Rethinking the Final Year of Medical School

Prioritized Recommendations Report for the Association of Faculties of Medicine of Canada

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The AFMC Final Year Task Force

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Foreword

The 2022 AFMC Board Invitational Session, a hybrid event facilitated by the AFMC Senior Education Deans Network during the Canadian Conference on Medical Education, was focused on the topic of rethinking the final year of medical school. Recognizing that the final year of medical school is an important point of transition along the medical education continuum that involves multiple stakeholders, the Board Invitational Session brought together representatives of Undergraduate Medical Education (UGME), Postgraduate Medical Education (PGME), Learner Affairs, students, resident doctors, medical regulators, medical regulatory bodies and others to share their viewpoints and diverse perspectives on the overall effectiveness of the transition from medical school to residency training in Canada.

Several challenges were identified, including electives, the match process, transition to residency, generalism, student health and wellness, community/patient/societal needs, and a need for complete and robust data. These themes provide directions for possible improvements. Of note, although the initial focus of the Board Invitational Session was on the final year of medical school, it became apparent that the challenges impact students' career planning and decision making longitudinally across all years of medical school, culminating in the transition from UGME to PGME. The above observations were summarized in a *Consultation Report* that was presented to the AFMC Standing Committee on Education and in turn to the AFMC Board of Directors in October 2022.

The AFMC Board of Directors requested that a Final Year Task Force (FYTF) be created for the purpose of providing recommendations that will build upon the observations contained in the *Consultation Report on Rethinking the Final Year of Medical School (2022)*. The FYTF was formed after seeking representation from diverse stakeholders, acknowledging the need to consult early and broadly with others.

Using the guiding principle: "The final year of medicine was originally designed to foster the consolidation and integration of knowledge and clinical skills to ensure an effective and healthy transition into residency", Task Force members identified recommendations for each theme outlined in the *2022 Consultation Report* by consulting academic resources. The recommendations were compiled within a working draft and distributed to several committee stakeholders for review and feedback. Consulted stakeholders included: AFMC Senior Education Deans Network, AFMC Committee on UGME, AFMC Committee on PGME, AFMC Committee on Student Affairs, AFMC Network on Distributed Medical Education, and the AFMC network on Interprofessional Education. Feedback was also solicited from the AFMC Network on Indigenous Health and the AFMC Network on Social Accountability. Feedback received from this stage was incorporated by the Task Force into the document in an iterative fashion. A *Draft Recommendations Summary Report* was brought for further broad input at the 2024 AFMC Board Invitational Event at ICAM, also facilitated by the AFMC Senior Educations Deans Network.

Following this event, the AFMC engaged Dr. Lorelei Lingard and Ms. Jennifer Shaw of the Centre for Education Research & Innovation at the Western University to apply qualitative research methods to help prioritize the recommendations. The process from this point is detailed in the *Prioritized Recommendations Report* attached with this Briefing Note.

The FYTF recognizes that implementation of the prioritized recommendations will require adequate investments (people, time, financial resources) in working towards these as national priorities. There will need to be a willingness of the leadership at all the medical schools to work on these common goals notwithstanding that they maintain independence over their curricula as required by accreditation, are funded by different provincial governments, have different funding models, and to some degree, variable mandates. The next step should involve the development of an implementation framework for the prioritized recommendations that identifies existing best practices and anticipated resource requirements.

Respectfully submitted by,

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Introduction

The final year of medical school has been recognised as having unique importance in the lives and careers of students. It serves as a capstone to three or four years of medical education, while also encompassing a range of actions to facilitate the transition to residency. Recognising the importance of the final year, in 2022 the Association of Faculties of Medicine of Canada (AFMC) undertook to review and rethink the final year. At the AFMC Board Invitational Session, held during the Canadian Conference on Medical Education in April 2022, the AFMC Senior Education Deans Network brought together various stakeholders, including representatives from undergraduate medical education, postgraduate medical education, learner affairs, students, residents, and others, to share their insights and thoughts on the final year of medical school.

This session identified six themes requiring attention: electives, the residency match process, transition to residency, generalism, learner health and wellness/wellbeing, and patient/community/societal needs. These were presented in the Consultation Report presented to the AFMC Standing Committee on Education. It was subsequently presented to the AFMC Board of Directors in October 2022. This report led to the creation of the Final Year Task Force (FYTF) to produce recommendations that were summarized in the Recommendations Report on Rethinking the Final Year of Medical School, a draft of which was presented in March 2024. This report contained 47 recommendations for improving the final year of medical school. It also added a seventh theme for consideration by including recommendations on equity, diversity, inclusion, accessibility and anti-racism (EDIA-AR).

Recognising that implementing 47 recommendations (see Appendix 1 for full list of recommendations) simultaneously would be difficult, the AFMC contracted with external researchers (Dr. Lorelei Lingard and Jennifer Shaw, from the Centre for Education Research and Innovation at the Schulich School of Medicine and Dentistry, University of Western Ontario) to assist with the goal of prioritizing the most relevant and actionable recommendations. This report describes the research process undertaken to achieve this goal and puts forward 20 priority recommendations for consideration.

Process

In March 2024, Lingard and Shaw reviewed relevant documents and reports, including the draft Recommendations Report, the two Future of Medical Education in Canada (FMEC) reports (2015, 2020), the Consultation Report on Rethinking the Final Year of Medical School from the 2022 AFMC Board of Directors' Invitational Sessional event. To update the data and seek stakeholders' assistance in prioritizing the original 47 recommendations, a survey was designed to rank recommendations and a world café session was created to gather stakeholders' insights at the AFMC Board of Directors' invitational event at the International Congress on Academic Medicine (ICAM) in April 2024. These data sources, the analytical procedures applied to them, and the consultative process undertaken between the researchers and the Task Force leads (Drs. Karwowska and Wong) are described in Appendix 2.

Priority Recommendation List

The final list of 20 priority recommendations derived from these analysis and consultation procedures is below (Figure 1). Appendix 1 shows these 20 recommendations within the original list of 47, for context. We also illustrate patterns within the 20 priority recommendations. Foundational recommendations require efforts across the medical school curriculum but were viewed as within the scope of the task force mandate because they constitute foundational work on which final year efforts will build (Appendix 3). Cross-cutting recommendations relate to more than one theme and were prioritized as adding more value (Appendix 4) Recommendations requiring national or local effort are illustrated in Appendix 5. These patterns within the priority recommendations are intended to inform individual schools as they decide where to focus their short- and longer-term efforts at transforming the final year of medical school.

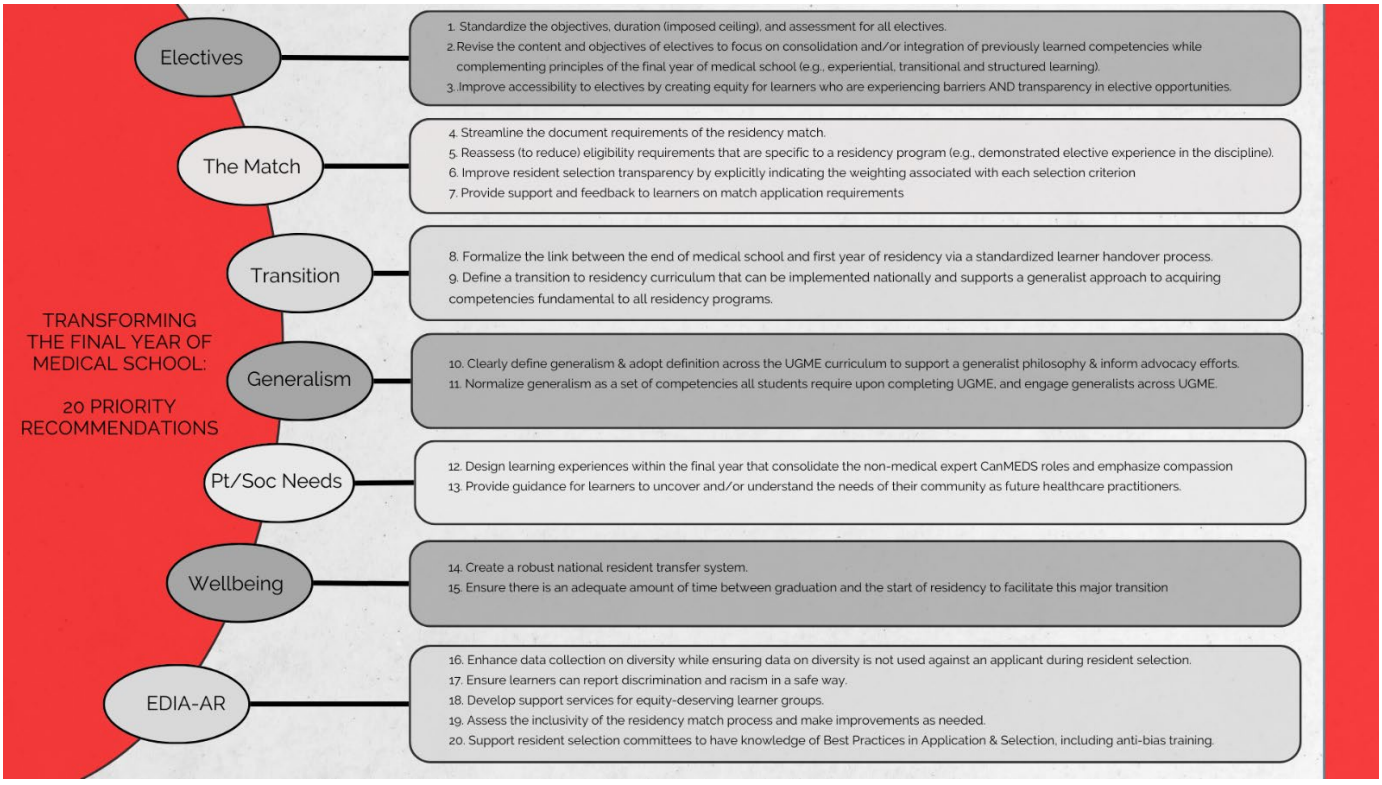


Figure 1: 20 Prioritized Recommendations

After this list was accepted by Drs. Karwowska and Wong, we reviewed the FYTF report to identify action items and key barriers related to each theme. We organized action items into four recurring domains: Vision and Process, Implementation, Learner Resources, and Equity. Action items contained in the report were not specific to each recommendation, hence the focus on theme. Furthermore, the degree of detail in the report varied by theme, which is reflected in varying levels of detail in the action items. Below we present the recommendations specific to each theme, followed by action items and key barriers.

Electives

Electives during the final year of medical school provide learners with the opportunity to explore different residency programs and sample various career options within different environments. However, they may also become auditions for residency programs, undermining their pedagogical intent and limiting an important opportunity for consolidation of undergraduate medical education (UGME) learnings.

Recommendations

1. **Standardize the objectives, duration (imposed ceiling), and assessment for all electives.**
2. **Revise the content and objectives of electives to focus on consolidation and/or integration of previously learned competencies while complementing principles of the final year of medical school (e.g., experiential, transitional and structured learning).**
3. **Improve access to electives by creating equity for learners who are currently experiencing barriers AND by creating a system that allows for transparency in elective opportunities.**

To achieve these recommendations, Action Items are proposed in the following four domains:

Vision and Process

a. Assemble electives leaders, learners and other stakeholders to co-produce a clear vision for an electives system that prioritizes learner growth rather than career auditioning.
b. Commit to a common assessment strategy rooted in core competencies (e.g., patient interactions, professional behavior, team collaboration) rather than discipline specific knowledge/skills.
c. Integrate electives portal data with residency match data to better understand the contribution of electives activity to initial match pathways.

Implementation

d. Document and share nationwide progress so far, given that efforts to improve electives have been ongoing (e.g., setting caps, electives diversification, lowering fees)
e. Collect & integrate data to make electives opportunities transparent and support candidate decisions. Includes information on availability (number & timing) of electives that schools and programs will likely offer in a given year, as well as policy documents.

Learner Resources

f. Create an electives platform that can monitor and visualize dynamic data (e.g., match/find rates, time of year barriers, historical average of elective positions at a program, or number of current applicants for an elective) in order to provide robust information to support learner decisions.
g. Explore technology enhancements that can automate policy (e.g., elective caps)

Equity

h. Undertake a process to review the needs of equity-deserving learners as they navigate the electives system.

i. Set/reinforce caps on numbers of electives or concurrent electives to level the playing field for all learners.
j. Establish value parity for home school and visiting electives.

Key barriers:

Inherent instability of the electives system; Cost of software and monitoring/updating

The Residency Match Process

The final year of medical school has exceedingly focused on the residency match process, which is associated with a number of pressure points such as potential burnout from high-stakes environment, detraction from clinical learning, a perceived need to pursue visiting electives, emotional anxiety, and potential disparity faced by learners from different geographical locations in regard to limited availability of certain residency programs.

Recommendations

1. **Streamline the document requirements of the residency match.**
2. **Reassess (with an aim to reduce) eligibility requirements that are specific to a residency program (e.g., demonstrated elective experience in the discipline).**
3. **Improve resident selection transparency by explicitly indicating the weighting associated with each selection criterion (e.g., weighting of visiting electives in the same discipline).**
4. **Provide support and feedback to learners on match application requirements, by scheduling structured time and curating resources for career planning, skills building and application preparation.**

To achieve these recommendations, Action Items are proposed in the following four domains:

Vision and Process

a. Assemble key stakeholders to review the current match process to identify which documents are necessary and useful and which can be eliminated from application process.

Implementation

b. Produce, with input from key stakeholders, clear and consistent messaging about requirements for residency match.
    i. Create a shared vision of the purpose and goals of the match process and communicate these to learners.
    ii. Clarify and communicate to learners the roles of school committees involved in making match decisions and the weighting committees give to selection criteria.

Learner Resources

c. Compile centralized library of resources for learners on career counselling, residency program selection, career exploration, learner advocacy, and residency program advocacy.
d. Publish information on selection criteria for all residency programs

Equity

e. Review match process to ensure there are no barriers for the equal participation of equity-deserving groups.
f. Review existing policies and structures for learners with prolonged training duration and create common language regarding such learners to ensure they are not penalized.

Key barriers:

Inadequately resourced system to meet the expectations of all interested parties.

Transition to Residency and Education Continuum

Currently the urgency to secure a residency position dwarfs experiential learning and growth within the final year of the medical school. We need to refocus attention around readiness of the learner for practice in less supervised environments, which means consolidating their generalist knowledge and competencies common to all residency programs.

Recommendations

1. **Formalize the link between the end of medical school and first year of residency via a standardized learner handover process.**
2. **Define a transition to residency curriculum that can be implemented nationally and supports a generalist approach to acquiring competencies fundamental to all residency programs.**

To achieve these recommendations, Action Items are proposed in the following four domains:

Vision and Process

a. Collaborate across UGME and PGME leadership to create a national transition curriculum that:
    a. Prepares learners for practice in less supervised environments.
    b. Prepares learners for key tasks in the beginning months of first-year residency.
    c. Consolidates non-medical expert CanMEDS roles.
b. Initiate a learner hand-off process, co-developed with the UGME program and based on a facilitated dialogue with the learner regarding their learning plan.

Implementation

c. Create national objectives and educational outcomes for a national curriculum focused on consolidating generalist knowledge and clinical skills common to all areas of medicine.
d. Identify entrustable professional activities (EPAs) to anchor the assessment strategy for the national transition curriculum.

Learner Resources

e. Create a national online preparatory curriculum for the Medical Council of Canada Qualifying Examination Part 1 (MCCQE-1) preparation.

f. Offer tailored training to improve weaker competencies identified in earlier years.
g. Strengthen coaching resources by building on existing programs

Equity

h. Deliver select curricular content virtually and/or via simulation to equitably reach learners at all schools.
i. Ensure that more work is not added to the learner's docket of responsibilities

Key barriers: Tension between *reaching consensus* with all schools on a national transition to residency curriculum and *respecting autonomy* of each school to set its own curriculum; Identifying and engaging resources to implement the curriculum, including sufficient time.

Generalism

Building on the work of FMEC (2015, 2020), we recognize the need for ongoing emphasis on generalism to meet the needs of society. Thus, our goal with these recommendations is renewed focus on producing generalist, polyvalent, interdisciplinary, and/or undifferentiated physicians upon graduation from medical school.

Recommendations

1. **Clearly define generalism & adopt this definition across UGME curriculum to support a generalist philosophy and inform advocacy efforts.**
2. **Normalize generalism as a set of competencies all students require upon completing UGME, and engage generalists across UGME.**

To achieve these recommendations, Action Items are proposed in the following four domains:

Vision and Process

a. Build upon the proposed definition created by the Collaborative PGME Governance Council in 2018: 'Generalism is a professional philosophy of practice, distinguished by a commitment to holistic, integrated, person-centered care, the broadest scope of practice within each discipline and collaboration with the larger health care team to respond to patient and community health needs.'
b. Introduce a generalist philosophy to students in their first year of medical school.
c. Expose learners to generalists as role models and teachers throughout UGME.

Implementation

d. Require that several electives be completed in generalist or primary care placements.
e. Standardize the inclusion of internal medicine and pediatrics subspecialties so they are treated like all other specialties to encourage diversification.

Learner Resources

f. Expose learners to generalists as role models and teachers throughout UGME, including community-based generalist physicians.
g. Provide opportunities for learners early on to experience undifferentiated patients and early presentation of illness within community contexts

Equity

h. Review admissions process and policies to include admittance of learners interested in generalist disciplines.

Key Barriers:

Lack of agreement about the definition of generalism; Current remuneration frameworks that limit the availability of generalist physician teachers and preceptors.

Patient, Community and Societal Needs

There is a continual need to maintain a direct focus on patients, communities, and society at large, including the health system needs, during a reimagination of the final year medical school experience.

Recommendations

1. **Design learning experiences within the final year that consolidate the non-medical expert CanMEDS roles.**
2. **Provide guidance for learners to uncover and/or understand the needs of their community as future healthcare practitioners.**

To achieve these recommendations, Action Items are proposed in the following four domains:

Vision and Process

a. Include patient partners in curriculum development.
b. Enhance student exposure to local communities through distributed medical education (DME)
c. Consolidate effective communication learning (e.g., active listening skills, empathy, compassion) through longitudinal exposure and experience with vulnerable populations in community settings.
d. Emphasize need for compassion as part of non-medical CanMEDS roles.

Implementation

e. Leverage the existing accreditation requirement of social accountability (CACMS accreditation standard 1.1.1)
f. Prioritize community engagement, patient-centredness, and social accountability
g. Address the hidden curriculum that seeks to treat communication skills as a tool for communicating medical expertise rather than as a therapeutic tool.

Learner Resources

h. Realign communication curricula to meet current patient expectations, e.g., https://www.mypcnow.org/fast-fact/patient-centered-interviewing/.
i. Emphasize learning activities that focus on developing skills of community engagement, understanding the social determinants of health, and applying them to the local community
j. Enable students to focus on merging technical skills with compassionate care.

Equity

k. Ensure funding to resource patient partnership in order that patients don't bear the cost of medical school learning involving them.

Key Barriers:
Accessing financial support to include meaningful and extensive patient partnership.

Learner Health and Wellness/Wellbeing

Learner health and wellness/wellbeing is closely linked to learning environment safety, inclusivity and the creation of a culture that encourages help-seeking and recognition of the impact on patient care outcomes and collegiality.

Recommendations

1. **Create a robust national resident transfer system.**
2. **Ensure there is an adequate amount of time between graduation and the start of residency to facilitate this major transition.**

To achieve these recommendations, Action Items are proposed in four domains. (Note: much of the detail in the March report related to recommendations that were not prioritized; therefore, this list of Action Items may require elaboration.)

Vision and Process

a. Address limitations on obligations and responsibilities in Student Affairs and Learner Experience Offices to better support learner success.

Implementation

b. Schedule regular breaks in the final year of medical school.

Learner Resources

c. Provide robust orientation, onboarding, mentoring, and early access to support during the transition to PGME.

Equity

d. Ensure that learner resources are responsive to the needs of all learners, including those from equity-deserving groups.

Key barriers:

Lack of consensus on national standards. Student Affairs and Learner Experience Offices have limits to obligations and responsibilities for the medical education system to support learner success.

Equity, Diversity, Inclusion, Accessibility and Anti-Racism (EDIA-AR)

Though not identified as one of the distinctive themes during the 2022 Board Invitational session, EDIA-AR was subsequently recognized as being of vital importance to the continuing improvement of medical school. It warrants specific mention because EDIA-AR cuts across all themes and are foundational to any changes in the final year of medical school.

Recommendations

1. **Enhance data collection on diversity while ensuring data on diversity is not used against an applicant during resident selection.**
2. **Ensure learners can report discrimination and racism in a safe way.**
3. **Develop support services for underrepresented cohorts (e.g. Indigenous, 2sLGBTQIA+, Black medical students, etc.).**
4. **Assess the inclusivity of the residency match process and make improvements as needed.**
5. **Support resident selection committees to have knowledge of Best Practices in Application and Selection, including anti-bias training.**

To achieve these recommendations, Action Items are proposed in the following four domains:

Vision and Process

a. Build anonymous and easily accessible systems so that learners can report discrimination and/or racism safely and with support.
b. Remove requirements for visiting electives as part of the resident selection process.
c. Improve diversity on selection committees in the match process.
d. Standardize elective time within curriculum.

Implementation

e. Enhance transparency on how programs ensure diversity is reflected within selection committees.

Learner Resources

f. Provide funding support for students to access visiting electives based on learner financial needs.
g. Provide mentorship throughout match process that allows underrepresented groups to see themselves reflected within the application process.

Equity Resources

h. Ensure resident selection committee members complete anti-bias training.
i. Leverage existing frameworks in inclusive selections (see references)
    i. https://www.sciencedirect.com/science/article/abs/pii/S1053482217300529
    ii. https://wmfdp.com/wp-content/uploads/2016/05/JOM-Inclusiveness.pdf
    iii. https://pubmed.ncbi.nlm.nih.gov/25545572/

Key barriers:

Developing national consensus on standardization and subsequent implementation; need for culture change.

Appendix 1: Data Sources, Analytical Procedures and Consultation Process

Data Sources and Analysis

There were three sources of data from the ICAM 2024 Board invitational. The first was the scribe notes from the world café roundtable discussions. Participants were invited to provide their feedback on the recommendations within each theme and what they felt were the most important to prioritize. There were 6 roundtable discussions for each theme: one facilitator hosted all six discussions/theme. Two themes (Learner Wellness and EDIA-AR) were combined into one roundtable, for a total of 36 roundtable discussions involving approximately 90 participants.

We conducted a qualitative content analysis on these notes, noting the pattern of discussion in each roundtable (e.g., both the recurrence or amount of discussion on a recommendation and the valence of participants' comments). Drawing on that content analysis and seeking another overview to compare, we then used ChatGPT to review all the scribe notes by theme and prompted it to categorize the recommendations into Most Supported, Least Supported, and Most Divisive based on its review of the scribe notes. The human and ChatGPT analyses were compared to verify the ChatGPT results; Lingard made corrections where ChatGPT's analyses contained errors. The verified and refined results reporting Most Supported, Least Supported and Most Divisive recommendations from the scribe notes were then shared with Dr. Karwowska in May to understand whether they resonated with AFMC insights at the national level.

The scribe notes provided a rich source of information from the discussions held at the Invitational. The notes did, however, also present some limitations. Although each of the six scribes at the world café discussions were provided with the same instructions, differences in style and focus meant that the level of detail in each set of notes varied. As the discussion followed the direction of the participants, the recommendations each group focused on also varied. We discussed these limitations with Dr. Karwowska at our May meeting, and stressed the importance of an integrative analysis that we would conduct once we had analyzed all sources of data.

The second source of data from the ICAM 2024 invitational was survey information. Participants were asked to rank each theme and then recommendations within each theme based on priority, potential impact, and feasibility. We worked with Marty Huynh, AFMC IT Operations Specialist, to turn the raw data from this survey into visual representations (see Fig. 2 for an example of what these looked like and see [LINK] for the full set of these visuals), which we then reviewed. As with the scribe data, the survey data presented challenges. Primarily, differences in how many people ranked each theme/recommendation (see Fig. 3) limits the interpretation of the data.

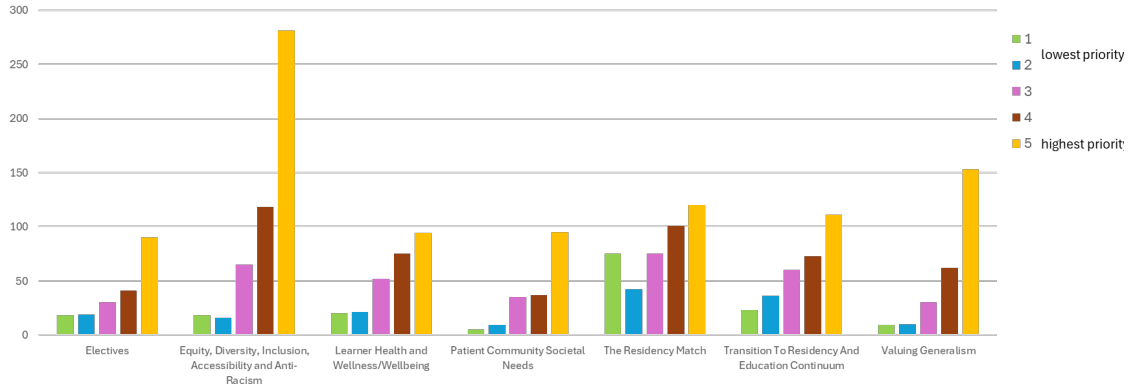


Figure 2: Example of visual representation of survey data showing Themes by Priority Ranking

Count of Rating	Column Labels					
Row Labels	**1**	**2**	**3**	**4**	**5**	**Grand Total**
Electives	**65**	**76**	**139**	**128**	**185**	**593**
(i) Priority	18	19	30	41	90	198
(ii) Potential Impact	24	23	39	52	59	197
(iii) Feasibility	23	34	70	35	36	198
Equity, Diversity, Inclusion, Accessibility and Anti-Racism	**76**	**118**	**300**	**384**	**602**	**1480**
(i) Priority	18	16	65	118	281	498
(ii) Potential Impact	17	26	98	137	217	495
(iii) Feasibility	41	76	137	129	104	487
Learner Health and Wellness/Wellbeing	**80**	**106**	**177**	**205**	**206**	**774**
(i) Priority	20	21	52	75	94	262
(ii) Potential Impact	20	36	63	66	71	256
(iii) Feasibility	40	49	62	64	41	256
Patient Community Societal Needs	**16**	**59**	**154**	**123**	**186**	**538**
(i) Priority	5	9	35	37	95	181
(ii) Potential Impact	2	15	51	50	63	181
(iii) Feasibility	9	35	68	36	28	176
The Residency Match	**201**	**163**	**272**	**298**	**298**	**1232**
(i) Priority	75	42	75	101	120	413
(ii) Potential Impact	68	66	103	85	87	409
(iii) Feasibility	58	55	94	112	91	410
Transition To Residency And Education Continuum	**84**	**129**	**229**	**217**	**242**	**901**
(i) Priority	23	36	60	73	111	303
(ii) Potential Impact	22	42	74	76	85	299
(iii) Feasibility	39	51	95	68	46	299
Valuing Generalism	**44**	**78**	**174**	**196**	**279**	**771**
(i) Priority	9	10	30	62	153	264
(ii) Potential Impact	9	17	60	78	92	256
(iii) Feasibility	26	51	84	56	34	251

Figure 3: Survey data showing differences in respondent numbers

The last source of data from the 2024 ICAM invitational was the school-based 'evaluation' data in which we asked each school to report what actions they have taken in relation to each theme. We attempt to analyze these data for content patterns nationally. However, the information provided by schools did not achieve its aim of a high-level sketch of national activity: many schools did not report any activity, while those who did report were selective in their reporting and offered few details. These gaps were confirmed in consultation with Dr. Karwowska, and it was decided that this information

should be weighed lightly as data to support our primary prioritization exercise, but could be used later to direct future steps.

Following analysis of these three data sources, we conducted an integrative analysis, in which we compared all analyses to understand variations in the results and get a more complex picture of participants' responses to the recommendations (see Figure 4 for an example of the integrative analysis). Our analysis is constructivist rather than positivist in its orientation; therefore, variations are viewed as valuable information rather than noise. Survey and scribe data are different types of data gathered in different ways. Rather than privilege one over the other, we take the position that, when they vary, both contain meaning: for instance, the survey may reflect what people privately think, while the scribe notes may reflect what they support in public discussion. Considering such variations can enrich our understanding of what recommendations people support, when and why.

Electives	
Recommendation	Integrative Analysis Notes
1. Improve accessibility to electives by **I. creating equity for learners who are currently experiencing barriers because of identifying as a member of an equity-deserving group, including but not limited to learners with disability and those with limited financial means.** **II. Creating a system that allows for transparency in elective opportunities, real-time capacity information and equitable access to registration.**	• From the scribe data: Strong support for increasing equity in access to electives, especially for students facing financial or personal barriers. Numerous suggestions for practical implementations like financial support and more transparent scheduling systems. • From the survey data – high priority numbers but low feasibility – why? • From school-based "evaluation" data – no comments mention accessibility – so some discrepancy between what appears as most supported recommendations and what people mention they're thinking about/doing locally

Figure 4: Example from Integrative Analysis

These preliminary integrative results were used to inform a draft priority list of recommendations. This list underwent three iterations, with Lingard and Shaw presenting each to Drs. Karwowska and Wong. Those discussions included strategizing for re-analysis, including highlighting cross-cutting recommendations and foundational recommendations. Cross-cutting recommendations relate to more than one theme and were prioritized as adding more value. Foundational recommendations extend beyond the final year: they require efforts across the medical school curriculum, but were viewed as within the scope of the task force mandate because they constitute foundational work on which final year efforts will build. We also identified additional data sources that might inform the next iteration of the priority list: for instance, we returned to the March 2024 FYTF report to closely analyze Enablers/Risks that might inform prioritization within themes, and we agreed on the need to review student survey data in case it could inform our prioritizations.

The third iteration of the draft priority recommendations list was presented to the FYTF on Sept 3, 2024. Members suggested limited wording changes to a few recommendations, as well as requesting an analysis of which recommendations require effort at the local or national level.

Appendix 2: Full List of 47 Recommendations from the FYTF on Rethinking the Final Year of Medical School Recommendations Report

Electives

1. Standardize the objectives, duration (imposed ceiling), and assessment for all electives.
2. Revise the content and objectives of electives to focus on consolidation and/or integration of previously learned competencies while complementing principles of the final year of medical school (e.g., experiential, transitional and structured learning).
3. Improve accessibility to electives by a) and b)
4. Request that learners explain their elective choices via narrative reflections on the rationale and how their choice aligns with the objectives [provide reference list] of the final medical school year. The rationale may be an interest, exploration of a new discipline in medicine, or part of a desired career path. The reflections will be used either for approval of the elective or in the learner's personal letter for the match application process. This creates an opportunity of individualized coaching for electives choices.

The Residency Match

5. Clarify the role of committees and/or groups at the level of each medical school in the decisions involved in organizing and governing the Match.
6. Streamline the document requirements of the residency match.
7. Reassess (with an aim to reduce) eligibility requirements that are specific to a residency program (e.g., demonstrated elective experience in the discipline).
8. Include templated prompts in the learner's personal letter that include narrative reflections on the electives while allowing for the learner to personalize the letter. For instance, the learner may indicate how the chosen electives illustrate specific skills and interests that the learner would bring to the program they are applying to, rather than relying on a simple documentation of an elective in a particular discipline being equated as supportive evidence of an application to the same discipline.
9. Improve resident selection transparency by indicating the weighting associated with each selection criterion (e.g., visiting electives in a single discipline).
10. Standardize the structure of reference letters across all programs in the same discipline that reflect the selection criteria & competencies being assessed.
11. Provide support and feedback to learners on match application requirements: a) and b).
12. Anonymize the residency application process (e.g., like high stakes examination process) to optimize the implementation of EDIA-AR principles.
13. Indicate whether MCCQE-1 results are used in the resident selection process.
14. Customize final year curriculum for students who complete MCCQE-1 early in the final year (e.g., the Fall)
15. Review the existing policies and structures that are related to learners with prolonged training duration, e.g., survey of terminology used, approaches, and program structures. The review should lead to adopting standard language regarding learners with prolonged training duration.
16. Implement a national and centralized process to facilitate evidence-based, specialty-specific limits on the maximum number of interviews each applicant may attend in the same discipline. Further discussion at the national level will be required to determine the maximum interview limit for each discipline.

Transition to Residency and Education Continuum

17. Develop learning plans for learners that are developmental in nature and support the concept of life-long learning in an education continuum. These plans would move with the learner from medical school into residency. A)
18. Define explicitly the pedagogical role of electives.
19. Formalize the link between the end of medical school and first year of residency via a standardized learner handover process.
20. Define a transition to residency curriculum that can be implemented nationally in addition to a focus on local pedagogical objectives. This curriculum should support a generalist approach to acquiring competencies that are fundamental to all residency programs. A, b, c, d
21. Provide the conditions that support continued evolution of professional identity formation. A)
22. Collect evaluation data on performance in early residency as a form of feedback for the UGME programs on their transition to residency curricula.

Valuing Generalism

23. Clearly define generalism in the broad sense and adopt the definition in the medical school curriculum across all years. A)
24. Prioritize addressing the hidden curriculum related to devaluing generalism.
25. Normalize generalism. A) and b)
26. Maintain diverse career options for all students that reflect the needs of communities/society.
27. Explore an alternative pathway to generalism that bypasses the residency Match. A)

Patient, Community, Societal Needs

28. Design learning experiences within the final year of medical school that consolidate the non-medical expert CanMEDS roles (e.g., communicator, collaborator, health advocate, leadership, professional). A)
29. Provide guidance for learners to uncover and/or understand the needs of their community as future healthcare practitioners. A)
30. Integrate data (e.g., health human resource, epidemiologic data from local community, etc.) to inform continuous quality improvement exercises.
31. Provide intentional mentorship for the progression of professional identity formation from student to professional wherein patient needs are primary. A)

Learner Health and Wellness/Wellbeing

32. Teach students how to develop a longitudinal and personalized wellbeing plan.
33. Give learners access to adequate resources for transition to residency prior to residency launch
34. Create a robust national resident transfer system.
35. Ensure there is an adequate amount of time between graduation and the start of residency to facilitate this major transition
36. Encourage learners to seek a family physician/primary healthcare provider while recognizing this is a challenge for all Canadians.

Equity, Diversity, Inclusion, Accessibility and Anti-Racism

Social Accountability

37. Standardize learning outcomes to address EDIA-AR a)
38. Enhance data collection on diversity while ensuring data on diversity is not used against an applicant during resident selection.
39. Address inequities in the visiting electives process (see section on Electives)
40. Address hidden curriculum and its impact on clinical learning environment, social accountability, and decolonization.

Learner Health and Wellness/Wellbeing

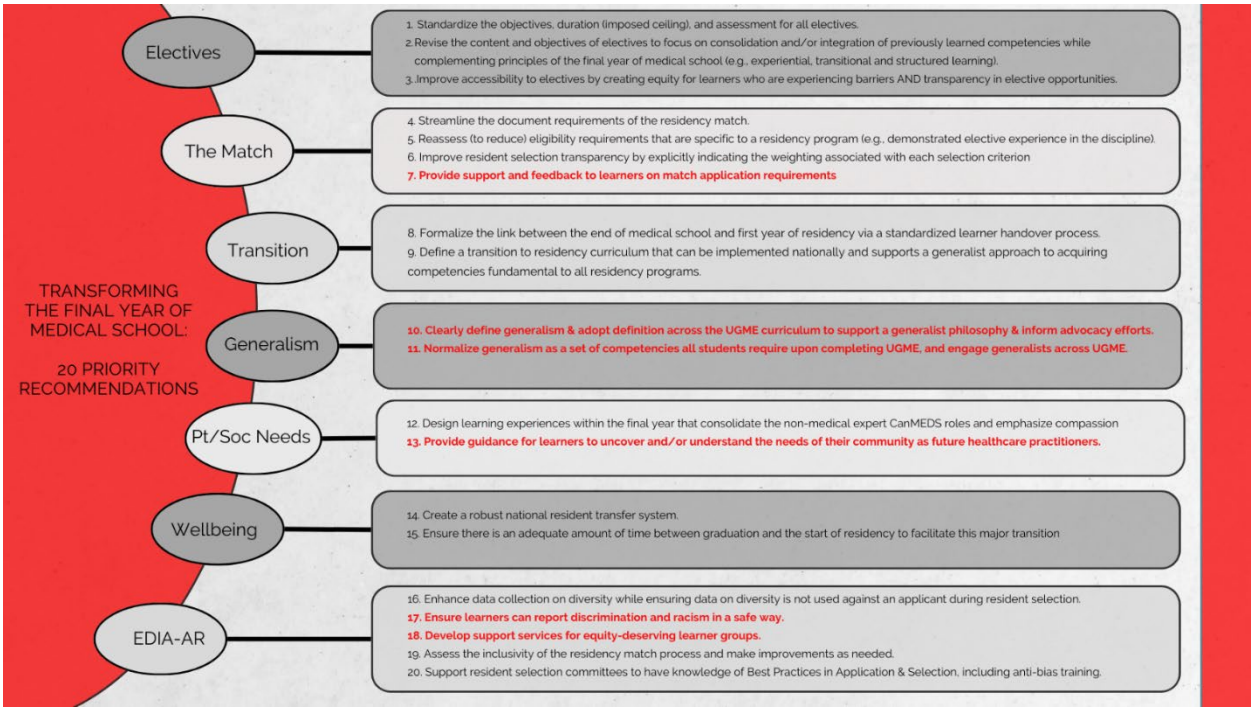
41. Ensure learners can report discrimination and racism in a safe way.
42. Develop support services for underrepresented cohorts (e.g., Indigenous, 2SLGBTQIA+, Black medical students, etc.)
43. Bridge the gap between medical school and residency learner support services. A)

44. Enhance mentorship.

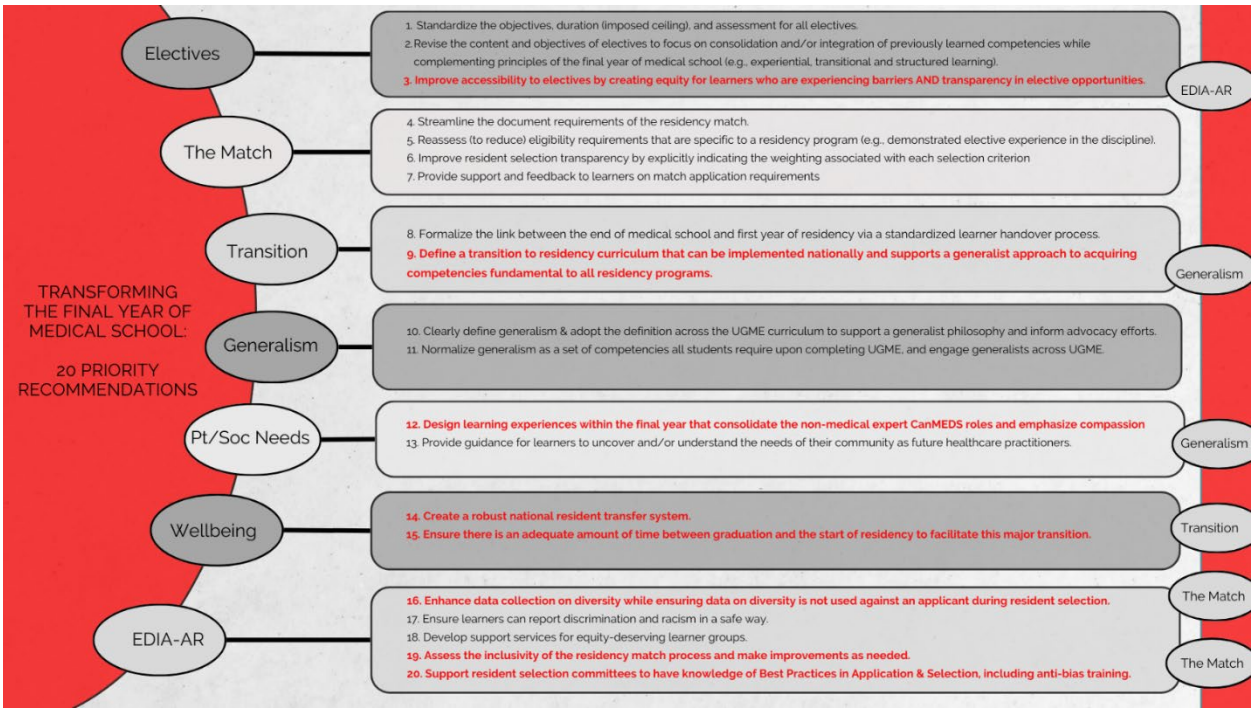
For Residency Match

45. Assess the inclusivity of the residency match process and make improvements as needed.
46. Review the content and the use of the MSPR.
47. Support resident selection committees to have knowledge of BPAS. A)

Appendix 3: List of 20 Prioritized Recommendations Highlighting 6 Foundational Recommendations



Appendix 4: List of 20 Prioritized Recommendations Highlighting 8 Cross-Cutting Recommendations



Appendix 5: Recommendations Requiring Effort at National, Local, or Both levels