Family Physicians of Canada (CFPC)</p>	<p>The CFPC has developed and advocates for the 'Patients Medical Home' as a model of care well suited to promote the Quadruple Aim. "Exemplary" accreditation requirements have been introduced to promote resident learning experiences based in this type of team environment. The CFPC Assessment objective (competency assessment requirements) contain standards of professional behavior expected in training.</p>	<p>No major barriers noted. Ongoing faculty developed required to identify and assess professional behavior.</p>	<p>Important</p>	<p>It is an essential element of effective education and paves the way for professional behaviors in practice.</p>
<p>Federation of Medical Regulatory Authorities of Canada (FMRAC)</p>	<p>Reporting mechanisms</p>		<p>Very Important</p>	<p>Everyone learns by example.</p>

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
Medical Council of Canada (MCC)	updated assessment modalities and a blueprint which focuses on the foundational knowledge, skills and attributes required by all physicians in demonstrating high quality, patient centered care and professional behaviours;	rapidly changing world of medical care provision and a need to respond to emerging skills such as virtual health care; big data enabled decision making and integration of technology	Important	positive role models and supportive environments lead to healthier physicians and improved patient care
Resident Doctors of Canada (RDoC)	<p>In 2015, RDoC released an updated position paper on Optimizing a Positive Work Environment by Addressing Intimidation & Harassment. We continue to work with Faculties of Medicine to promote and ensure a positive learning and working environment for resident doctors. In keeping with our objective to enrich the experience of medical education, inspire a redefined work environment for resident doctors, and promote a culture of respect, our current focus in this area now, is to recognize Intimidation and Harrassment (I&H) prevention as necessary to improving the work and learning environment for residents. RDoC believes that residency programs should focus on creating and maintaining a positive work environment for staff physicians, resident doctors, medical students, and all members of the healthcare team.</p> <p>In 2019, RDoC hosted an inaugural Positive Working Environment Summit that involved multi-disciplinary partners from nursing, physiotherapy, social work, and others. Participants discussed major themes related to</p>	<p>According to RDoC’s 2018 National Resident Survey, more than three quarters of residents (78.2%) experienced at least one form of intimidation or harassment during the year preceding the survey. Yet, only 10.4% of those used their institutions’ resources for support. When asked if their program, medical school, or university has a policy to address intimidation and harassment, one fifth of respondents did not know the answer. Of those who knew about such policies and who had experienced a form of harassment, 10.4% had used that institutions’ resources to these events. When the latter were asked if they felt that resources to address intimidation and harassment were adequate in their program, medical school or university, the majority, 61.2%, said no. The 2018 RDoC national survey shows that intimidation and harassment remains a serious issue for Canada’s resident doctors and much more needs to be done to create positive and supportive learning and work environments.</p>	Very Important	<p>Intimidation and harassment is a risk in any workplace, and it is unfortunately prevalent in medical residency. Intimidation in medical education is defined as any behaviour, educational process, or tradition that induces fear in the learner or has a detrimental effect on the learning environment.</p>

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	<p>fostering a positive working environment in healthcare, including awareness, work/life balance, conflict resolution, and the hierarchical model of care. RDoC’s Wellness Committee has also developed infographics on using “pro-wellness language” to foster positive change in the culture of medicine.</p> <p>Link: Optimizing a Positive Work Environment by Addressing Intimidation & Harassment Link: Intimidation & Harassment Prevention Area of Focus</p>			
<p>Royal College of Physicians and Surgeons of Canada</p>	<ul style="list-style-type: none"> - through accreditation visits this can be monitored and the current emphasis on quality improvement will assist with shifting the culture - ongoing work with CanERA to present a unified approach 		<p>Important</p>	

Recommendation 4: Integrate Competency-Based Curricula in Postgraduate Programs

Develop, implement, and evaluate competency-based, learner-focused education to meet the diverse learning needs of residents and the evolving healthcare needs of Canadians.

Competency-based education is still in its infancy. It involves moving away from a strictly time-based training model towards one that identifies the specific knowledge, skills, and abilities needed for practice. Some of these competencies will be generic and needed by all physicians; some will be specific to specialties or groups of specialties; and others will be specific to the needs of particular communities. Each needs to be identified, explicitly taught, and assessed.

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Canadian Federation of Medical Students (CFMS)	In partnership with the Royal College workshops/info sessions have been held at the 2018 and 2019 CFMS SGM meetings to help educate students on CBME. We have a CBME file lead within the Education portfolio and pass on information to our members on CBME.	While competency based medical education is often discussed as something we are “moving to”, it has been unclear what effect, if any, this really is have within UGME. As observers to the transition to CBME in postgrad, it seems that current methods of assessment are barriers to fully implemented CBME. In addition, we often hear of the notion that there are “so many evaluations to fill out”, which also has an effect on students as they have certain “EPA—like” evaluations to be completed as well.	Moderately Important	It is important to evaluate the effectiveness of this transition and more clearly consider the effects and implications to undergraduate education.
Collège des Médecins du Québec (CMQ)	Residency programs in Quebec adhere to the principles of the competency-based approach. The transformation of residency programs into a competency-based approach is widely deployed in			This recommendation is already well established in Quebec.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	family medicine and is well underway in other recognized specialty training programs in Québec. Here again, the accreditation standards for residency programs ensure that they adequately integrate this approach.			
College of Family Physicians of Canada	The CFPC successfully introduced a CBME transformation with the "Triple C Competency Based Curriculum" in 2010. This has undergone extensive evaluation and some course correction underway through the Outcomes of Training Project.	The metrics and data available to study outcomes of training (re: scope, mix and distribution) are quite limited in family medicine. There needs to be an investment in better health workforce data to guide evaluation and decision-making re: training positions.	Very Important	To ensure a safe and highly skilled physician workforce.
Federation of Medical Regulatory Authorities of Canada (FMRAC)	Only indirectly		Very Important	What is important is what the physician can actually do - in a real practice setting. This approach also recognizes that people learn and acquire skills at different rates.
Medical Council of Canada (MCC)	<i>Recommendation not applicable</i>	<i>Recommendation not applicable</i>	Moderately Important	somewhat untested approach with respect to outcomes at this time
Resident Doctors of Canada (RDoC)	In 2016, RDoC released the position paper Implementing a Competency-Based Approach to Medical Education . Since that time, we continue to have a central advocacy role in CBME implementation in Canada. Through national advocacy work on behalf of our members and ongoing formal communication with the Colleges, we help to ensure that the learner's point of view is taken into consideration in any proposed changes. In March 2020, the RDoC Board of Directors approved Top Ten Tips : A Guide for CBME from a Resident Perspective , to ease the transition to		Very Important	Competency-based medical education (CBME) has emerged as an important construct in medical education in recent years. Interest and debate on the topic continues to grow with the pending paradigm shift in Canadian medical residency programs. It offers several exciting opportunities for medical education but also raises some implementation concerns. CBME will impact the entire medical education community through significant changes to assessment, credentialing, and accreditation processes.

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	<p>CBME for residents. It is hoped that by reading through these tips, residents become familiar with the principles of CBME, and are open to discussing their questions and concerns with others so they become better prepared for the utilization of CBME during their postgraduate training.</p> <p>Our commitment to CBME is further demonstrated by our involvement with such stakeholder-run groups at the the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.</p> <p>Link: Competency-Based Medical Education Area of Focus Link: Implementing a Competency-Based Approach to Medical Education Link: Top Ten Tips : A Guide for CBME from a Resident Perspective</p>			
<p>Royal College of Physicians and Surgeons of Canada</p>	<ul style="list-style-type: none"> - CBD - Fundamental Innovations in Residency Education (FIRE proposals) 	<ul style="list-style-type: none"> - costing concerns, some related to CBD and others related to longer term under funding of PGME - resistance to change on a number of fronts - multiple electronic platforms and data sharing concerns - Limit/delay progress of CBME 	<p>Very Important</p>	<p>the key to current issues with the system</p>

Recommendation 5: Ensure Effective Integration and Transitions along the Educational Continuum

The Canadian PGME system prepares physicians for practice. This requires development through the increase of responsibility across the medical education continuum and effective transitions from UGME into PGME, within PGME, and from PGME into practice.

The transitions from medical school to residency and, later, into practice are key opportunities for learning; however, they need to be managed and used more effectively. In particular, entry to residency and the final year of residency training need to be better structured to maximize learning and readiness to practice. The different phases of training also need to be better integrated.

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Canadian Federation of Medical Students (CFMS)	The transition from medical school to residency is stressful and a very large step in the medical education journey. From a wellbeing perspective we know transitions are usually very difficult. The CFMS has been engaged in the discussion on entry routes to residency and participated on past and current working groups on the issue. We have monitored the conversation on residency transfers and support opportunities to be more transparent on transfer systems. Linking learner competencies from undergrad to postgrad is critical and we support this work though feel like it has not been fully undertaken. We have discussed concerns regarding timing and utility of certain assessments that are currently requirements of the medical education process. Part of this issue is the lack of information that students have about career opportunities prior to the CaRMS Match which we have detailed in Recommendation 1.	Work on entry routes to residency seems stalled. Much of the focus has been on barriers to change, instead of having truly generative discussions about how entry routes may be impacting our ability to provide comprehensive generalist care, impact on the undergraduate education process etc. While we do not as an organization have a position on how many entry routes there should be we find the current processes being undertaken to address the issue ineffective. How has the patient and public perspective been integrated? What entry routes/training methods would produce the best physicians and healthcare system? Is it the current model? Is there evidence to support that?	Important	Transitions along the medical learner continuum are a known source of significant stress to wellbeing. A number of important outstanding issues including entry routes and residency transfers need to be effectively addressed as they have significant implications for HHR planning and the overall effectiveness of medical education.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
		<p>Many of these issues including timing of exams, residency transfers etc have not had significant progress. We believe a renewed focus on how they affect patient outcomes and the Canadian health system may allow us to address them more effectively.</p>		
<p>Collège des Médecins du Québec (CMQ)</p>	<p>a) Quebec has fewer entry routes to residency than some other provinces.</p> <p>b) The Comité des études médicales et de l'agrément (CÉMA), a standing committee of the CMQ, makes decisions on matters related to undergraduate and postgraduate medical education, policies, procedures and standards to be followed in medical education and accreditation. In particular, it ensures that undergraduate and postgraduate medical education adequately prepares candidates for the practice of medicine and studies any related issues. It collaborates with university partners, other colleges and organizations involved in medical education to gather relevant medical education evidence and make recommendations.</p> <p>The CÉMA has been involved in discussions regarding the RC's Competence by Design and the CFPC's Triple C Competency-based Curriculum, transformative educational measures aimed in particular at preparing physicians for practice.</p> <p>c) The RC's Competence by Design model emphasizes that all examinations be successfully completed prior to the final year of residency to optimize the transition to practice. It should also be noted that the internal</p>			<p>This recommendation is already well established in Quebec.</p>

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	<p>medicine examination has been advanced by one year and is now taken in the 3rd year of residency.</p> <p>d) Québec has a well-established policy on transfer between residency programs. A special quota also makes it possible to offer residency positions, in particular to physicians wishing to access a residency program after having practiced in another specialty.</p>			
<p>College of Family Physicians of Canada (CFPC)</p>	<p>As part of the Outcomes of Training project the CFPC is conducting an international and cross-disciplinary review of PG training design re: transitions to establish if there is any 'best evidence'. Some attention is paid to this currently by requiring each resident to have a primary preceptor/competency coach that follows them through the entire training period, achieving some continuity to assist in educational transition planning.</p>	<p>Educational capacity and funding to follow 'alumni' out into practice and/or to provide early career mentorship.</p>	<p>Important</p>	<p>For efficient use of resources and to support preparedness for practice.</p>
<p>Federation of Medical Regulatory Authorities of Canada (FMRAC)</p>	<p>Monitoring and ensuring that no major decision is passed on to the next part of the continuum when it should be dealt with now.</p>	<p>Fear of being sued</p>	<p>Very Important</p>	<p>It is not a series of discrete, unrelated steps.</p>
<p>Medical Council of Canada (MCC)</p>	<p>ongoing project with multisource feedback as a formative tool for use in UME; potential for the use of multisource feedback as a baseline measure during transition to practice given that there is increasing focus on continuing professional development using this as an in-practice tool</p>	<p>Mandatory assessments such as the MC Qualifying exams could be effectively used to identify areas of focus for targeted learner assistance or support - currently a lost opportunity at the time of transition and in early stages of residency</p>	<p>Important</p>	<p>current system is very disjointed and disconnected for what is referred to as the continuum of learning and much better flow of information is needed</p>
<p>Resident Doctors of Canada (RDoC)</p>	<p>RDoC has advocated for longitudinal career counselling that reflects the best available evidence on all aspects of medical school, residency, and practice. We believe that better data, planning and analysis is needed to ensure the provision of appropriate resources and</p>		<p>Important</p>	<p>A sustainable health care system must ensure an appropriate specialty and distribution mix that is responsive to population needs. This requires effective physician resource planning and training – but for resident</p>

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	<p>supports, including career counselling and mentoring to residents as they make career decisions.</p> <p>In 2013, RDoC developed Principles on Resident Transfers to increase resident awareness of the inter- and intra-provincial transfer process and promote transparency and consistency amongst educators, residents and programs.</p> <p>In 2019, RDoC took this one step further and is advocating for the development of a pan-Canadian transfer system. We advocate that this new system should have, as its foundation, principles of transparency, coordination, fairness, freedom from intimidation and harassment, and accessibility.</p> <p>These principles are intended to be broadly applicable to all resident transfers, are inclusive of transfers between programs within one postgraduate institution, between postgraduate institutions within a province, and those across provincial lines. The primary goal of these principles is to create a guideline for developing a new transfer system, with the goal of maximizing the number of successful resident transfers - into programs that have the capacity to accept transfers; into programs that suit the resident and that the resident has been able to gain experience in; and, through a process that is streamlined and agreed upon by all stakeholders across the country. These principles will guide our ongoing advocacy nationally as we continue to explore appropriate solutions to best meet the needs of our members.</p>			<p>doctors, anxiety may also exist surrounding how to go about actually finding jobs when the time comes. It is also the case that resident doctors frequently transfer from one residency program to another. While each postgraduate medical education office across Canada has policies in place to guide residents interested in transferring within and between institutions, RDoC is advocating for an integrated residency transfer system to optimize the number of successful resident transfers, increase equity, transparency and consistency in the transfer process, and align practices across Canadian medical institutions</p>

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	<p>RDoC also addresses this issue through our advocacy and support for national licensure. RDoC believe that a robust and thorough licensure process is necessary for the protection of patients and ethical self-regulation of the profession and that patients across all regions of Canada have a right to high-quality care.</p> <p>Currently, the application process for medical licensure requires physicians to submit separate applications to each of the thirteen Provincial/Territorial medical regulatory authorities that license physicians. This limits physicians from providing services in multiple jurisdictions without going through a separate licensure process for each province/territory. This poses a challenge to residents and staff physicians who strive to deliver care to patients easily and flexibly. The ability to access timely clinical coverage support for respite and assistance is crucial to the recruitment, retention, and well-being of physicians working in rural and remote regions. This would also offer exposure to different models of care in a variety of regions, fostering the development of well-rounded physicians who are comfortable functioning in diverse practice environments. RDoC supports the creation of physician mobility agreements and strongly advocates that any such agreements do not exclude physicians who have held an independent license for less than three years.</p> <p>A third critical area RDoC addresses the concept of effective integration and transition along the educational continuum is with its work on entry</p>			

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	<p>routes. In 2017, RDoC, together with the Association of Faculties of Medicine of Canada (AFMC), struck a collaborative Entry Routes Working Group composed of members from the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, le Collège des médecins du Québec, Fédération médicale étudiante du Québec, the Canadian Federation of Medical Students and the Deans (PG Dean, UG Dean, Student Affairs/Learner Wellness). This Working Group was co-led by RDoC and the AFMC to develop recommendations, informed by the best available evidence, on appropriate entry routes into residency to ensure that we are meeting the current and future needs of Canadians.</p> <p>Links: Career Planning Area of Focus Resident Transfers Area of Focus Principles on Resident Transfers pan-Canadian transfer system National Licensure Area of Focus</p>			
<p>Royal College of Physicians and Surgeons of Canada</p>	<ul style="list-style-type: none"> - transition to discipline and transition to practice stages of CBD to assist with entry and exit from residency - increased flexibility to move between programs based on acquired competencies 		<p>Slightly Important</p>	

Recommendation 6: Implement Effective Assessment Systems

Assess competence and readiness to practice through a combination of formative and summative feedback and assessments. The science of assessment is continually evolving, and there is increasing recognition that new assessment tools are required as we further develop competency-based medical education. Assessments need to be appropriately timed to provide ongoing feedback to learners and to maximize all learning opportunities within a residency program.

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Canadian Federation of Medical Students (CFMS)	We have continued to monitor situation from undergraduate assessments (introduction of EPAs in undergrad, fully implementing pass/fail grading systems etc). CFMS has representation on the AFMC Pan-Canadian EPA working group. We support the importance of ensuring undergraduate competencies are linked to postgraduate competencies and that learners are well supported for the transition to residency.	Providing regular, effective feedback is time-consuming for faculty. Providing effective feedback is a skill that we must all continue to develop and should be better emphasized even in undergraduate education.	Moderately Important	As we implement CBME, there is opportunity to re-evaluate how assessments are approached in medical education.
Collège des Médecins du Québec (CMQ)	Programs are accountable for providing regular and appropriate formative feedback and must use a variety of sources of feedback and competency assessment. Frequent formative observations and feedback are central to the competency-based approach. Each residency program implements a workplace assessment system, based on "Entrustable Professional Activities" (EPA). As well, each medical school establishes a competency committee for each specialty. This committee makes decisions and recommendations based on, among other things, data from observation of a series of EPAs (http://www.royalcollege.ca/rcsite/cbd/implementation/cbd-milestones-epas-f), and identifies trends in a resident's performance and progress toward competency.			This recommendation is already well established in Quebec.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	The CMQ also collaborates with its partners to establish eligibility criteria for certification examinations.			
College of Family Physicians of Canada (CFPC)	Improved workplace-based assessment is a work in progress starting with the introduction of CBME in 2010. The CFPC developed a committee (CPAC) devoted to the development and implementation of effective assessment functioning as advisory to the Board of Examinations and Certification. The CFPC has published standards of Competency Assessment for individuals "The Assessment Objectives in FM" along with best practices for programmatic assessment – CRAFT (Continuous Reflective Assessment for Training).	Ongoing faculty development required. Earlier detection/correction of educational needs is occurring, but program directors still needs more institutional support to enforce evaluation and remediation decisions as there is ongoing concern (albeit improvements) in the "failure to fail".	Very Important	To support high standards of effective and safe practice.
Federation of Medical Regulatory Authorities of Canada (FMRAC)	Indirectly involved		Very Important	This is the defensible element. It may mean redefining what and how assessment is carried out.
Medical Council of Canada (MCC)	MCC provides objective and independent assessment of core foundational skills, knowledge and professional behaviours expected of all physicians through its mandatory qualifying exams. These exams are required as a component of eventual independent licensure for medical students and residents. MCC assessments are highly standardized, valid, predictive of future outcomes and are based on requirements identified by the medical education experts at Canadian Faculties of Medicine. Independent assessment of learning closes the loop between external program accreditation - which assess what is being taught and the educational environment, and the demonstration in an independent and standardized manner that what has been taught has been learned. Work is always ongoing with regard to updates for exam	Mandatory assessments such as the MCC Qualifying Exams could be effectively used to identify areas of focus for targeted learner assistance or support - currently a lost opportunity at the time of transition and in early stages of residency	Very Important	otherwise how do you know when learning has taken place? Part of the "shows how"...

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	<p>currency and future directions. MCC also has extensive educational and preparatory resources available to assist learners.</p>			
<p>Resident Doctors of Canada (RDoC)</p>	<p>RDoC has developed four principles and calls for action to help ensure a smooth transition to competency-based medical education (CBME). These principles emphasize the importance of a clear, robust, and comprehensive transition strategy to facilitate successful implementation, seamless incorporation, and buy-in of new assessment methods and teaching approaches in residency.</p> <p>Specifically on assessment, RDoC advocates for the development of assessment methods that use multiple assessment tools, enlist various assessors, adapt to varied learning environments, and promote formative feedback and self-reflection; that assessment and promotion in CBME must be transparent to residents to ensure that progress through their training truly reflects their status along the competency continuum and does not unduly reflect service demands or other secondary needs of the system or program; and that examinations for the purposes of licensure or certification should be composed of content that accurately reflects an eligible trainee’s stage of training and competency regardless of their exam timing. Additional key and important principles on implementing effective assessment systems are outlined in RDoC’s Position Paper on Implementing a Competency-Based Approach to Medical Education.</p> <p>Link: Implementing a CompetencyBased Approach to Medical Education</p>		<p>Important</p>	<p>Competency-based medical education (CBME) has emerged as a new curricular paradigm for the medical education continuum. Its focus lies on outcomes-driven education and assessment to ensure that graduates are able to meet the needs of their patients rather than spend a pre-specified amount of time in training. As a new paradigm, CBME will result in a dramatic shift in the way physicians are trained. We must ensure, from a resident and patient-centered point of view, that our medical education and postgraduate training systems continue to meet the needs of our patients. The ongoing transition to CBME must harness the strengths of our current approach while mitigating any unintended consequences.</p>

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
Royal College of Physicians and Surgeons of Canada	<ul style="list-style-type: none"> - CBD focus on performance/assessment <u>for</u> learning over <u>of</u> learning - more emphasis on supervisor observation with summative decisions made by competence committee (as stated below) - coaching model based on frequent low stakes observations - exam reform, both content and timing. Introduction of electronic exams - decision on deliberate promotion made by competence committee 	<ul style="list-style-type: none"> - concerns expressed about burden on faculty of assessing trainees - lack of alignment on universal electronic recording platform 	Very Important	it is essential the assessment is based on clinical performance and not just exams. CQI

Recommendation 7: Develop, Support, and Recognize Clinical Teachers

Support clinical teachers through faculty development and continuing professional development (CPD), and recognize the value of their work. Teaching of residents in medicine now occurs in a wide range of clinical settings, with instruction by a variety of physicians and other healthcare professionals—all of whom possess varying levels of teaching skills. Clinical teachers should be supported to provide excellent instruction, responsible role-modelling, and effective feedback and assessment.

Teachers must be provided with effective and appropriate faculty/professional development support in order to optimize educational outcomes and recognition (e.g., remuneration, academic merit/promotion, awards).

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Canadian Federation of Medical Students (CFMS)	We have not been actively involve in any national strategy work on this topic, however, we are constantly engaged in opportunities to improve learning opportunities for students. We want to be involved in any process focused on developing, supporting and recognizing clinical teaching. Most recently, the CFMS had our “Culture Changers” campaign on National Physician’s Day to recognize those involved in our medical education who had made a positive impact in improving medical culture.	Some barriers we have observed include the current physician remuneration models which may not take into account teaching activities. There are opportunities to improve professional	Important	Clinical teaching is obviously critical to medical education. Ensuring professional development is readily available for clinician educators and that teaching activities are recognized and rewarded will continue to improve the learning environment.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
		development opportunities for faculty.		
Collège des Médecins du Québec (CMQ)	For Continuing Professional Development (CPD), the CMQ accredits, with the CACME, the CPD units of the 4 Faculties of medicine in Quebec and, independently, 39 other organizations providing CPD activities in Quebec. The Direction de l'amélioration de l'exercice at the CMQ participated in the FMEC CPD project. In addition, the accreditation process for residency programs contains requirements for faculty development, evaluation and evaluation of teachers.			This recommendation is already well established in Quebec.
College of Family Physicians of Canada (CFPC)	The CFPC Section of Teachers has shifted its mandate more towards support for front line teachers.	Teachers in the community setting are still very under-supported in terms of administrative support, faculty development that reaches them in a practical way, and time/remuneration for teaching activities. This situation is most dire in rural environments.	Important	Essential to the viability of the educational enterprise.
Federation of Medical Regulatory Authorities of Canada (FMRAC)	<i>Recommendation not applicable</i>	<i>Recommendation not applicable</i>	Important	
Medical Council of Canada (MCC)	<i>Recommendation not applicable</i>	<i>Recommendation not applicable</i>	Important	
Resident Doctors of Canada (RDoC)	RDoC recognizes the work of clinical teachers through the work of our Awards Committee. Through its Awards Program, RDoC honours individuals who have contributed to improving various elements of the lives of resident doctors in Canada. There are currently three awards bestowed annually in the following categories: (a) wellness, (b) medical education, and (c) service to resident doctors.		Important	

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>Past recipients have included resident doctors, program directors, postgraduate medical education (PGME) administrators, and organizations that support resident doctors. RDoC award recipients gain both national and local recognition for their efforts. Because of this, the RDoC Awards Program is perhaps one of the most continually successful projects that we undertake.</p> <p>RDoC also addresses issues of resident fatigue, sleep deprivation, and other factors affecting patient safety, quality of care, resident learning, and resident health. Our infographic “Optimizing the Working Conditions of On-Call Residents: National Standards for Resident Call Rooms” outlines expectations and recommendations for resident call rooms. Our Wellness Project Team also addresses issues such as nutrition and accessibility in its work.</p> <p>Link: RDoC Awards Link: National Standards for Resident Call Rooms</p>			
Royal College of Physicians and Surgeons of Canada	<ul style="list-style-type: none"> - CBD faculty development materials extensive, posted on web. - multiple outreach visits to Faculties - Education awards presented at ICRE 		Important	

Recommendation 8: Foster Leadership Development

Foster the development of collaborative leadership skills in future physicians, so they can work effectively with other stakeholders to help shape our healthcare system to better serve society.

Both the FMEC MD and PG projects recognize that collaborative MD leadership is essential. Leadership development must begin in medical schools and be further developed through residency and into practice.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
Canadian Federation of Medical Students (CFMS)	Leadership development in medical education is consistently a topic of interest for medical students.	The CANMEDS role of "Leader" seems to contain most of the objectives under Manager.	Important	As one of the CANMEDs roles, leadership continues to be critically important as a core competency. Physician leadership in the

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>The CFMS created two leadership development co-file leads in 2019 to help further develop learning opportunities for students, focus on partnership for curriculum development etc</p> <p>We are also working with many national organizations like CSPL and the CMA enterprise to provide more opportunities for learners.</p> <p>We have an organization position paper in 2016 on the topic and it is currently being updated. We also continue to advocate for increased faculty support of students engaging in leadership opportunities.</p>	<p>What is the definition of "Leadership" in medicine?</p> <p>We feel overall there has not been significant work done on this area in UG education. While we are not sure of the work done in postgrad one barrier seems to be coordination amongst UG and PG on this issue as a national core leadership curriculum has not been developed.</p> <p>In addition, it is important for Faculties to explicitly support leadership development and involvement amongst learners. Unfortunately, learners experience highly variable levels of support from faculty in order to pursue learner representative leadership opportunities.</p>		<p>continually evolving healthcare setting is very important. We need to be leaders in developing a more effective healthcare system, we need leaders to continue improving medical education etc etc. We have much work to do to create a national curriculum/competencies which will continue to improve the medical graduate competencies that are required to be a successful physician in today's world.</p>
<p>Collège des Médecins du Québec (CMQ)</p>	<p>It seems to us that AFMC has taken the initiative to develop this national leadership program across the continuum. The CMQ has a Code of Ethics that all learners (students, residents, instructors) and practicing physicians must follow and which clearly addresses certain obligations related to management competence. The Direction de l'amélioration de l'exercice of the CMQ also offers leadership training workshops. In addition, the Direction des études médicales has developed a guide on the role and responsibilities of the learner and the</p>			<p>This recommendation is already well established in Quebec.</p>

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	supervisor, which is sent to all learners and to the four Faculties of medicine in Quebec.			
College of Family Physicians of Canada (CFPC)	The CFPC has an "everyday leadership" working group looking at residency level leadership competencies and teaching approaches.	The short duration of training is a barrier to residents experiencing a progression of leadership responsibilities including teaching.	Important	As an investment in ongoing improvements to the system; leadership is about 'getting to better'.
Federation of Medical Regulatory Authorities of Canada (FMRAC)	<i>Recommendation not applicable</i>	<i>Recommendation not applicable</i>	Important	
Medical Council of Canada (MCC)	<i>Recommendation not applicable</i>	<i>Recommendation not applicable</i>	Moderately Important	beyond general learning of leadership skills, focused support for emerging leaders is needed rather than a one shoe fits all approach
Resident Doctors of Canada (RDoC)	In 2013, RDoC published a position paper on Mentorship in Residency to increase the awareness of the importance of mentorship in residency. We advocate that program directors consider establishing a formal or informal mentorship structure within their residency program and as part of their residency curricula. Mentoring is an important part of academic medicine and we hope that this position paper will lead to the development of a more structured approach to mentorship in residency education. Link: Mentorship in Residency	The most commonly sighted barrier to effective mentorship is the perceived lack of time due to increasing clinical, research and administrative responsibilities. This speaks to the importance of the creation of a working environment that fosters mentorship. In order for mentoring programs to be successful, there needs to be a culture of mentorship, which is supported by both faculty and administration. Faculty promotion in academic medicine has historically been based on research output and clinical productivity. It is important to recognize mentorship as an important teaching activity and reward physicians who are committed to this endeavor. In contrast to other academic roles such as the clinical researcher or educator, there is also the challenge of isolation in that mentors may feel isolated from other mentors	Important	Mentorship is a key component of the education and professional development of resident doctors. Mentorship fosters important network connections, supports residents in the development of their clinical, academic and non-academic skills, and helps to prepare the next generation of physicians for opportunities in academic and clinical areas of foci. Mentors can become essential resources for advice and guidance pertaining to topics outside of the regular academic curriculum, such as research, career planning, networking, work-life balance, and transition into practice. Mentorship also helps to prepare the next generation of physicians for positions in academic and clinical leadership. In fact, the success of residents in the competitive academic environment of modern medicine, demands the need for

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
		and therefore not able to benefit from sharing experiences. This can also impact the mentors' perception of lack of preparation and clarity about their role. More formalized recognition of their role and support for training in this context, would be important.		mentoring and exposure to mentors in all disciplines. Recent factors which have changed the field of medicine, and which makes mentorship even more important, are restrictions on resources in the form of time, a lack of commitment to teaching from consultants, duty hour restrictions and a shortage of identifiable mentors.
Royal College of Physicians and Surgeons of Canada	- CanMEDS 2015 specifically calls out leadership - CBD faculty development materials		Moderately Important	

Recommendation 9: Establish Effective Collaborative Governance in PGME

Recognizing the complexity of PGME and the health delivery system within which it operates, integrate the multiple bodies (regulatory and certifying colleges, educational and healthcare institutions) that play a role in PGME into a collaborative governance structure in order to achieve efficiency, reduce redundancy, and provide clarity on strategic directions and decisions.

There is widespread acknowledgement that the PGME system in Canada is complex and, at times, somewhat inefficient. There are many stakeholders, decision points, governance challenges, and vested interests involved. Some of these interests must be recognized and supported, while others require re-evaluation and reconceptualization in order to create more effective governance.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
Canadian Federation of Medical Students (CFMS)	The CFMS was an observer on PGME GC. We had actively participated on working groups of the council when issues were also directly relevant to undergraduate education.	PGME GC spent significant time trying to “find its purpose”. As observers to the process it seemed like the group lacked a clear mandate and authority. These would be considerations as the postgraduate community consider next steps.	Moderately Important	There is now opportunity to “rethink” the governance approach. A collaborative council is in theory a good way to approach this. Whether or not that will be effective is dependent on how much we are willing to make it happen.
Collège des Médecins du Québec (CMQ)	The CMQ was part of the initial 3-year project of this Collaborative Governance Council.			This recommendation is already well established in Quebec.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>The CMQ also works closely with the RC and the CFPC on matters related to the accreditation of residency programs, certification examinations, assessment of credentials of certification candidates, CanMEDS and CanMEDS-FM and the Red Book, as well as with the CACME for the accreditation of university CPD units.</p> <p>At the Quebec level, the <i>Table de concertation</i> and the CÉMA are also two of the bodies contributing to the collaboration of the various organizations involved in PGME.</p>			
<p>College of Family Physicians of Canada (CFPC)</p>	<p>The CFPC was an active participant in the PGME Collaborative Governance Council, and is saddened by recent events, leading to our decision to withdraw.</p>	<p>In our opinion, the credibility of the PGME Collaborative Council was undermined when the AFMC bypassed the Council and created a separate 'Entry Routes Working Group'. As other partner organizations dropped off of Council, the CFPC decided that the Council was unlikely to be viable/effective.</p>	<p>Important</p>	<p>To improve efficiency, effectiveness, accountability and a collegial healthcare system. To address the hidden curriculum.</p>
<p>Federation of Medical Regulatory Authorities of Canada (FMRAC)</p>	<p>Participation on governing council</p>	<p>The fact that the council has no authority whatsoever</p>	<p>Important</p>	
<p>Medical Council of Canada (MCC)</p>	<p>Participation in the PGME Governance Council and Canadian Medical Forum; regular meetings and interactions with all levels of medical education - UME --> CPD; interactions with Health Canada and FPT government officials</p>	<p>the multitude of stakeholders and no clear sense of ownership or oversight in a highly fragmented system; no study of relevant or comparable governance models has been undertaken</p>	<p>Moderately Important</p>	<p>Very challenging with so many stakeholders and very difficult to have everyone at the table. Especially the funders...the most difficult to act on with any evident success. Perhaps should be renamed since this is less about "governance" and perhaps more about strategic alignment which is currently missing</p>
<p>Resident Doctors of Canada (RDoC)</p>	<p>RDoC collaborates with external partners on the Postgraduate Medical Education Governance</p>		<p>Moderately Important</p>	

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>Council (PGME GC), the Canadian Medical Forum and through other committees and working groups of our national partners in medical education. RDoC’s work on PGME GC, has included participation and leadership on the PGME Disability Accommodations Working Group and the PGME Generalism Working Group. Through work with these groups, RDoC has been involved in the development of two Position Papers: Accommodations in Residency Training and Examinations provided recommendations for a national resource centre, professional conduct, and cross-country alignment, while the Generalism group’s Position Paper recommended ways that PGME could better align with the needs of the healthcare system and, more broadly, support the health care needs of Canadians and their communities.</p>			
<p>Royal College of Physicians and Surgeons of Canada</p>	<ul style="list-style-type: none"> - active member of PGGC - participation and contributions to statements and discussions 	<ul style="list-style-type: none"> - lack of buy in to the Council - multiple issues addressed outside of Council diminishing usefulness/utility of the table - a number of original members have dropped out 	<p>Slightly Important</p>	<ul style="list-style-type: none"> - despite best efforts and intentions i am skeptical that the time and attitude is right for this move

Recommendation 10: Align Accreditation Standards

Accreditation standards should be aligned across the learning continuum (beginning with UGME and continuing through residency and professional practice), designed within a social accountability framework, and focused on meeting the healthcare needs of Canadians.

Much of the same information is gathered several times over. The standards of accreditation can be set by the appropriate body, but the conduct of accreditation can be shared and aligned. Standards of training and accreditation systems are in place to ensure that quality physicians are trained. It is up to these systems to ensure that physicians in training are prepared for practice and maintain their competence throughout their careers.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
Canadian Federation of Medical Students (CFMS)	Student representation on CACMS and participation in upcoming CACMS review. Students are integral to all UGME accreditations and the CFMS supports them through our accreditation file leads, accreditation/ISA tool kit and any other opportunities possible.	Complexity of accreditation process makes it difficult to put forward suggestions for change. Current undergrad accreditation process is very cumbersome, but learners perceive there are many standards that are too broad. There are many other opportunities to strengthen requirements on standards (e.g. social accountability) as medical education needs to adapt to societal demands. We are very supportive of there being a review process for accreditation.	Important	Accreditation standards heavily influence the nature of medical education. It is critical that these standards reflect the needs of the population and are coordinated across the learning continuum to support the training of physicians who are well equipped to serve Canadian patients.
Collège des Médecins du Québec (CMQ)	The postdoctoral sector has put a lot of effort into harmonization with the UGME and CPD (CACME) sectors, including the development of potential data harmonization mapping. Given the constraints of accreditation at the UGME level (CACMS and LCME), the three colleges that accredit and certify for the			This recommendation is already well established in Quebec.

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>postgraduate sector have decided to move forward with harmonization of postgraduate accreditation in which AFMC and the medical schools have been closely involved. As a result, the Canadian Residency Accreditation Consortium (CanRAC) was created. Modernized accreditation standards (...CanERA) are in place and an electronic Accreditation Management System (AMS) has been implemented.</p>			
<p>College of Family Physicians of Canada (CFPC)</p>	<p>The CFPC is an active partner in CanRAC now with conjoint general accreditation standards (Program and institution level with the other certifying colleges. This is working well and there is now a CQI cycle applied to the ongoing improvement of accreditation standards via this process (ASIC - Accreditation Standards Improvement Committee).</p>		<p>Important</p>	<p>A shared definition of education quality makes it easier to work together and to achieve quality -- in a complex and interdependent health care and educational system.</p>
<p>Federation of Medical Regulatory Authorities of Canada (FMRAC)</p>	<p>Member of ASIC.</p>		<p>Very Important</p>	
<p>Medical Council of Canada (MCC)</p>	<p><i>Recommendation not applicable</i></p>	<p><i>Recommendation not applicable</i></p>	<p>Moderately Important</p>	<p>Important but much work is already in place so perhaps less relevant as a focus going forward</p>
<p>Resident Doctors of Canada (RDoC)</p>	<p>RDoC is committed to supporting the development of a robust accreditation system. Accreditation is a key strategic area for RDoC and we engage with resident members on a regular basis, to gather their input on accreditation matters of importance to residents and to ensure that our accreditation documentation remains current and applicable.</p> <p>Our work in this area includes administering the RDoC Pre-Accreditation Questionnaire to residents in programs undergoing full accreditation. We have administered this</p>		<p>Very Important</p>	<p>The Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and the Collège des médecins du Québec maintain the national standards for the accreditation of PGME institutions and PGME training programs in Canada. The three Colleges have partnered to create the Canadian Residency Consortium (CanRAC), and they have spearheaded the development of a new conjoint system of residency accreditation. The work of CanRAC has resulted in the creation of new</p>

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	<p>questionnaire since 1983 to ensure that residents’ perspectives and concerns are voiced in a safe and confidential manner. It is an invaluable tool that gathers the resident on-the-ground perspective on their training prior to an onsite postgraduate medical education accreditation and the confidential results are made available to the resident surveyors on the Royal College and CFPC survey teams to guide their review during a review.</p> <p>The resident voice and presence during accreditation reviews are a central and critical element. RDoC facilitates the appointment of resident surveyors on Royal College and CFPC accreditation survey teams and, in this way, residents are continually involved both before and during the onsite accreditation review.</p> <p>RDoC supports the transfer of knowledge about accreditation, and the accreditation process, to resident surveyors and to residents in programs undergoing full accreditation. This includes collaborating with the Colleges on accreditation workshops and supporting the involvement of residents in training opportunities. RDoC accreditation workshops were first started in 2009 with the most recent workshop taking place in February 2020 for University of Toronto residents ahead of their November 2020 accreditation review.</p> <p>We also participate on many stakeholder groups including the Conjoint Task Force on Resident Input into the Accreditation Process, Royal College Accreditation Committee, Royal College Residency Accreditation</p>			<p>standards for the accreditation of PGME institutions and residency programs, that aligns with competency-based medical education (CBME) and leading best practices in accreditation. The strength of Canada’s approach to residency accreditation is reflected in the increased focus on outcomes and improved processes, but it also preserves the strengths of the current system.</p>

Organization	Update on Work of Organization	Comment on Barriers Experienced	Importance of Recommendation	Why is this recommendation important/relevant?
	Committee, Royal College Simulation Accreditation Committee, Royal College Conjoint Residency Accreditation Standards Improvement Committee and the CFPC Residency Accreditation Committee. Link: Accreditation Area of Focus			
Royal College of Physicians and Surgeons of Canada	<ul style="list-style-type: none"> - work of CanRAC and CanERA - alignment between CFPC, CMQ and Royal College - development of Accreditation Management System - offers to work with UG and CPD accreditation processes 	- organizations not aligned on the alignment of accreditation	Important	

New FMEC PG Recommendations

All organizations were invited to provide suggestions, following are the responses of the organisations who chose to respond. Note that all responses were received prior to or during the early phases of the COVID-19 pandemic.

The Canadian Federation of Medical Students (CFMS) provided a detailed response.

We should develop and implement dedicated recommendations on BIPOC (Black, Indigenous, and People of Colour) health. Faculties of medicine have an important role to play in addressing the health disparities experience by BIPOC individuals. In addition, our Faculties do not reflect the population we serve and this must have more concerted focus. Recommendations that more explicitly support action on Equity, Diversity and Inclusivity are critical for moving forward. As the AFMC has committed to the *Commitment to Action on Indigenous Health* report, this should be clearly highlighted in FMEC recommendations. Over the last few weeks, medical education organizations and our Faculties have released statements addressing the role we play in developing anti-racist cultures. This is a perfect opportunity to take action and implement changes that we all committed to.

We need to review the residency selection process. More recently there has been growing concern over the current interview process and its impact on the environment, cost to learners and the significant stress of the whole process, which is of course compounded by the stress of matching. Aside from this though, the larger issue is that we should also be reviewing the selection process as a whole. While BPAS and related projects has helped provide some clarity for applicants as to what programs are looking for we wonder if the current system as a whole is the best in being able to identify which individuals will make the best residents in certain programs. What other information is necessary? Are there any things we currently ask for that aren't helpful or unfairly disadvantage certain groups of students? Why can't we further employ technology for our interviews? These are just some of the many questions that should be raised as part of a review process.

(note: this point was written prior to the significant changes for the 2021 match year as a result of the disruptions caused by COVID-19). While changes are now accelerated for this year and will serve to help inform how things may be adjusted in the future, it is critical that we commit to constantly re-evaluating and improving this process.

The Medical Council of Canada (MCC) indicated prior to COVID-19 pandemic.

See #9 - reframe to a focus on Strategic Alignment of PGME Related Activities

Completely misses anything with respect to international medical graduates whether accessing residency training, fellowship, or as visa trainees.

FMEC Continuing Professional Development (CPD)

The Future of Medical Education in Canada –Continuing Professional Development (FMEC-CPD) Report was released in April 2019. Since that time, the Coalition for Physician Learning and Practice Improvement (CPLPI) has been established. This is a group of 8 collaborating organizations who have agreed to establish priorities and projects that further the implementation of the vision and recommendations of FMEC CPD. These include

- Association of Faculties of Medicine of Canada (AFMC)
- Canadian Medical Association (CMA)
- Canadian Medical Protective Association (CMPA)
- College of Family Physicians of Canada (CFPC)
- Fédération des médecins spécialistes du Québec (FMSQ)
- Federation of Medical Regulatory Authorities of Canada (FMRAC)
- Medical Council of Canada (MCC)
- Royal College of Physicians and Surgeons of Canada (RCPSC)

Representatives from each of these organizations as well as the Chair of the AFMC CPD Committee and a patient representative comprise the leadership team. The team’s mandate includes establishing and actioning a prioritized list of projects that advance the FMEC CPD recommendations.

The CPLPI has facilitated the launch of an online Community of Interest for physician learning and practice improvement which is hosted by the CMA. This is an online community for CPD providers, leaders, administrators, accreditors and patient partners. It was launched in October 2019 with the goal to create conversations and support initiatives that help build a CPD system in Canada that supports physician learning and practice improvement. It is currently hosting webinars in the site to engage the members. A Working Group of Community of Interest Champions has also been engaged to advise on the evolution of the community and to drive engagement.

Development of a bilingual, Canadian university CPD provider survey is nearing completion. This survey will be distributed to all university CPD units in the Fall of 2020. The second phase of this project will be a subsequent survey of a wider group of Canadian CPD providers, including national specialist societies, CFPC chapters, and other large CPD providers.

In order to fulfill the recommendation to “create national training programs to enable CPD developers and providers to acquire the core competences required to design, implement, and evaluate educational interventions”, a working group has been established to develop a new national CPD credential. The working group conducted an environmental scan of existing programs, certifications and resources and has recommended two routes to credentialing: a leadership route and course-based study route. The group has provided a detailed outline of the process. Intake of applications for the first course-based study group is anticipated to begin in November 2020.

In the context of this relatively new mandate and active ongoing work to fulfill the FMEC CPD recommendations, FMEC 2020 has not focused on receiving updates on this work. The FMEC CPD

recommendations are, however, very important to consider in discussions on the continuum of medical education.

FMEC 2020 Continuum

Medical education in Canada follows a continuum from Undergraduate, Post-Graduate, and Continuing Professional Development. To begin to determine the future of medical education, one must delve deeply into the issues facing the system along its entire continuum. To that end, AFMC has widely surveyed our Faculties, our partners and the medical education community to map our collective progress. First, a voluntary focus group of stakeholders was convened to elicit feedback on the Canadian medical education system and provide a chance for deep discussion of issues that is not typically possible in surveys. Second, AFMC widely deployed a brief poll that simply asked respondents to indicate what, in their opinion, were the top three issues that faced medical education in Canada across the continuum. The information gathered provides further reflection on those key recommendations that are of the utmost import to drive forward now. These touch points also provided new opportunities to identify emerging priorities that we face today.

FMEC 2020 Focus Groups

Focus groups were held as part of the series of consultations for FMEC 2020. These focus groups allowed the collection of in-depth perspectives from medical education stakeholders including patients.

Methods

The focus group participants self-selected from a broad group of stakeholders who were asked to complete the FMEC 2020 surveys. Participants were assigned to groups of 4-6 people based on their availability. The groups were facilitated by the AFMC VP Education, and sessions generally lasted 40-60 minutes. A summary of the 31 FMEC recommendations was provided to participants ahead of time for their review. At the beginning of each session, the participants introduced themselves, identified if they were representing an organization, and committed to supporting respectful and non-judgmental communication. An introductory preamble reviewed the goals of the meeting and set the stage. The participants were informed that the meeting was being recorded and that the information they provided would be collated and shared as part of the FMEC 2020 Report. Guiding questions were used to elicit opinions and discussion about the FMEC MD, PG and CPD recommendations, as well as vision for the future. These were broadly structured:

As a medical education community:

- 1) What are we doing well that we need to **keep** doing?
- 2) What are we doing that do we need to **stop** doing?
- 3) What are we not doing that we need to **start** doing?

A total of 5 focus group sessions were conducted. Participants' comments were tracked and summarized. Common categories and themes were then identified then collated.

Findings

There was overall strong agreement that the FMEC recommendations remain relevant and work should continue to foster their implementation. Aligning the recommendations to map them onto each other along the continuum in order to highlight the longitudinal nature of career development was suggested.

Participants raised the need to enhance accountability for implementation of the recommendations at individual Faculties, and suggested the need to move “from inspiration to operation” by prioritizing actions and making schools accountable for their implementation, possibly through accreditation that is aligned along the continuum. Improving information sharing between schools regarding implementation challenges and successes as a means of supporting best practices was also highlighted.

Prioritizing and enhancing social accountability was a theme that wove through all the focus group sessions. Enhancing admissions processes, ensuring the right mix, distribution and number of physicians to meet societal needs, facilitating physician access to learning activities to address their practice needs, creation of CPD networks to facilitate the monitoring, planning and evaluation of educational interventions required to address patient, community and population health needs and priorities were seen as enabling actions. In addition, recognizing the patient as a primary stakeholder in our healthcare systems and building strong patient partnerships to leverage the patient lens in medical education, enhancing interprofessional education that improves communication, collaboration and information sharing, and fostering and valuing generalism were also viewed as enablers.

Recognizing that community health needs vary across jurisdictions, it was suggested that there is a need to enhance the alignment of the goals of the Faculties of Medicine, which teach and train medical learners and provide ongoing Continuing Professional Development, with the needs of the communities they serve. The goal to have a medical education curriculum along the continuum that reflects advances in technology as well as the changing needs of the community was discussed.

The hidden curriculum and creating positive and supportive learning and work environments were highlighted as key priorities that require action moving forward. Participants felt that little work has been done on these complex yet vital recommendations. Fostering medical leadership was also identified as a priority.

Summary

The FMEC recommendations remain relevant. The need for improved accountability for implementation of the recommendations at the Faculty of Medicine level was identified. Key priorities identified by focus group participants include enhancing the social accountability mandate, leveraging multiple enabling factors and focusing on improving the learning and working environment along the continuum of medical education.

FMEC 2020 Poll

A poll was sent to all individuals on AFMC’s mailing list and was shared extensively on social media (i.e., Twitter) starting on February 6th, 2020 and responses were accepted until April 3rd, 2020. The AFMC mailing list consists of almost 2,800 unique email addresses. Individuals who received an invitation to the poll include:

- subscribers to AFMC newsletters
- members of AFMC committees
- leadership at Faculties of Medicine
- researchers interested in medical education in Canada
- members of key stakeholder organizations
- medical students and residents

The poll closed in early April 2020 and led to 322 submissions from 113 respondents. Respondents were asked to indicate what best describes their role and were allowed to select more than one option (see Table 1, below).

Table 1: Roles selected by respondents to FMEC 2020 Continuum Survey (N = 113)

Role	%
Student	5.31
Resident	4.42
Faculty of Medicine Member	53.10
Faculty of Medicine Staff	16.81
National Organization	22.12
Other	16.81

Note: Respondents may self-identify in multiple roles. Therefore, percentages will not sum to 100.

For the respondents who indicated “Other” 8/19 also selected at least one or more other roles. The most common selection being either “Faculty of Medicine Staff” or “National Organization”. The remaining respondents who only selected “Other” were a mix of individuals all associated with medical education (e.g., Education Coordinator, Librarian; University Affairs Director) or the administration of health care (e.g., Registered Nurse).

Each submission was evaluated as to whether it currently fit into one of the 31 existing FMEC recommendations (MD, PG, CPD). Overall, 258 of the issues (80.1%) identified by respondents in the poll corresponded to one of the FMEC recommendations (see Figure 2). Three sets of FMEC recommendations across the continuum are quite similar.

- Foster Medical Leadership (MD) and Foster Leadership Development (PG; Foster Medical Leadership and Development)
- Adopt a Competency-Based and Flexible Approach (MD) and Integrate Competency-Based Curricula in Postgraduate Programs (PG; Competency-Based Approach and Curricula)
- Address the Hidden Curriculum (MD) and Create Positive and Supportive Learning and Work Environments (PG; Address the Hidden Curriculum/ Create Positive and Supportive Learning and Work Environments)



Figure 2: Issues cited that corresponded to FMEC recommendations.

As the poll was anonymous, responses that fell into either category were combined since they could not be confidently attributed to a single recommendation.

Of the remaining 64 responses, they were examined to identify common themes that were not explicitly covered by the FMEC recommendations (see Table 2).

Table 2: Themes identified in at least two responses in remaining issues.

Theme	n
Curriculum Content	18
Financial Considerations	17
Technology	13
Healthcare System	6
Other	10
Total	64

The three most prevalent issues brought up in the pole that did not correspond to an FMEC recommendation were related to curriculum content ($n = 18$), financial considerations ($n = 17$), and technology ($n = 13$).

Many of the issues raised classified as curriculum content revolved around the ability to change medical school curricula in a quickly evolving world. Some respondents also raised concerns that medical education is either too broad or for other respondents too specific.

Comments concerning financial considerations generally revolved around two topics. First, many respondents were concerned about funding cuts to the medical education system. Second, a group of respondents were concerned about the cost of medical school and CPD.

Some common themes emerged from issues raised concerning the impact of technology. Several respondents wanted to see use of Artificial Intelligence and Big Data addressed in medical school. With the exception of a single respondent, all comments raised were positively related to the use of technology in medical education and practice.

C. Conclusion

We would like to thank the Faculties of Medicine, our stakeholders and our medical education community at large for their important contributions to this report. Your responses have enabled a better understanding of the progress made to date and the areas that still require substantial work.

This report will be considered by the AFMC Board of Directors in the fall of 2020 as part of its overall strategic planning exercise.

Together, we will carve out a clear and actionable way forward to address the gaps in our medical education system and reignite our common vision of medical education in Canada.

D. Appendix

CFMS Unmatched Canadian Medical Graduates Think Tank.

Purpose

To coordinate strategy and collaborate on directing advocacy as it pertains to the unmatched Canadian medical graduate (uCMG) crisis. Furthermore, supervising the completion of key initiatives required to advance matters relating to the uCMG issue. This issue is one that has roots within multiple portfolios and timepoints within medical education, thus requiring concerted effort across multiple portfolios.

Undergraduate Education

- Admissions -
 - Developing strategies for recruitment of students from underserved communities and marginalized populations (e.g. Pipeline Programs, quotas)
 - Collaborating with Future Admissions of Canada Think Tank (FACTT) to improve EDI within admissions
- Career Exploration/Entry Routes -
 - Communicating to medical students expectations of social accountability
 - Ensuring students have adequate exposure and mentorship opportunities related to all entry route programs through initiatives such as Royal College specialty videos, RDoc resident profiles, Resident teleconferences, etc.
 - Advocating that programs provide early exposure to and incentivize interest in underserved specialties/programs (e.g. family medicine, geriatric medicine, and rural practices)
 - Collaborating with the Royal College on appropriately reducing direct entry residency programs
- Electives -
 - Ensuring fair and transparent processes are in place for visiting electives
 - Reduction in financial and logistical barriers to securing visiting electives
 - Collaborating with AFMC to evaluate outcomes of the Electives Diversification policy

R1 Match

- Application & Process -

- Advocating for improvements to the CaRMS application and process to ensure it meets applicants' needs and facilitates applicant success (e.g. Application Review Committee, Timelines, Interview Communication, etc.)
- Best Practices in Application & Selection (BPAS) -
 - Collaborating with CaRMS & PGME to ensure programs are transparent with their program requirements and selection criteria
 - Advocating for programs to value diversification in an applicant's experiences (e.g. diversity in electives, community/urban placements, research/leadership/community engagement, etc.)
- Match Day Communications -
 - Ensuring communication regarding Match Days is coordinated and in line with current data/results
- Interpretation of CaRMS Match Data -
 - Conduct short-term and long-term analysis of match data for use in advocacy efforts and publications (e.g. MatchStats, CFMS Matchbook)

Supports

- Preparing students for residency match -
 - Updating, revising, and disseminating the CFMS Matchbook and other resources (e.g. MatchStats, Interview/Electives Databases) to support medical students
 - Advocating for UGME information sessions and ensuring that information sessions are thorough and inform students regarding key policies (e.g. Match Violations Policy, BPAS Program Descriptions, etc.)
- Supporting students during residency match -
 - Travel discounts and other supports for students during the interview period, including virtual interview formats
 - Collaborating with external stakeholders (e.g. MDFM) to alleviate financial burdens and promote community engagement amongst applicants
- Assistance for students going unmatched -
 - Implement a communication strategy to ensure that students are aware of supports that includes appropriate stakeholders (e.g. UGME, SA, etc.)
 - Increasing and improving supports for unmatched students after each R1 Match iteration (e.g. financial, wellness, career planning, mentorship)
 - Reviewing uptake and engagement with supports offered to students

Advocacy

- National & local advocacy -
 - Preparing backgrounder to be utilized for both national advocacy (e.g. DoA2) and local advocacy (e.g. municipal or provincial)
 - Advocating for increase in residency positions to meet ratio of 1.2:1 of residency positions to students
 - Preparing contact list of relevant stakeholders (e.g. government officials, PGME, policy makers) to discuss uCMG-related issues
 - Mobilizing GAACs to organize local efforts
- HHR strategy -
 - Providing updates on progress of HHR TF and conclusions
 - Advocating for pan-Canadian approach to HHR
 - Updating on CFMS communications with Physician Resource Planning Advisory Committee (PRPAC)
 - Advocating for student representation on residency allocation committees
- Separation of 2nd iteration streams -
 - Advocating to Deans/funders within each province for separation of CMG/IMG streams
- MOTP Surge
 - Collaborating with Canadian Armed Forces to increase MOTP positions and advocating for spots to be made available as early as possible
- Resident transfer process -

Collaborating with RDoc on a reasonable solution that benefits both uCMGs but also facilitates fair transfers for residents seeking alternate careers