***54 of 95 CACMS Accreditation Elements that Students can comment upon***

* **Element in Blue**
* Sub-elements listed below as #.# then a letter

***1.2 CONFLICT OF INTEREST POLICIES***

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

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

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

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

i. research

ii. faculty with academic and teaching responsibilities

iii. commercial support for continuing professional development

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

***1.5 BYLAWS***

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

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

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

***3.1 RESIDENT PARTICIPATION IN MEDICAL STUDENT EDUCATION***

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

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

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

*3.2 COMMUNITY OF SCHOLARS/RESEARCH OPPORTUNITIES*

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

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

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

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

***3.3 DIVERSITY/PIPELINE PROGRAMS AND PARTNERSHIPS***

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

3.3 a The medical school in accordance with its social accountability mission has defined the various categories of diversity it wishes to achieve in its students, faculty and senior academic and educational leadership.

3.3 b The medical school engages in ongoing, systematic and focused recruitment activities to achieve mission-appropriate diversity outcomes among its:

i. students

ii. faculty

iii. senior academic and educational leadership

3.3 c The medical school engages in ongoing, systematic and focused retention activities to achieve mission-appropriate diversity outcomes among its:

i. students

ii. faculty

iii. senior academic and educational leadership

3.3 d The medical school monitors the diversity of enrolled students, employed faculty and senior academic and educational leadership in each of the school-defined diversity categories to measure its progress in achieving the desired diversity in these populations.

3.3 e The policies and practices, programs or partnerships used by the medical school aimed at achieving diversity among qualified applicants for medical school admission are appropriate to achieve the expected outcomes.

3.3 f The medical school evaluates and monitors the effectiveness of its policies and practices, programs or partnerships in achieving diversity among qualified applicants to the medical school.

3.3 g The medical school is moving toward the achievement of mission-appropriate diversity among its students, faculty and senior academic and educational leadership.

***3.4 ANTI-DISCRIMINATION POLICY***

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

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

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

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

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

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

***3.5 LEARNING ENVIRONMENT/PROFESSIONALISM***

***A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, implement appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.***

3.5 a The medical school has defined the professional attributes (behaviors and attitudes) that medical students are expected to develop.

3.5 b These expected professional attributes are effectively communicated to faculty, residents and others in the medical school and clinical learning environments.

3.5 c The medical school and its clinical affiliates collaborate in the periodic evaluation of the learning environment using appropriate methods, and share the results of these evaluations to identify positive and negative influences on the development of medical students’ professional attributes, especially in the clinical setting.

3.5 d The medical school and its clinical affiliates have implemented appropriate strategies to a) enhance the positive influences and b) mitigate the negative influences on medical students’ development of the expected professional attributes.

3.5 e The medical school and its clinical affiliates identify and promptly correct violations of professional standards in the learning environment.

***3.6 STUDENT MISTREATMENT***

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

3.6 a There is a defined and published code of conduct addressing the faculty-student relationship and student mistreatment.

3.6 b There are formal policies or procedures for responding to allegations of medical student mistreatment including the venues for reporting and mechanisms for investigating reported incidents.

3.6 c Medical students, residents, faculty responsible for required learning experiences and those who teach or assess medical students and other individuals who interact with students in the medical school or clinical environment are informed about the medical school’s standard of conduct in the faculty-student relationship and about medical student mistreatment policies.

3.6 d Mechanisms for reporting and investigating incidents of mistreatment protect students from retaliation.

3.6 e Medical students are informed of the procedures for reporting mistreatment and investigating reported incidents in a way that protects them from retaliation.

3.6 f Data from the AAMC CGQ, and the AFMC GQ, the ISA or more recent data collected by the medical school show that the majority of respondents agree/strongly agree that they are aware of the school’s policies regarding student mistreatment.

3.6 g Data from the AAMC CGQ, the AFMC GQ, the ISA or more recent data collected by the medical school show that the majority of respondents agree/strongly agree that they know the procedures for reporting student mistreatment.

3.6 h Allegations of student mistreatment are investigated and resolved in a timely manner.

3.6 i AAMC CGQ, and AFMC GQ data student mistreatment data and other reports of mistreatment collected by the school are reviewed by individuals/committee(s)in the medical school and clinical learning environments with the authority to take steps to reduce the level of mistreatment.

3.6 j The medical school monitors the reasons why students do not report mistreatment and has taken steps to reduce barriers to reporting.

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

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

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

***5.4 SUFFICIENCY OF BUILDINGS AND EQUIPMENT***

***A medical school has, or is assured the use of, buildings and equipment sufficient to achieve its educational, clinical, and research missions.***

***Note: If the medical school operates one or more geographically distributed campus, provide the data separately for each campus.***

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

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

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

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

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

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

***5.5 RESOURCES FOR CLINICAL INSTRUCTION***

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

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

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

***5.7 SECURITY, STUDENT SAFETY, AND DISASTER PREPAREDNESS***

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

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

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

i. on campus during regular classroom hours

ii. on campus outside of regular classroom hours

iii. at clinical teaching sites used for required learning experiences

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

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

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

***5.8 LIBRARY RESOURCES / STAFF***

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

5.8 a Data from the AAMC CGQ and the AFMC GQ show that the majority of students at each campus are satisfied/very satisfied with the library.

5.8 b Data from the ISA shows that the majority of students at each campus are satisfied/very satisfied with ease of access to the library resources and holdings (includes virtual access both on and off campus).

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

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

5.8 e Medical students and faculty have access to electronic and other library resources across all instructional sites both on and off campus, including geographically distributed campuses.

***5.9 INFORMATION TECHNOLOGY RESOURCES / STAFF***

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

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

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

i. ease of access to electronic learning materials;

ii. adequacy of wireless network in classrooms;

iii. study spaces in the medical school;

iv. availability of electrical outlets in teaching and study space at the medical school; and

v. adequacy of audio-visual technology used to deliver educational sessions (e.g., lectures, academic half-days).

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

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

i. being involved in curriculum planning and delivery;

ii. assisting faculty in developing instructional materials;

iii. assisting in developing or maintaining the curriculum database or other curriculum management applications; or

iv. assisting faculty to learn to use the technology for distance education.

***5.11 STUDY / LOUNGE / STORAGE SPACE / CALL ROOMS***

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

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

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

5.11 c If study space is not available in the medical school at a campus, or in an affiliated clinical facility, study space is available to students at another accessible location.

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

5.11 e Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with storage space at clinical facilities used for required learning experiences.

5.11 f In required clinical learning experiences in which students are required to stay overnight, secure on-call rooms are available for their use at each campus.

5.11 g Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with on-call rooms for required clinical learning experience.

***6.1 FORMAT / DISSEMINATION OF MEDICAL EDUCATION PROGRAM OBJECTIVES AND LEARNING OBJECTIVES***

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

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

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

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

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

6.1 e The medical education program objectives are made know to all medical students and faculty members with leadership roles in the medical education program and others with substantial responsibility for medical student education and assessment.

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

***6.2 REQUIRED CLINICAL LEARNING EXPERIENCES***

***The faculty of a medical school define the types of patients and clinical conditions that medical students are required to encounter, the skills and procedures to be performed by medical students, the appropriate clinical settings for these experiences, and the expected levels of medical student responsibility.***

6.2 a The faculty has described each patient type, clinical condition, required procedure and skill, and the clinical setting in which they take place for each required clinical learning experience and for those experiences as a whole, including for longitudinal integrated clerkship if offered.

6.2 b For each required patient encounter and procedural skill, the faculty has made explicit the required level(s) of student responsibility in each required clinical learning experience and in those experiences as a whole, including in longitudinal integrated clerkship if offered. In nearly every instance the stipulated level of responsibility is: to assist or perform.

6.2 c The list of required patient encounters and procedural skills was reviewed and approved by the ‘curriculum committee’ or other appropriate oversight committee for relevance and comprehensiveness.

6.2 d The faculty expect that students have the majority of required patient encounters with real patients keeping in mind patient safety.

6.2 e Alternative experiences (e.g., standardized patients, simulations, virtual patients) have been developed for the required patient encounters that are rare, severe or seasonal.

6.2 f Medical students, faculty, and residents are informed of the required patient encounters and procedural skills in each required clinical learning experience in which they participate.

***6.3 SELF-DIRECTED AND LIFE-LONG LEARNING***

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

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

i. Identify, analyze, and synthesize information relevant to their learning needs

ii. Assess the credibility of information sources

iii. Share the information with their peers and tutor/facilitator

iv. Apply their knowledge to the resolution of the clinical case

v. Receive feedback and are assessed on their skills in self-directed learning

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

***6.4 INPATIENT / OUTPATIENT EXPERIENCES***

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

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

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

***6.5 ELECTIVE OPPORTUNITIES***

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

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

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

6.5 c The medical school has or follows a policy (e.g., the AFMC UGME/PGME Policy on Diversification of Electives) that ensures the diversification of electives. Medical students’ elective choices are reviewed and adjustments made to ensure the policy is followed.

***6.6 SERVICE-LEARNING***

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

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

6.6 b Data from the ISA show that the majority of medical respondents are satisfied/very satisfied with their access to opportunities to participate in service learning activities.

6.6 c The medical school informs medical students about service learning opportunities and encourages medical students to participate in service learning activities.

6.6 d The medical school supports student participation in service learning activities (e.g., coordination of student placements, development of opportunities in conjunction with community partnerships or provision of financial support).

***6.7 ACADEMIC ENVIRONMENTS***

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

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

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

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

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

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

***7.1 BIOMEDICAL, BEHAVIORAL, SOCIAL SCIENCES***

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

7.1 a The topics listed in Table 7.1-1 of the DCI are taught and assessed in the curriculum either as an independent required learning experience, or integrated in a required learning experience(s).

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

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

7.1 d Data from the AAMC CGQ and the AFMC GQ in Table 7.1-4 of the DCI show that the majority of respondents agree/strongly agree that they have a fundamental understanding of the listed issues in social sciences of medicine.

***7.5 SOCIETAL PROBLEMS***

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

7.5 a The curriculum includes instruction and has relevant learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of domestic violence/abuse.

7.5 b The curriculum includes instruction and has relevant learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting (if relevant), and treatment of the medical consequences of substance abuse.

7.5 c The curriculum includes instruction and has relevant learning objectives in required learning experiences that address the diagnosis, prevention, appropriate reporting (if relevant), and treatment of the medical consequences common societal problems.

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

***7.7 MEDICAL ETHICS***

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

7.7 a The medical curriculum includes instruction and assessment of the following topics in an independent required learning experience, and/or integrated into a required learning experience(s):

i. biomedical ethics

ii. ethical decision-making

iii. professionalism

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

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

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

***7.8 COMMUNICATION SKILLS***

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

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

i. communicating with patients and patient’s families

ii. communicating with physicians (e.g., as part of the medical team)

iii. communicating with non-physician health professionals (e.g., as part of the health care team)

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

***7.9 INTERPROFESSIONAL COLLABORATIVE SKILLS***

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

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

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

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

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

***8.1 CURRICULAR MANAGEMENT***

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

8.1 a There is a duly constituted faculty body (commonly called the curriculum committee) that has authority and responsibility for the medical education program.

8.1 b The membership of the ‘curriculum committee’ includes faculty, students, educational leaders and administrative staff.

8.1 c The ‘curriculum committee’ and its subcommittees or other structures that achieve the same functionality, oversee the curriculum as a whole and have responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum as articulated in the terms of reference of these committees.

8.1 d The committees or groups that implement and deliver the curriculum (e.g., directors of required learning experiences, chairs of committees for years or segments or themes of the curriculum) operate under the authority of the ‘curriculum committee’ and its subcommittee (i.e., there are reporting lines of these operational committees/groups to the ‘curriculum committee’).

8.1 e The minutes of the ‘curriculum committee’ provided in the DCI from the last two years show that the ‘curriculum committee’ has overseen the curriculum as a whole and has demonstrated its responsibility by reviewing and approving any changes to the medical education program objectives and the learning objectives of required learning experiences; changes to the design of the program; ensuring that curriculum content is coordinated and integrated within and across academic years; monitoring the overall quality and effectiveness of all required learning experiences, and the curriculum as a whole; and ensuring that identified deficiencies are addressed (i.e. quality improvement).

***8.2 USE OF MEDICAL EDUCATIONAL PROGRAM OBJECTIVES***

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

8.2 a The ‘curriculum committee’ ensures the medical education program objectives are used to select curriculum content and determine its placement in required learning experiences throughout the educational program.

8.2 b The ‘curriculum committee’ ensures that the medical education program objectives are used to evaluate the effectiveness of curriculum.

8.2 c Directors of required learning experiences and other educational leaders contribute to the development of the linkage between the learning objectives and the medical education program objectives. The ‘curriculum committee’ has the overall responsibility to ensure that the medical education program objectives are appropriately linked to the learning objectives of all of the required learning experiences so that the medical education program objectives can be achieved.

8.2 d There is appropriate linkage between the medical education program objectives and the learning objectives of required learning experiences.

***8.3 CURRICULAR DESIGN, REVIEW, REVISION/CONTENT MONITORING***

***The faculty of a medical school are responsible for the detailed development, design, and implementation of all components of the medical education program, including the medical education program objectives, the learning objectives for each required learning experience, and instructional and assessment methods appropriate for the achievement of those objectives.***

***The curriculum committee oversees content and content sequencing, ongoing review and updating of content, and evaluation of required learning experiences, and teacher quality.***

***The medical education program objectives, learning objectives, content, and instructional and assessment methods are subject to ongoing monitoring, review, and revision by the curriculum committee to ensure that the curriculum functions effectively as a whole such that medical students achieve the medical education program objectives.***

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

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

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

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

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

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

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

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

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

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

***8.5 USE OF STUDENT EVALUATION DATA IN PROGRAM IMPROVEMENT***

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

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

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

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

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

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

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

***8.6 MONITORING OF COMPLETION OF REQUIRED CLINICAL LEARNING EXPERIENCES***

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

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

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

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

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

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

*8.7 COMPARABILITY OF EDUCATION/ASSESSMENT*

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

8.7 a The overview data for Standard 6 Tables 6.0-1 through 6.0-3 and DCI Tables 9.4-2 through 9.4-5 show that medical curriculum includes comparable/similar educational experiences and equivalent/same methods of assessment across all locations within a given required learning experience.

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

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

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

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

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

***8.8 MONITORING TIME SPENT IN EDUCATIONAL AND CLINICAL ACTIVITIES***

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

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

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

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

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

8.8 e There is a policy or equivalent document related to the time students spend in educational and clinical activities during required clinical learning experiences, including on-call requirements.

8.8 f The policy described in 8.8.e. was developed by appropriate faculty members, approved by the ‘curriculum committee’ and disseminated to students, faculty, residents and others involved in required clinical learning experiences.

8.8 g The ‘curriculum committee’ (or its subcommittee) monitors the effective application of the policies for required clinical learning experiences on a regular basis.

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

***9.3 CLINICAL SUPERVISION OF MEDICAL STUDENTS***

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

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

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

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

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

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

9.3 f AAMC CGQ data show that the majority of respondents at each campus agree/strongly agree that they were appropriately supervised and were given an appropriate level of responsibility.

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

***9.4 ASSESSMENT SYSTEM***

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

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

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

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

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

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

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

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

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

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

***9.5 NARRATIVE ASSESSMENT***

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

9.5 a A narrative description of a medical student’s performance, including his or her non-cognitive achievement is included as a component of the assessment in all required learning experiences of four weeks duration or greater with small group, or 1:1 learning activities for which there is a summative performance assessment by the tutor/preceptor.

***9.7 TIMELY FORMATIVE ASSESSMENT AND FEEDBACK***

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

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

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

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

i. Formal feedback occurs at least at the mid-point of the learning experience or

ii. Formal feedback occurs approximately every six weeks for required learning experiences that are semester or year-long (e.g., longitudinal integrated clerkship).

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

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

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

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

9.7 h Administrative data or evaluation data for the last three academic years show that students in longitudinal integrated clerkships receive formal feedback approximately every six weeks at all instructional sites.

***9.8 FAIR AND TIMELY SUMMATIVE ASSESSMENT***

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

9.8 a All students receive their final grades no more than six weeks after the end of a required learning experience at each campus.

9.8 b Provision of final grades is monitored and steps are taken to meet the expected timeline.

9.8 c The medical school has a policy or guidelines specifying the timeline for provision of final grades for all required learning experiences.

***9.9 SINGLE STANDARD FOR PROMOTION / GRADUATION AND APPEAL PROCESS***

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

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

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

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

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

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

***10.4 CHARACTERISTICS OF ACCEPTED APPLICANTS***

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

10.4 a The mean overall premedical student performance data for new first year students admitted to the medical school for the last three years provided in Table 10.0-1 of the DCI, indicate that the medical school selects applicants who possess the intelligence necessary for them to become competent physicians.

10.4 b The personal and emotional characteristics of applicants considered during the admission process are necessary for them to become competent physicians.

10.4 c The personal and emotional characteristics of applicants considered during the admission process were developed, reviewed, and approved by appropriate individuals or groups.

10.4 d Members of the admission committee and the individuals who interview applicants (if different than members of the admission committee) are prepared and trained to assess applicants’ personal and emotional characteristics.

10.4 e There are standard forms used to guide and/or evaluate the results of applicant interview.

***11.1 ACADEMIC ADVISING***

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

11.1 a The medical school has a system of academic advising in place for medical students (identified as needing assistance based on performance or through self-referral) that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff.

11.1 b There are means by which the medical school identifies students experiencing academic difficulty.

11.1 c Medical students can self-refer for academic counseling if they perceive the need.

11.1 d Medical students at each campus are informed about the availability of academic advising and how they may be identified as needing these services, or how they can access these services if they perceive the need for academic advising.

11.1 e Academic advising/counseling is available to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkship).

11.1 f The medical school ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or promotion decisions about them.

11.1 g The data provided in Table 11.1-4 of the DCI show that a only small percentage of first year medical students and of all medical students at each campus withdrew or were dismissed from the medical school in the last three academic years.

11.1 h The data provided in Table 11.1-5 of the DCI show that a small number of medical students at each campus in years 1-4 over the past two academic years:

i. withdrew or were dismissed

ii. were required to repeat the entire academic year

iii. were required to repeat one or more required learning experience

iv. moved to a decelerated curriculum

v. took a leave of absence as a result of academic problems

11.1 i The overall graduation rate, and the percentage of medical students that graduated in four years at each campus is very high.

11.1 j AAMC CGQ and AFMC GQ data over the last three academic years show that the majority of respondents at each campus were satisfied/very satisfied with academic advising/counseling.

11.1 k Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with academic advising/counseling services.

***11.2 CAREER ADVISING***

***A medical school has an effective and where appropriate confidential career advising system in place that integrates the efforts of faculty members, clerkship directors, and student affairs staff to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs.***

11.2 a Faculty members, clerkship directors, and student affairs staff provide career advising to medical students at the main campus and any geographically distributed campuses.

11.2 b The career advising system provides appropriate mandatory and optional, and where appropriate confidential career advising activities to students in each year of the program to assist them in evaluating career options, choosing electives and applying to residency programs.

11.2 c The medical school provides career advising to students at each campus and to students, who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).

11.2 d There are print or online resources available to medical students to support their career investigations.

11.2 e There is an individual(s)who is primarily responsible for providing guidance to medical students on their choice of intramural and extramural electives during each year of the curriculum at each campus and to students who are away from the medical school for a six-month or more consecutive period.

11.2 f A faculty member is responsible for formally approving medical students’ elective choices.

11.2 g The percentage of participating medical students who remained unmatched at the end of the second iteration of the Canadian Residency Match Service (CaRMS) match has been low for the last three academic years.

11.2 h AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus were satisfied/very satisfied with career planning services and information about specialties.

11.2 i Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with career advising.

11.2 j AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus were satisfied/very satisfied with guidance when choosing electives.

11.2 k Data from the ISA show that the majority of respondents at each campus in all years of the MD program were satisfied/very satisfied with guidance when choosing electives.

***11.3 OVERSIGHT OF EXTRAMURAL ELECTIVES***

***If a medical student at a medical school is permitted to take an elective under the auspices of another medical school, institution, or organization, a centralized system exists in the dean’s office at the home school to review the proposed extramural elective prior to approval and to ensure the return of a performance assessment of the student and an evaluation of the elective by the student. Information about such issues as the following are available, as appropriate, to the student and the medical school in order to inform the student’s and the school’s review of the experience prior to its approval:***

***a) Potential risks to the health and safety of patients, students, and the community;***

***b) The availability of emergency care;***

***c) The possibility of natural disasters, political instability, and exposure to disease;***

***d) The need for additional preparation prior to, support during, and follow-up after the elective;***

***e) The level and quality of supervision; and***

***f) Any potential challenges to the code of medical ethics adopted by the home school.***

11.3 a There is a centralized system in the dean’s office of the home school at each campus to review and approve proposed electives taken by the school’s own students under the auspices of another medical school, institution, or organization before the medical student is permitted to begin the elective.

11.3 b There is an appropriate mechanism for the review of the following points for extramural electives where is a potential risk to medical student and patient safety.

i. potential risks to the health and safety of patients, students, and the community;

ii. the availability of emergency care;

iii. the possibility of natural disasters, political instability, and exposure to disease;

iv. the need for additional preparation prior to, support during, and follow-up after the elective;

v. the level and quality of supervision; and

vi. any potential challenges to the code of medical ethics adopted by the home school.

11.3 c The medical school effectively prepares and supports medical students before, during, and after electives where there is a risk to student and patient safety.

11.3 d The centralized system described in 11.3.a., ensures that a performance assessment of the student and an evaluation of the elective experience by the student are returned to the medical school.

11.3 e The evaluation data on extramural electives provided by students to the centralized system in the dean’s office of the home medical school at each campus is used to inform, among other things, future decisions regarding approval of other requests for the same elective experience from other medical students.

***11.5 CONFIDENTIALITY OF STUDENT EDUCATIONAL RECORDS***

***At a medical school, student educational records are confidential and available only to those members of the faculty and administration with a need to know, unless released by the student or as otherwise governed by relevant legislation. A medical school follows policy for the collection, storage, disclosure and retrieval of student records that is in compliance with relevant privacy legislation.***

11.5 a The medical school at each campus has and follows policy(ies) for the collection, storage, disclosure and retrieval of student academic/educational records that is in compliance with relevant privacy legislation.

11.5 b A medical student’s academic/educational record/file is kept in a separate location from his or her health record/file at each campus.

11.5 c There is a policy and procedure that specifies which individuals have the right to review a medical student‘s academic/educational file. The individual(s) at each campus who is responsible for providing access to a student’s academic/educational file ensures that only those authorized individuals are given access.

***11.6 STUDENT ACCESS TO EDUCATIONAL RECORDS***

***A medical school has policies and procedures in place that permit a medical student to review and to challenge his or her educational records, including the Medical Student Performance Record, if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.***

11.6 a The medical school has policies and procedures in place that permit a medical student to review all components of their educational records including the Medical Student Performance Record. Students do not have access to any reference letter used in the admission process when the referee was assured would not be provided to the student.

11.6 b Medical students are given access to review their educational records in a reasonably short period of time after the request has been made at each campus.

11.6 c A medical student can challenge the following if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.

i. content of the MSPR

ii. examination performance, tutor/preceptor assessment in a required learning experience

iii. final grade for a required learning experience

11.6 d Formal medical school policies and procedures related to medical students’ ability to review and challenge their records, including the length of time it takes for students to gain access to their records are made known to students and teaching faculty at each campus.

11.6 e The Medical Student Performance Record is completed using objective data by an individual(s) who has had no role in providing personal counseling, or health services including psychiatric/psychological counseling.

11.6 f The medical school corrects factual errors, and removes misleading and/or inappropriate information from the educational record of a medical student once the error, misleading and/or inappropriate information has been identified, investigated and confirmed.

***12.1 FINANCIAL AID / DEBT MANAGEMENT COUNSELING/ STUDENT EDUCATIONAL DEBT***

***A medical school provides its medical students with effective financial aid and debt management counseling and has mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) on medical student indebtedness.***

12.1 a The medical school ensures that required and optional financial aid and debt management counseling/advising activities (including one-on-one sessions) are available to medical students in each year of the curriculum at each campus.

12.1 b The medical school ensures that financial aid management services are available to students who are away from the medical school for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).

12.1 c The medical school initially determines and subsequently evaluates the adequacy of financial aid staffing.

12.1 d The medical school ensures that conflicts of interests for those providing debt management counselling and information on student loans are identified and appropriately managed.

12.1 e The medical school has awarded bursaries, grants and scholarships and extended loans to students over the past three academic years.

12.1 f Since the time of the last full survey, the medical school or university has engaged in activities to increase the amount and availability of scholarship, bursary, grant and loan support for medical students.

12.1 g The medical school and the university have worked to limit tuition increases or limit student debt since the time of the last full survey.

12.1 h AAMC CGQ and AFMC GQ data show that the average medical education debt of all graduating students over the last three years is comparable to that of other Canadian medical schools.

12.1 i Data from the AAMC CGQ and the AFMC GQ and the ISA show that the majority of respondents at each campus are satisfied/very satisfied with financial aid administrative services, and overall educational debt management counselling.

***12.3 PERSONAL COUNSELING / WELL-BEING PROGRAMS***

***A medical school has in place an effective system of personal counseling for its medical students that includes programs to promote their well-being and to facilitate their adjustment to the physical and emotional demands of medical education.***

12.3 a The medical school provides personal counseling and well-being programs to students at each campus and to students who are away from the medical school campus for a six-month or more consecutive period (e.g., longitudinal integrated clerkship, or distributed rotation-based clerkships).

12.3 b Medical students are informed about the availability of personal counseling and well-being programs provided by the medical school at each campus.

12.3 c Data from the AAMC CGQ and the AFMC GQ over the past three academic years show that the majority of respondents at each campus are satisfied/very satisfied with personal counseling provided by the medical school.

12.3 d Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with the availability and confidentiality of personal counseling services provided by the medical school.

12.3 e Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with well-being programs provided by the medical school.

12.3 f Data from the AAMC CGQ and AFMC GQ show that the majority of respondents at each campus are satisfied/very satisfied with programs that promote effective stress management, a lifestyle balance and overall well-being.

***12.4 STUDENT ACCESS TO HEALTH CARE SERVICES***

***A medical school facilitates medical students’ timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required learning experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care.***

12.4 a The medical school at each campus facilitates medical students’ timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of required learning experiences.

12.4 b Medical students at all instructional sites and campuses are informed about availability and access to health services.

12.4 c The medical school at each campus has policies and procedures in place that permit students to be excused from required learning experiences including required clinical learning experiences to seek needed care.

12.4 d The policies and procedures described in 12.4.c. are disseminated to medical students, faculty, and residents.

12.4 e The AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with student health services and mental health services.

12.4 f Data from the ISA show that the majority of respondents at each campus are satisfied/very satisfied with student health services and mental health services.

***12.6 STUDENT ACCESS TO HEALTH AND DISABILITY INSURANCE***

***A medical school ensures that health insurance is available to each medical student and his or her dependents and that each medical student has access to disability insurance.***

12.6 a Health insurance is available to each medical student and his or her dependents at each campus.

12.6 b Medical students at each campus are informed of the availability of health insurance on entry into the medical education program.

12.6 c AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with the availability of health insurance.

12.6 d Disability insurance is available to each medical student at all campuses.

12.6 e Medical students are informed about the availability of disability insurance on entry into the medical education program.

12.6 f AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with the availability of disability insurance.

***12.8 STUDENT EXPOSURE POLICIES / PROCEDURES***

***A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards, including:***

***a) The education of medical students about methods of prevention.***

***b) The procedures for care and treatment after exposure, including a definition of financial responsibility.***

***c) The effects of infectious and environmental disease or disability on medical student learning activities.***

***All registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk.***

12.8 a The medical school has policies in place that address medical student exposure to infectious and environmental hazards that include:

i. education of medical students about methods of prevention.

ii. procedures for care and treatment after exposure, including the definition of financial responsibility.

iii. effects of infectious and environmental disease or disability on medical student learning activities.

12.8 b Medical students and visiting medical students learn how to prevent exposure to infectious diseases, especially from contaminated body fluids al all instructional sites before students are permitted to participate in patient-care activities.

12.8 c Medical students and visiting medical students are informed of the medical school’s policies and procedures related to exposure to infectious and environmental hazards (contaminated body fluids, infectious disease screening and follow-up, hepatitis B vaccination, and HIV testing) at all instructional sites before students are permitted to participate in patient-care activities.

12.8 d Medical students and visiting students at all instructional sites learn about the procedures to be followed in the event of exposure to blood-borne (e.g., needle-stick injury) or air-borne pathogens.

12.8 e AAMC CGQ and AFMC GQ data show that the majority of respondents at each campus are satisfied/very satisfied with the education about exposure to and prevention of infectious diseases (e.g., needle-stick).

12.8 f AAMC CGQ and AFMC GQ data show that a very high percentage of respondents at each campus indicate that: “I know what to do if I am exposed to an infectious or environmental hazard like a needle stick injury”.

12.8 g Data from the ISA show that the majority of respondents at each campus are familiar with the protocol following exposure to infectious and environmental hazards.