2024-2025 Independent Student Analysis (ISA)
Manitoba Medical Students' Association

Max Rady College of Medicine,
Rady Faculty of Health Sciences,
University of Manitoba

Prepared in accordance with the Committee on Accreditation of Canadian Medical Schools (CACMS) for 2026-2027 Visits

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Section 1: Abbreviations & Glossary of Terms

BSc (Med) or BSc. Med	Bachelor of Science (Medicine)
CACMS	Committee on Accreditation of Canadian Medical Schools
CaRMS	Canadian Resident Matching Service
IAU	Integrated Accreditation Unit
ISA	Independent Student Analysis
MMSA	Manitoba Medical Students' Association
NBME	National Board of Medical Examiners
OSCE	Objective Standardized Clinical Examination
TTC	Transition to Clerkship
UGME	Undergraduate Medical Education
CPA	Comprehensive Patient Assessments
MSPR	Medical Student Performance Record
POCUS	Point-of-Care Ultrasound

The following terms may be used interchangeably in this report, unless otherwise specified:
Year 1 = Med 1 = Medicine 1 = Class of 2028
Year 2 = Med 2 = Medicine 2 = Class of 2027
Year 3 = Med 3 = Medicine 3 = Class of 2026
Year 4 = Med 4 = Medicine 4 = Class of 2025

Pre-Clerkship = first and second year of medical school; didactic learning
Clerkship = third and fourth year of medical school; clinical learning

Section 2: Executive Summary

The 2024-2025 Independent Student Analysis (ISA) was prepared by the Manitoba Medical Students' Association (MMSA) ISA Steering Committee in accordance with the Committee on Accreditation of Canadian Medical Schools (CACMS) Guide to the Independent Student Analysis for 2026-2027 site visits. Although this iteration of the report will not be used as part of an official site visit, its purpose is to analyze student responses to the 2024-2025 ISA Survey. The ISA Survey collects student feedback on various aspects of the medical school, including curriculum, learning environments, and services provided to students. The 2024-2025 ISA was made available for completion by all students enrolled in the Max Rady College of Medicine from April 2nd at 9:00 AM CST to May 5th at 11:59 PM CST. The response rate of each class was as follows:

- Class of 2025, Year 4: 80/105 (76%)
- Class of 2026, Year 3: 46/113 (41%)
- Class of 2027, Year 2: 102/120 (85%)
- Class of 2028, Year 1: 121/136 (89%)
- Max Rady College of Medicine, aggregate response rate: 349/474 (74%).

The results of the survey were analyzed by the ISA Steering Committee, which consisted of 15 students in total, with representation from the Classes of 2025 (n=1), 2026 (n=2), 2027 (n=4), and 2028 (n=8). The survey results were analyzed and compiled into this report. We have included key strengths, areas for improvement, and recommendations below. Please see the remaining sections of this report for more details.

Key Strengths:

- The medical school excels at facilitating an environment that involves community-based learning by involving residents frequently throughout the undergraduate medical education.
- The medical school strives to encourage all medical learners to participate in scholarly learning, while providing them with an abundance of opportunities to do so.
- Medical learners found the medical school to foster an environment built on respect, one that frequently incorporates student feedback across all aspects of undergraduate training, while ensuring that learners have a thorough understanding of how to report mistreatment.
- Student safety is a core value of the medical school, with learners reporting an appreciation for the services in place during and outside of regular classroom hours.
- The library and IT resources available to medical students were found to be exceptional and accessible to all learners both on- and off-campus.
- The curriculum offered at the medical school provides students with a strong foundation in generalist care across the various stages of the life cycle and within a broad range of clinical settings and environments, while developing strong clinical judgement and problem-solving that takes into account the importance of cultural competence and safety.

- The emphasis placed on the importance of reporting personal health and/or post-hazardous exposure by the medical school on medical learners was greatly appreciated by the student body.
- The academic advising, career counselling, and elective exposures offered at the medical school were praised by medical students across all four years of training.
- The medical school was identified to boast a high quality of educators, while offering a flexible curriculum delivery model that is accommodating to individual student learning needs and extra-curricular commitments.
- The clinical reasoning course was reported to be a strong component of the pre-clerkship curriculum.
- The clerkship program offered at the medical school was felt by learners to foster the development of a competent and independent medical learner; the clerkship program reflects and values the unique learning needs and requests of clerkship students, providing learners with access to strong study resources.

Key Areas for Improvement:

- While medical students expressed an abundance of research opportunities throughout pre-clerkship years, more senior students reported a desire for additional research opportunities during the latter half of medical school.
- Medical students across all four years expressed a strong understanding of how to report mistreatment and access support while doing so, however it was identified that the subsequent steps following a reporting were often unclear– particularly, how they pertained to the protection of student anonymity throughout the process, as well as alternative, informal ways of reporting mistreatment outside of “Speaking Up”.
- College-wide, students reported unclear expectations from clinical preceptors, as well as a lack of awareness of UGME policies and procedures amongst clinical preceptors– whether as Year 1 students during *Community Exposures* or as clerks during select rotations.
- Study and lounge spaces were expressed by students to be inadequate for their needs, both on- (with expanding class sizes) and off-campus (major teaching sites and facilities). Furthermore, students reported similar sentiments towards personal storage spaces, particularly amongst clinical year students, where locker space is often unavailable and the security of personal belongings is not guaranteed.
- Pre-clerkship students reported that standardized patient encounters and clinical exposures were insufficient, expressing a desire for additional opportunities to explore career and specialty interests.
- Across all years, students reported multiple instances where the time required or expected of learners to complete certain clinical and didactic activities where inappropriate to the time allotted or outlined; notably, these inconsistencies were observed amongst select “Assigned studies”, *CPAs* for Year 2 students, and during “post-call” rounding for clerks.
- Pre-clerkship students expressed a lack of awareness of some of the advising services that are made available to them. Similarly, the same students expressed an interest in additional sessions outlining CaRMs.

- Students across the college expressed a lack of awareness of the policies and procedures regarding the handling of their academic records.
- Year 1 and 2 learners unanimously identified the *Clinical Skills* curriculum as a major area requiring improvement; concerns pertained to OSCE expectations not aligning with the information or teaching students received, a desire for a document explicitly outlining expectations, as well as the formal addition of POCUS to the *Clinical Skills* curriculum.
- Similarly, Year 1 and 2 medical students identified the *Population Health* curriculum as needing improvement, with concerns related to lecture content being outdated, disorganized, as well as a reference to a disconnect between materials covered within lectures and those examined.
- Lastly, the *Indigenous Health* curriculum was identified by multiple students as in need of revision. Namely, the material provided on traditional teaching is insufficient, there is limited exposure to the community, and the few scheduled sessions are often not designated as “Unique Learning Opportunities,” resulting in multiple students missing out on the important material delivered during this time. Students also expressed a desire for additional sessions on effective and culturally safe communication.

Key Recommendations:

- That additional scholarly research opportunities be implemented in the senior years of medical school.
- That the medical school provide additional information to learners on the subsequent steps and proceedings following the reporting of mistreatment, particularly as they pertain to student anonymity and alternative/informal ways of reporting mistreatment.
- That the medical school ensures that all clinical preceptors outline expectations of medical learners and are aware of the policies outlined by UGME.
- That the medical school explore additional study and lounge spaces for learners on- and off-campus, particularly at clinical sites and facilities. Similarly, the medical school ensure that learners have access to secure spaces to store personal belongings at all clinical sites.
- That the medical school provide junior medical students with additional standardized patient encounters and exposure opportunities/flexibility, to build confidence amongst learners while allowing them to have the opportunity to explore career options.
- That the time expectations are aligned with the allotted time for sessions and are in accordance with policies outlined by UGME, namely, during “Assigned studies”, *CPAs*, and during “post-call” rounding for clerks.
- That additional sessions outlining advising services and CaRMs be implemented for junior learners.
- That additional sessions are provided to all learners regarding the policies (access to and challenging of-) outlining the handling of student academic records.
- That the *Clinical Skills* curriculum be revised to ensure that OSCE expectations reflect the content delivered during clinical skills sessions, that students are provided with an explicit outline of OSCE expectations, and that POCUS be formally introduced into the *Clinical Skills* curriculum.

- That the *Population Health* curriculum be revised to ensure that lecture content is current and is reflected more appropriately on examinations.
- That the *Indigenous Health* curriculum be revised to provide students with a greater familiarity with traditional teachings, as well as greater confidence in culturally safe and competent communication. Furthermore, more tutorials are designated as “Unique Learning Opportunities” to increase attendance by the student body.

Section 3: Contributors to the ISA Process

ISA Steering Committee Members:
Amy Lloyd, Class of 2028 President, Class of 2028
Ahmed Zalam, Report Co-Lead, MMSA Vice-Stick Internal Junior, Class of 2028
Kristi Loeb, Class of 2028 Academic Representative, Class of 2028
Andy Duong-Do, MMSA Global Health Liaison Senior, Class of 2028
Roland Salacup, MMSA Programmer, Class of 2028
Patricia Machekera, MMSA Vice-Stick Equity, Diversity, Inclusivity (EDI) Junior, Class of 2028
Raeann Benjamin, MMSA Lounge Coordinator, Class of 2028
Josh Broom, MMSA Treasurer Junior, Class of 2028
Devin Habon, MMSA University of Manitoba Students' Union Representative, Class of 2027
Dustin Erickson, Report Co-Lead, MMSA Vice-Stick Internal Senior, Class of 2027
Jaime McNicholl, MMSA Vice-Stick External Senior, Class of 2027
Josh Waldman, Class of 2027 President, Class of 2027
Max Fidel, Report Co-Lead, MMSA Senior Stick, Class of 2026
Riley Sierhuis, Class of 2026 President, Class of 2026
Dr. Emmit Hameed, Outgoing MMSA Senior Stick, Class of 2025

University of Manitoba Faculty/Staff:
Dr. Aaron Chiu, Associate Dean, Quality Improvement and Accreditation
Dr. Kevin Brown, MMSA Honorary Senior Stick
Anu Bajwa, Continuous Quality Improvement (CQI) and Accreditation Coordinator
Danna Arciniegas, Project Coordinator, Rady Integrated Accreditation Unit
Nathalie Buisse, Project Coordinator, Rady Integrated Accreditation Unit
Anna Urbanik, Enrolment Administrator, Undergraduate Medical Education
Nadine Allain, Year 1 Course Administrator, Undergraduate Medical Education
Destiny Weimar, Year 2 Course Administrator, Undergraduate Medical Education
Maggie Eade, Pre-Clerkship Program Lead, Undergraduate Medical Education
Eliya Ichihashi, Clerkship Assistant Lead and Coordinator, Undergraduate Medical Education

Section 4: Introduction

The Independent Student Analysis or ISA is an annual survey that is administered to all students enrolled in the Max Rady College of Medicine. This year, the survey was administered to a total of 474 students across four years of medical school classes, ranging from first-year medical students in the Class of 2028 to final-year medical students in the Class of 2025, whose members have graduated as of May 2025. The purpose of the ISA is to receive student feedback in several key areas and to formally report on it. This feedback, compiled within this report, makes up a component of the school's accreditation process. This feedback is also reviewed with the medical school faculty to make note of the program's strengths and to identify weaknesses and areas of potential improvement.

The ISA Steering Committee was formed by extending an open invitation to all 30 Manitoba Medical Students' Association (MMSA) council members, as well as Dr. Emmit Hameed, the outgoing MMSA Senior Stick. The ISA Steering Committee consisted of 15 members: one from the Class of 2025, two from the Class of 2026, four from the Class of 2027, and eight from the Class of 2028. Due to high levels of involvement in student life by all members of the committee, we feel that our decisions and recommendations reflect a broad view of the student body. The committee met four times virtually via Zoom, with an initial meeting to clarify expectations and three subsequent meetings to discuss the survey results. Before each meeting, we assigned committee members the task of reading a section of the survey results and noting areas for discussion at the meeting. Meetings were chaired by Max Fidel (Report Co-Lead; MMSA Senior Stick) and notes were taken by Dustin Erickson and Ahmed Zalam (Report Co-Leads; MMSA Vice-stick Internal Senior and Junior, respectively). All members of the committee were allowed to comment on each survey item.

The 2024-2025 ISA Survey was made available for completion by all students enrolled in the Max Rady College of Medicine from April 2nd at 9:00 AM CST to May 5th at 11:59 PM CST. Throughout the process of preparing this report for the interim accreditation, logistical assistance was generously provided to us by the Rady Integrated Accreditation Unit (IAU). The IAU assisted us with preparing the survey, which was administered using the program LimeSurvey.

The IAU also assisted us in offering financial incentives for the completion of the survey. At the class level, a financial incentive of $1000 was offered to classes that achieved a 75% survey response rate, with the purpose of the $1000 to go towards each class's respective graduation fund. Gift cards for individuals were also offered. Students who completed the survey within one week of its release (before April 10 at 11:59 pm CST) were entered in a draw to win a $500 gift card, students who completed the survey within two weeks of its release (before April 18 at 11:59 pm CST) were entered in a draw to win a $250 gift card, and students who completed the survey before it closed (before April 30th at 11:59 pm CST) were entered in a draw to win one of three $100 gift cards. To track individual and class participation rates in the survey, the department of Undergraduate Medical Education (UGME) assisted by sending student names and email addresses to the report co-leads and the IAU for the purposes of tracking completion.

Members of the University of Manitoba Undergraduate Medical Education office had the opportunity to review a draft of this report and comment on its factual correctness. They did not

edit, revise the report, or pressure students to change its content, conclusions, or recommendations.

Section 5: Methodology

The survey was administered using the platform LimeSurvey. The survey was administered to all 474 students enrolled in the Max Rady College of Medicine. The survey was open from April 2nd at 9:00 am CST to May 5th at 11:59 PM. This time period was chosen for the administration of the survey as this was prior to the summer break for the Classes of 2027 and 2028, and prior to the graduation of the Class of 2025.

We utilized multiple reminder methods. The first method was regular email reminders from the IAU to all students who had not yet completed the survey. The second method was regular email reminders sent to the entire student body by Max Fidel (Report Co-Lead, MMSA Senior Stick). Lastly, each class was scheduled for one hour of dedicated, in-person time to complete the survey using the school's online scheduling platform, Entrada. Nadine Allain (Year 1 Course Administrator), Destiny Weimar (Year 2 Course Administrator), Maggie Eade (Pre-Clerkship Program Lead), and Eliya Ichihashi (Clerkship Program Lead) from UGME assisted in booking times and physical spaces for students to use. During these sessions, one of the report co-leads (Max Fidel, Ahmed Zalam, or Dustin Erickson) was present to oversee survey completion and answer student questions. It should be noted that attendance at these sessions from every class was low.

The quantitative portion of this report is made up of survey items to which students answered "Yes" or "No." A "Not Applicable" (NA) option was available for certain items. To identify potential areas of weakness, we chose a cutoff of 80%. Items with fewer than 80% of students answering "Yes" (or greater than 20% of students answering "No" in regards to select "negative" questions) were identified and focused on. While we recognize that this cutoff criterion is high, we believe it to be appropriate as it provides a consistent way of identifying potential areas of concern and areas for improvement; some responses were deemed borderline, if they were within a few percent of the cutoff, and were commented on accordingly. Open-ended questions were analyzed through discussion with the ISA Steering Committee. Each open-ended question and associated responses were thoroughly reviewed by all members of the committee prior to and during committee meetings. We guided our narrative exploration of these open-ended questions by taking into consideration items that were mentioned by multiple students, as well as any common experiences shared by members of the ISA steering committee.

Section 6: Survey Results

Key Descriptive Statistics:

Table 1 | Descriptive statistics of response rates

Campus	Number (%)			
	Year 1	Year 2	Year 3	Year 4
University of Manitoba Bannatyne Campus	121/136 (89%)	102/120 (85%)	46/113 (41%)	80/105 (76%)

In total, 349 out of 474 (74%) students from across all four years of medicine completed the 2024-2025 ISA survey. Year 1 had the highest response rate of all classes (89%), followed by Year 2 (85%), Year 4 (76%) and finally Year 3 (41%). These response rates are similar to the 2023-2024 ISA survey, which was completed by 347 out of 456 (78%) of students. These high response rates likely reflect the financial incentives and frequency of reminders by both the IAU and the MMSA. In keeping with the previous survey (2023-2024), Year 3 had the lowest response rates, 46/113 (41%; 2024-2025) and 72/109 (66%; 72/109). This low response rate from Year 3 may be a reflection of the heavy clinical schedule; however, future surveys should continue to explore additional dedicated time or alternative reminders for students who may feel preoccupied with clinical work and responsibilities.

Standard 3: Academic & Learning Environment

3.1: Resident Participation in Medical Student Education (Table 3.1-1 B, Appendix 1):

Discussion:

Nearly 100% (99%) of all medical students reported having worked with a resident in at least one required clinical learning experience at this point in their medical training. It was noted from the discussion by the ISA Steering Committee that the incorporation of medical residents in undergraduate medical education was invaluable, with members attesting to the patience and practical perspectives that residents had to offer, whether on the task at hand or in the specialty of their residency.

Strengths:

- The current medical school program excels at exposing all medical students to medical residents of diverse specialties, each of which is capable of providing unique perspectives and guidance.

Areas for Improvement:

- Although not directly assessed, the ISA Steering Committee consisted of a variety of students across the four years of medical school, with members of the first- and second-

year classes noting a desire to interact with more junior physicians, who very well may be their senior residents one day.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue their current practice, but consider the involvement of junior residents earlier on in the undergraduate medical curriculum, more frequently.

3.2: Medical Student Participation in Research/Scholarly Activities (Table 3.2-2 C, Appendix 1):

Discussion:

Research drives the development of evidence-based medicine, contributing to enhanced patient care and novel approaches, and so medical students must be exposed to research early on in their training. Evident in the results, medical students across all four years of training felt that they were adequately encouraged by the college to participate in research and other scholarly activities, with students reporting that there were sufficient opportunities to do so. In addition to the MD/MSc and MD/PhD programs, which are standard amongst most universities, the Max Rady College of Medicine also provides first- and second-year medical students with the opportunity to participate in the Bachelor of Science (Medicine) Program (BSc Med..) or the One-Summer Research Project. The BSc Med.. involves a two-year summer research project that medical students can participate in their first two summers of medical school, working under a clinician scientist or professor in the faculty while receiving a stipend for their work, and upon completion of which, earning themselves a BSc Med. degree in addition to their Medical Doctorate, recognizing their work. The One-Summer Research project functions to expose students to research over a single summer, providing students with an invaluable but flexible alternative. In addition to these two programs, students also have the opportunity to participate in the *Home for the Summer Program*, which serves as a rural clinical exposure for students to partake in, but also requires that students present a case report from their experience in order to complete the program. All of these opportunities serve to explain the rationale behind the reported satisfactory rates (>80%) of Years 1 and 2 medical students and the continued satisfaction of Year 3 and 4 medical students, within this element. However, it was noted through discussion by the ISA Steering Committee that several students expressed the desire for additional research opportunities outside of pre-clerkship. Still, the Max Rady College of Medicine encourages participation in and exposes students to a plethora of early research exposures, with some students wishing there were additional opportunities in the later portion of their training.

Strengths:

- The Max Rady College of Medicine excels at encouraging medical students' participation in research and scholarly activities across all four years.
- The Medical school succeeds at providing medical students with an abundance of research opportunities that students can tailor to their individual career goals.

Areas of improvement:

- While the medical school excels in exposing medical learners to research and scholarly activities early on in their training, some medical students expressed the desire for additional research opportunities throughout their training.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue their support of research and scholarly endeavour, but consider the integration of additional opportunities into the later years of medical school through “Research Blocks” or more longitudinal research.

3.3: Fostering an Environment of Respect (Table 3.4-2 B, Appendix 1):

Discussion:

Inherent in the success of any community of learners is the perceived sense of respect to learn without the fear of any repercussion or harm, with medical student learners being of no exception. All four years of medical students unanimously reported that the medical school fosters an environment in which people are treated with respect, with satisfactory rates ranging from 85% to 100% across first and third year medical students, respectively. Furthermore, third and fourth-year medical students all reported that the hospitals they were assigned to fostered environments where people were treated with respect (97% and 87%, Years 3 and 4, respectively). It is worth noting that students were able to select “Not applicable” if they were never assigned to a hospital, as in the case of first and second year medical students, yet amongst those who had exposure, satisfactory rates of 95% and 99% were still noted amongst first and second year medical students, respectively. The ISA Steering Committee felt that the reported satisfaction rates were a result of the numerous measures in place that aim to foster respect. Notably, the medical school succeeds at incorporating student voices in the evaluation of courses and clinical rotations, scheduling is flexible and considerate of unique student needs, and the reporting of mistreatment is emphasized by the medical school, with mandatory evaluations requesting the reporting of mistreatment at all stages of medical school training.

Strengths:

- The medical school excels at fostering an environment of respect across all four years of training and at all sites of learning, frequently incorporating student feedback, and ensuring frequent assessment of mistreatment of all medical learners.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue to perpetuate an environment of respect across all four years of medical school and at all sites of learning.

3.4, 3.5, and 3.6: Safe Mechanisms for Reporting Discrimination, Medical Students Reporting Discrimination, and Without Fear of Retaliation of Thereof (Table 3.4-4 B, Table 3.6-4 A, and Table 3.6-6 C; Appendix 1):

Discussion:

In the previous element, it was deemed that medical students across all four years of training deemed the Max Rady College of Medicine to be an institute that fostered respect on- and off-campus at clinical sites. However, it is pertinent to assess instances of discrimination on an individual level in an effort to strive for a space that is truly safe for all. When students were asked whether they felt that the medical school discriminated against them, 9%, 8%, 5%, and 6% of Year 1, 2, 3, and 4 medical students responded, “Yes” (Item Table 3.4-4 B), respectively. While these results are “satisfactory” as defined by this report (<20%, as this is a “negative question”), only 27% of these medical students responded “Yes” when asked if they felt that the school provides a safe mechanism for reporting incidents of discrimination, which was deemed “unsatisfactory” (<80%). When asked whether students felt discriminated against at one or more hospitals to which they were assigned, 5% of Year 3 students and 13% of Year 4 students responded “Yes” to feeling that they were discriminated against, which was deemed “satisfactory” (<20%). Yet, when these students were asked whether they felt that their hospital provided a safe mechanism for reporting this discrimination, 0% (n=1) of Year 3 students and 43% of Year 4 students felt that they were provided a safe mechanism to report their discrimination, which was deemed “Unsatisfactory” (<80%).

Items 10 and 11 sought to explain why this may have been the case. Item 10 pertained to medical learners’ understanding of the discrimination reporting policies and procedures; when asked whether students felt that they understood how they can report mistreatment, 84% and 83% of Year 1 and 2 medical learners, respectively, responded “Yes” (Table 3.6-4 A), which was deemed “satisfactory” (>80%). Item 11 continued to explore the topic of discrimination and pertained to student access to supports when reporting discrimination; when asked whether students felt that they could access support when reporting mistreatment, 85% and 93% of Year 1 and 2 students responded “Yes” (Table 3.6-6 C), which was deemed “satisfactory”. When interpreting these results, Items 10 and 11 demonstrated that the majority of students seemed to understand how to report mistreatment, and they also felt that they could access support when doing so. Despite this, those who did experience mistreatment still felt that the school did not provide a safe mechanism by which they could report mistreatment. Upon discussion of why this may have been the case, student anonymity was an area of concern that was identified by the ISA Steering Committee. Exploring this concern further, it was identified that outside of the sessions held during the orientation week of Year 1, they could not recall any subsequent instruction on the proceedings and subsequent steps following a report of discrimination. Fortunately, and evident in these results, is that discrimination towards medical students occurs few and far between, and when it does occur, it is approached on a case-by-case basis– still, there may be benefit in the reiteration of what a typical proceeding may look like, and how student anonymity can be preserved in these instances.

When assessing the results of Year 3 and 4 students, 96% and 97% of Year 3 and 4 students, respectively, responded “Yes” to Item 10– understanding how they can report mistreatment (Table 3.6-4 A). While in Item 11, 95% and 89% of Year 3 and 4 students, respectively, responded “Yes” to feeling that they can access support when reporting mistreatment (Table 3.6-6 C). Both of these items were “satisfactory” amongst the clinical

students (>80%). This was felt, by the ISA Steering Committee, to be 1) due to the consistent end-of-rotation evaluations, which prompt students to report mistreatment, and 2) due to rotation directors explicitly inquiring about any instances of mistreatment during students' one-on-one exit interviews, which may have fostered a sense of support and confidence for students.

Strengths:

- The medical school facilitates a robust understanding amongst medical students across all four years when it comes to reporting mistreatment and accessing support.

Areas of improvement:

- Limited information on subsequent steps and proceedings following "Speaking up"/reporting of discrimination against students.
- Concern amongst students about their anonymity when reporting mistreatment; students are deterred from reporting mistreatment due to a potential fear of retaliation.

Recommendations:

- The ISA Steering Committee recommends that the medical school provide more longitudinal sessions that inform students on the policies, protocols, and procedures about the subsequent steps and proceedings when reporting discrimination, with additional clarification on student anonymity throughout the reporting process.

Standard 5: Educational Resources & Infrastructure

5.4: Sufficiency of Facilities and Equipment (Table 5.4-1 C, Appendix 1):

Discussion:

Essential to learning are adequate facilities and equipment to meet the educational needs of students and to empower them to develop their clinical skills. When asked whether students consider the teaching facilities sufficient for their educational needs, 83%, 81%, 90%, and 92% of Year 1,2, 3, and 4 medical students responded "Yes" (Table 5.4-1 C), which was deemed "satisfactory" (>80%). Item 13 assessed whether students consider the equipment used for their teaching to be sufficient. Year 1 and 4 medical students deemed the equipment to be "satisfactory" (>80%), with 88% and 84% responding "Yes", respectively. While only 77% and 79% of Year 2 and 3 medical students, respectively, responded "Yes", which, although borderline, was deemed "unsatisfactory". When interpreting these results, Year 2 and 3 medical students on the ISA Steering Committee drew from their experiences and recalled that students were having difficulties booking rooms that were equipped with clinical equipment that they could use when preparing for their OSCEs. This limitation in room-booking may have been in part a result of some students booking multiple spaces, due to the absence of any restrictions. Alternatively, this may have been a result of limited space, with the expanding class sizes. However, ISA Steering Committee members across all four years of training reported that their individual classes appreciated the lecture-recording capabilities of the audiovisual equipment within teaching facilities that greatly enhanced their learning of didactic material.

Strengths:

- Lecture-recording capabilities of audiovisual equipment found within teaching facilities greatly enhanced the didactic learning of medical students across all four years.

Areas of improvement:

- Students felt that there were limited room-booking options for the practice of clinical skills.

Recommendations:

- The ISA Steering Committee recommends that the medical school consider the addition of spaces equipped with tools for practicing clinical skills, while adding restrictions to how many rooms individual students can book in a given time frame.
- The ISA Steering Committee recommends that the medical school continue to utilize the lecture-recording capabilities of audiovisual equipment found within lecture theatres.

5.5: Resources for Clinical Instruction and Access to Patients (Table 5.5-1 B and Table 5.5-2; Appendix 1):

Discussion:

In addition to teaching facilities within school premises, it is equally important that students have sufficient resources for clinical instruction at ambulatory and inpatient settings. When asked whether students considered the resources for clinical instruction at ambulatory settings to be appropriate, 86%, 93%, and 91% of Year 1, 3, and 4 medical students responded “Yes” (Table 5.5-1 B), which was deemed “satisfactory” (>80%). While only 78% of Year 2 medical students responded “Yes” to the same question, which, although borderline, was deemed “unsatisfactory” (<80%). When considering why this may have been the case, several members of the ISA Steering Committee recalled that during their Community Exposure sessions, where they were tasked with shadowing a family physician in clinic, there were times when preceptors were unaware of students being scheduled with them– resulting in some students being left feeling that their sessions were not as meaningful as they had hoped for them to be. Additionally, several students recalled that during their mandatory shadowing as part of their second year of training, some of their classmates expressed difficulty in finding family physicians to shadow. When students were asked whether they considered the resources for clinical instruction within inpatient settings to be appropriate, >80% of medical students across all four years responded “Yes” (Table 5.5-1 B), which was deemed “satisfactory”. When considering why this may have been the case, clerkship students within the ISA Steering Committee recalled that prior to any of the clinical rotations, the corresponding administration staff of the rotation would always distribute resource material well in advance of the rotation.

Another important consideration is student access to patients within clinical facilities. Item 16 assessed whether students had sufficient access to an adequate number of patients/simulated patients to complete their required learning, to which >80% of Year 1, 3, and 4 medical students responded “Yes” (Table 5.5-2 B), which was deemed “satisfactory”. While only 70% of Year 2 students responded “Yes” to the same item (Table 5.5-2 B), which was

deemed “unsatisfactory” (<80%). Item 17 assessed whether students had sufficient exposure to different types of patients/simulated patients, to which again, only Year 2 medical students' responses were deemed “unsatisfactory” (<80%), with only 70% of the cohort responding “Yes” (Table 5.5-2 B). When interpreting these results, Year 2 medical students who were on the ISA Steering Committee recalled that their classmates would have appreciated additional sessions with standardized patients to practice their clinical skills sessions with.

Strengths:

- Clinical-level medical students felt that there were always sufficient resources distributed before the commencement of a clinical exposure that they were assigned to, empowering them with the opportunity to prepare for their exposures.

Areas of improvement:

- Pre-clerkship students felt that it was difficult to schedule a family physician preceptor for their mandatory family medicine shadowing.
- Pre-clerkship students felt that the family medicine preceptors for their community exposures were not always informed of the students' upcoming attendance.
- Pre-clerkship expressed the desire for additional sessions with standardized patients.

Recommendations:

- The ISA Steering Committee recommends that the medical school revise their resources for current family physicians who are open to medical students shadowing, while also ensuring that family medicine preceptors who are assigned students as part of community exposures are better informed on when a medical student is scheduled with them.
- The ISA Steering Committee recommends that the medical school consider incorporating additional sessions with standardized patients as part of the pre-clerkship curriculum.

<u>5.6: Sufficiency of Informational Resources and Instructional Facilities (Table 5.6-1 B and Table 5.6-2 B; Appendix 1):</u>

Discussion:

Critical to medical student participation at hospital/clinical facilities is the availability of adequate information and computer access that is available for their use. When asked whether medical students considered their access to computer/internet resources sufficient at off-campus facilities, >80% of medical students across years 1, 3, and 4 of training responded “Yes” (Table 5.6-1 B), which was deemed “satisfactory” (>80%) – with only year 2 students having an “unsatisfactory” response (<80%; 75%). When considering why this may have been the case, it was discussed by the committee that there were only a handful of instances in Year 2 that would require students to have computer access while in a hospital/clinical facility. One of those instances was during *Comprehensive Patient Assessments (CPAs)*, during which students were tasked with performing a history and physical on an assigned patient; however, several Year 2 medical students on the committee recalled having difficulties accessing patient

charts, as they may not have had access to electronic patient records at that time. Item 19 assessed whether students had sufficient information resources available to them, other than computer/internet access, while at clinical facilities. 98% and 88% of Year 3 and 4 medical students, respectively, responded “Yes” (Table 5.6-1 B), which was deemed “satisfactory” (>80%). While similar to the previous item (Item 18), <80% of medical students in both Years 1 and 2 responded “Yes”. This is difficult to interpret in the context of the pre-clerkship students, given the limited exposure to clinical sites in these years. However, some Year 2 medical students on the ISA Steering Committee recalled from discussion with peers that following their training on Electronic Patient Records (EPR), students did not have immediate access to their accounts on live systems. Lastly, when asked whether medical students felt that the instructional facilities were sufficient for their learning needs at hospital/clinical facilities, 95% of both Year 3 and 4 medical students, respectively, responded “Yes” (Table 5.6-2 B), which was deemed “satisfactory” (>80%). As before, Year 1 and 2 responses are difficult to interpret given their minimal assignment within clinical spaces.

Strengths:

- Clinical/Clerkship medical students consistently reported having access to all clinical and informational resources while on clinical rotations, empowering their participation in assigned tasks.
- The clinical sites that clerkship medical students are assigned to rotate at boast strong instructional facilities.

Areas of improvement:

- Access to computers was felt to be limited at times for some clerkship medical students on select clinical rotations.
- Following EPR training for Year 2 medical students, some students reported difficulties with accessing their account when attempting to log in at clinical sites as part of their extracurricular activities.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue to advocate for medical student resources and spaces equipped with computers to allow medical students to participate in all aspects of their clinical rotations.

<u>5.7: Safety and Security by Curriculum Year (Table 5.7-1 B, Appendix 1):</u>

Discussion:

Physical safety is prudent for all medical students; it is essential that while students use school facilities, their safety is assured, and that measures are in place to protect them outside of classroom hours. Based on the results of the survey, students felt that the security systems in place were adequate to ensure their safety during classroom hours, with >80% of students across all four years of training sharing this sentiment (Table 5.7-1 B). Similarly, when outside of regular campus hours, >80% of medical students across all four years considered that the security systems in place were adequate to ensure their safety. Both of these results were

deemed “satisfactory” (>80%). From discussion with the ISA Steering Committee, several security measures during campus hours were noted, such as frequent patrolling by security staff and student-card swipe access. When outside of campus hours, students were able to recall additional measures in place, such as “Safe Walk”, which is a service provided by the Security staff, where a security guard can escort you to your car. When students were asked whether they felt the security systems in place were adequate at clinical teaching sites, >80% of all students responded “Yes”, which was deemed “satisfactory” (>80%). However, this item was difficult to interpret for pre-clerkship students due to limited assignments at clinical sites that are off-campus, once again posing a limitation of the survey.

Strengths:

- The medical school excels at ensuring the safety of medical students both during and outside of regular classroom hours, hosting an array of services for medical students to utilize to maintain their safety.

Recommendations:

- The ISA Steering Committee recommends that the medical school strive to continue increasing awareness amongst students about the security services in place for them outside of regular classroom hours, such as the “Safe Walk” service.

5.8: Access to Library Resources (Table 5.8-1 B, Appendix 1):

Discussion:

Despite the increasing prevalence of digital resources, library resources remain essential to the success of medical students as they are able to provide them with resources to supplement their learning while hosting an array of study spaces for students to utilize. When asked to assess the accessibility of library holdings and technologies, the breadth of holdings, and sufficiency of technology resources, >80% of medical students across all four years of training found the library resources to be sufficient across these avenues (Table 5.8-1 B), which was deemed “satisfactory”. When interpreting these results, the ISA Steering Committee praised the library for having flexible hours to meet student needs, staff that was readily available to assist them with any of their needs, and the breadth of resources offered by the library to exceed their expectations.

Strengths:

- The medical school provides its students with exceptional library resources that are readily accessible and can fit the varying needs of students.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue to support the services that the library can provide to medical students.

5.9: Access to Information Technology Resources (Table 5.9-1 B, Appendix 1):

Discussion:

Information Technology (IT) resources form the foundation of most modern-day instructional and clinical facilities; assessment of the access and availability of these resources to medical students is crucial. When asked to assess the sufficiency and general accessibility of IT resources, >80% of medical students across all four years deemed them to be “satisfactory” (Table 5.9-1 B). Accessibility was then assessed while on- and off-campus, and while on-campus, students across all four years expressed the same sentiment as previously. Similarly, when assessing the sufficiency of IT resources when off-campus, all four years of medical students found them to be “satisfactory” (>80%). While difficult to interpret for Years 1 and 2, who largely stay on campus, Year 3 and 4 medical students on the ISA Steering Committee recalled how accessible the IT support team was at the various clinical placements that students were on.

Strengths:

- The medical school boasts satisfactory IT resources that are accessible and empowering of medical students and their learning, particularly when on- and off-campus.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue to provide support for IT resources for medical students on- and off-campus.

5.11: Adequacy of Study-, Lounge-, Personal Storage-Space, and Secure Call Rooms (Table 5.11-1 B, 5.11-2 B, 5.11-3 B, and 5.11-4 B; Appendix 1):

Discussion:

Foundational to medical student life are key quality of life measures such as adequate study spaces, lounge spaces, personal storage spaces, and call rooms for students to use. When asked to assess study space adequacy while on campus, medical students across Years 1, 2, and 3 of training reported either “unsatisfactory” (<80%) or borderline responses (Table 5.11-1 B), with only Year 4 medical students having a “satisfactory response” of 86% (>80%). When tasked to interpret these results, members of the ISA Steering committee reported that there were limited quiet study areas and quiet spaces with computer access, with those advertised as being quiet often still being distracting. Additionally, the members of the ISA Steering Committee reported that their classmates have expressed a strong desire for additional desks with standing capabilities, in an effort to promote student wellness when studying. When asked the same question, but at the hospital that students were assigned to, the result demonstrated a similar sentiment, with only 57% and 41% of Year 3 and 4 medical students reporting spaces to be adequate while off-campus, which was deemed “unsatisfactory” (<80%). When interpreting these results, clerkship students were unanimous in reporting that there was virtually no designated study space for medical students to use while off-campus.

Similarly, when asked to assess the adequacy of lounge spaces, medical students across Years 1, 2, and 3 of training reported either “unsatisfactory” (<80%) or borderline responses (Table 5.11-2 B), with only Year 4 medical students having a satisfactory response of

85%. Discussion amongst the ISA Steering Committee revealed that at the time of this survey, there was no lounge space that was exclusive for medical students to use. The only lounge space that was reported to be available for use was shared with other faculties, resulting in concerns for cleanliness and the absence of space for medical students to enjoy with their peers alone, whereas other healthcare faculties on campus had spaces designated for them alone. When the adequacy of lounge spaces at clinical sites was assessed, responses from medical students across Years 3 and 4 were “unsatisfactory” (<80%), 54% and 43% of students responded “Yes”, respectively. Reports from clerkship students on the ISA Steering Committee demonstrated that there were consistently no lounge spaces designated for medical student use at any of the clinical facilities where medical students were assigned. As a result, medical students often found themselves spending their free time in wards or in hospital cafeteria spaces. While the ISA Steering Committee recognized that this may fall outside of the scope of the medical school, students still reported that they would appreciate designated lounge spaces for them to enjoy when at clinical sites.

Personal storage spaces were assessed next, with medical students across all four years of medical school reporting that when on campus, access to secure personal storage space was “satisfactory” (>80%, Table 5.11-3 B). However, the same sentiment was not shared for storage spaces when off-campus at clinical sites, with only 50% and 47% of Year 3 and 4 medical students finding them “satisfactory” (>80%). When discussing these results, several students recalled that only a handful of rotations, like surgery, anesthesia, and obstetrics/gynecology, assigned dedicated locker spaces for medical students to use. In instances when these storage spaces were unavailable, students would be required to leave their belongings in insecure spaces. Furthermore, the availability of storage spaces for services that required students to change into hospital wear could not be guaranteed.

Lastly, the security and adequacy of call rooms were assessed. 83% and 93% of Year 3 and Year 4 medical students found that when required, call rooms were secure and adequate (Table 5.11-4 B), which was deemed satisfactory (>80%). When interpreting why this may have been the case, several points were raised by the ISA Steering Committee. Firstly, call rooms were always assigned when a rotation might require an overnight stay. However, the location of call rooms was not always clear; furthermore, the accessibility of call rooms in relation to the medical service often varied, with some call rooms being in the same hallway as the service, while others were in other buildings. Furthermore, the increased satisfactory response from Year 4 students may be a reflection of the familiarity and experience that comes with the navigation of a clinical site upon completion of Year 3.

Strengths:

- The medical school does a great job at providing all medical students with secure personal storage spaces while on campus.

Areas of improvement:

- Study spaces are limited both on- and off-campus, with the majority of medical students reporting that they were inadequate for their needs.
- Lounge spaces are limited both on- and off-campus, with the majority of medical students reporting that they were inadequate for their needs.

- Personal storage space is limited while off-campus, resulting in insecurity of medical students' personal belongings.
- While call rooms are always available for medical students when they might require them, their locations are inconsistent, with some students unclear of their locations.

Recommendations:

- The ISA Steering Committee recommends that the medical school implement additional study and lounge space both on- and off-campus for students to be able to use throughout their medical training.
- The ISA Steering Committee recommends that the medical school advocate for personal storage space for medical students while off-campus at clinical teaching sites.
- The ISA Steering Committee recommends that the medical school strive to increase awareness amongst medical students on the location of secure call rooms while on various medical services.

Standard 6: Competencies, Curricular Objectives, and Curricular Design

6.1: Student Awareness of Program and Learning Objectives (Table 6.1-4 B and Table 6.1-5 B; Appendix 1):

Discussion:

Critical to the promotion of medical students within the medical program is an awareness and understanding of the required curricular learning objectives. When asked whether students were made aware of the medical education program objectives and the individual learning objectives for each required learning experience, >80% of medical students across all four years of training responded with “Yes” (Table 6.1-4 B and Table 6.1-5 B), which was deemed “satisfactory” (>80%). Preclerkship students on the ISA Steering Committee recalled being made aware of the medical education program objectives early on in their orientations, with all subsequent modular courses outlining individual learning objectives at the beginning of every introductory lecture. While clerkship students on the ISA Steering Committee recalled having been made aware of the required clinical exposures before the beginning of every clinical rotation, these are the unique, required learning objectives for each rotation.

Strengths:

- The medical school excels at informing students of all years of training of the required learning objectives on an individual course/rotation level, as well as the broader medical education program objectives.

6.4: Student Exposure to a Variety of Clinical Settings: Inpatient, Outpatient, and Rural/Underserved Communities (Table 6.4-1 B, Table 6.4-2 B, and Table 6.4.1-2 B; Appendix 1):

Discussion:

Medical students, upon completion of medical school, will go on to serve patients in a variety of different settings. It is therefore important that students receive adequate exposure while training in the various settings of medical practice. When asked whether students had an exposure to an ambulatory clinical setting, >80% of medical students across all four years of training responded “Yes” (Table 6.4-1 B), which was deemed “satisfactory” (>80%). Similarly, when asked about inpatient and rural/underserved settings, only Years 2, 3, and 4 had a satisfactory response rate of >80% (Table 6.4-2 B and Table 6.4.1-2 B). Across clerkship years, this is a reflection of the broad clinical exposure that the Max Rady College of Medicine has to offer– with most rotations containing an inpatient and outpatient clinic component, and with the Family Medicine rotation requiring students to be placed within a rural community for six weeks. When interpreting why Year 1 students had an “unsatisfactory” (<80%) response rate to exposure to rural/underserved clinical settings, the timing of the survey needs to be considered. The first year curriculum contains a unique rural exposure called “Rural Week,” where students are placed in a rural Manitoban community for one week, where they get the opportunity to experience rural life and the practice of medicine within this setting. However, this experience occurred in June, which would have been after the survey delivery timeline, explaining the unsatisfactory response rates amongst the Year 1 students, but the satisfactory response rates for Year 2 students. When interpreting the unsatisfactory response rates of Year 1 students to adequate inpatient clinical exposure, several pre-clerkship students on the ISA Steering Committee expressed a desire amongst both them and their classmates, for the opportunity to incorporate an earlier exposure to inpatient settings within the pre-clerkship curriculum than currently offered.

Strengths:

- The medical school excels at exposing medical students to a broad range of clinical settings across all four years, and increasingly during the clerkship years of medical school.

Areas of improvement:

- Pre-clerkship medical students, specifically Year 1 students, felt that the pre-clerkship curriculum should entail earlier inpatient clinical exposures as part of the curriculum.

Recommendations:

- The ISA Steering Committee recommends that the medical school consider the implementation of inpatient clinical exposures earlier in the medical school curriculum.

<u>6.4.1: Student Exposure to Generalist Care and Comprehensive Family Medicine (Table 6.4.1-1 B, Appendix 1):</u>

Discussion:

While medical students must receive adequate exposure to various practices, all students must receive adequate exposure to comprehensive generalist care. However, the results of this element were difficult to interpret, with members of the ISA Steering Committee finding the questions unclear; Items 44 and 45, as well as 46 and 47, were virtually identical,

differing slightly to read “I had broad exposure..” and “I had experience..” (Table 6.4.1-1 B). Still, >80% of Year 2, 3, and 4 medical students reported having adequate exposure to generalist care and comprehensive family medicine, which was deemed “satisfactory”. Again, this is a reflection of the strong family medicine exposures and tailoring of both clinical and didactic material to generalist care that the medical school strives for. When interpreting the “unsatisfactory” and borderline responses of Year 1 medical students, the timing of the survey delivery was before Year 1 students had the opportunity to have their “Rural Week” exposure, which may have been reflected differently in this survey had it been delivered after the fact. Still, Year 1 medical students on the ISA Steering Committee had expressed the desire for more clinical exposures in their first year, to complement the existing few Community Exposures and “Rural Week”.

Strengths:

- The medical school provides students with a strong foundation in generalist care and comprehensive family medicine through the tailoring of modular content and clinical skills teaching.

Areas of improvement:

- Pre-clerkship medical students, specifically Year 1 students, felt that the pre-clerkship curriculum should entail additional early family medicine exposures as part of the curriculum.

Recommendations:

- The ISA Steering Committee recommends that the medical school implement additional family medicine exposure earlier in medical school training.

<u>6.5: Student Elective/Selective Opportunities (Table 6.5-1 C, Appendix 1):</u>

Discussion:

Critical to medical school training is the opportunity for medical students to explore careers and fields that may be of interest to them. When asked whether students had 1) the opportunity to supplement their learning experiences with elective experiences, 2) the opportunity to gain exposure to medical specialties, and 3) the opportunity to pursue individual academic interests in their electives, >80% of medical students in Years 3 and 4, responded with “Yes” (Table 6.5-1 C), which was deemed “satisfactory”. However, most of the three items performed “unsatisfactory” (<80%) across Year 1 and 2 students, except Item 50, which saw a borderline performance, with 80% of Year 2 students responding “Yes”. When interpreting these results for Year 3 and 4 students, responses reflect the medical school’s curriculum and its ability to provide clinical medical students with opportunities to explore and pursue individual interests. It is worth noting that the incoming Year 3 students (Class of 2027) will have an additional elective as part of their clerkship curriculum that was not offered in previous years, which was a revision that was implemented upon the previous ISA Steering Committee’s recommendations. While the results of Year 1 and 2 medical students were “unsatisfactory” (% of responses for “Yes” <80%), there was no “Not Applicable” option provided for this question,

which may have been of benefit for pre-clerkship students as electives are often standard in clerkship years, amongst Four-year medical school programs, such as the one offered at the Max Rady College of Medicine. Still, discussion from the ISA Steering Committee revealed that pre-clerkship students have limited time to explore fields of interest while completing their pre-clerkship portion of their curriculum, which was thought to be a desire expressed by several students. Of note, the latter portion of the second year curriculum permits two dedicated shadowing sessions; students felt that this was insufficient to adequately explore interests before beginning clerkship.

Strengths:

- The medical school offers a strong elective experience as part of the clerkship curriculum, with the implementation of additional elective opportunities before the CaRMs application deadline.

Areas of improvement:

- Pre-clerkship students felt that the opportunities to explore careers and individual specialty interests were insufficient during the current pre-clerkship curriculum.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue to explore the implementation of additional elective time as part of the Clerkship to be more competitive with other Canadian Medical Schools.
- The ISA Steering Committee recommends that the medical school revisit the current scheduling of the pre-clerkship curriculum to implement more dedicated curricular time for career exploration.

6.6: Student Service Learning Opportunities (Table 6.6-1 F, Appendix 1):

Discussion:

Service-learning provides medical students with an opportunity to work with the community, serving to provide students with first-hand experience in providing care to members of the community that they will one day be serving. When asked whether medical students were encouraged to and provided with the opportunity to participate in service-learning activities, >95% of medical students across all four years responded “Yes” (Table 6.6-1 F), which was deemed “satisfactory” (>80%). This excellent response rate across all four years of training highlights the strong service-learning curriculum that the medical school has to offer to its students.

Strengths:

- The medical school boasts a strong service-learning component as part of its training program, equipping students with meaningful experiences working in communities that they will inevitably serve as medical providers.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue to underscore the importance of service-learning, while providing medical students with opportunities to participate in service-learning.

Standard 7: Curricular Content*

*All items comprising the elements within Standard 7 were only answerable to final year medical students (Class of 2025), as items were dependent on completion of the whole curricular content.

7.2: Curriculum Across the Life Cycle (Table 7.2-2 B, Appendix 1):

Discussion:

To prepare effectively for residency, the clerkship must provide students with adequate exposure to healthcare at all stages of life. Among Year 4 medical students responding, >80% reported having clinical experiences involving continuity of care, preventative care, acute care, and end-of-life care. Clinical experiences in chronic and rehabilitative care are vital for providing students with the skills to address the long-term, complex health needs of aging populations. Of all the areas of care, rehabilitative care was the least experienced, with only 75% of year 4 medical students reporting “Yes” (Table 7.2-2 B) to having had experience within this area of care, which was deemed “unsatisfactory” (<80%). It was noted by the ISA Steering Committee that while students may have had indirect exposure to the aforementioned area of care through consultation with other healthcare professions, there was a marked gap in direct exposure to rehabilitative medicine. Specifically, those who recalled having specific experience in it had done it as part of their *Internal Medicine* rotation, which offered rehabilitative medicine as an option for a two-week selective. Further prioritizing experiences in managing long-term conditions and recovery processes is essential for future practice readiness.

Strengths:

- Clinical exposure to a broad range of care across the stages of the life cycle.

Areas of improvement:

- Final year medical students felt that exposure to rehabilitative care is currently insufficient.

Recommendations:

- The ISA Steering Committee recommends that the medical school strive to increase exposure to rehabilitative care during clerkship years to ensure medical students are prepared for all clinical settings.

7.4: Enhancement of Student Clinical Judgement/Problem-Solving Skills (Table 7.4-3 B, Appendix 1):

Discussion:

Clinical reasoning is a key priority in medical education. To be adequately prepared for residency, medical students must develop skills in appraisal of evidence, critical thinking, and decision-making. >95% of all Year 4 medical students answered “Yes” to all items within this element. This response reflects that students were satisfied with the development of the aforementioned skills throughout the curriculum.

Strengths:

- The medical school cultivates a learning environment throughout the four years of education that emphasizes the development of students' clinical judgment and problem-solving skills.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue to prioritize and emphasize critical reasoning skills throughout its curriculum. The medical school should strive to maintain its current practice.

7.6: Student Preparation of Cultural Competence and Health Care Disparities (Table 7.6-2 E, Appendix 1):

Discussion:

An increasingly multicultural and diverse patient population requires that medical schools emphasize cultural competency, safety, and provide students with the skills required to recognize healthcare disparities. This element evaluates the curriculum’s integration of these skills. A “satisfactory” percentage (>80%) of medical students in their final year answered “Yes” (Table 7.6-2 E) to all items in this element, indicating a satisfactory emphasis on the aforementioned skills. It is critical that the medical school recognizes the importance of cultural competency and continues to educate students on the interactions between the social determinants of health and the physical, mental, and spiritual health of patients.

Strengths:

- The medical school continues to foster a necessary focus on cultural competency and awareness of healthcare disparities throughout its curriculum.

Recommendations:

- The ISA Steering Committee recommends that the medical school maintain its emphasis on the importance of culturally competent and safe physicians.

Standard 8: Curricular Management, Evaluation, and Enhancement

8.5: Medical Student Curricular Feedback (Table 8.5-1 F, Appendix 1):

Discussion:

Integral to the continuous quality improvement of medical schools is learner feedback. Student appraisal of opportunities to evaluate their educators, courses, and other required

learning experiences is reflected in this element. Students across all four years felt that opportunities for feedback and curricular evaluation were exceptional, with >90% of students responding “Yes” to all items within this element (Table 8.5-1 F).

Strengths:

- The medical school provides students with appropriate opportunities to evaluate their required learning experiences and educators.

Recommendations:

- The ISA Steering Committee recommends that the medical school continue to seek student input and provide adequate evaluation opportunities regarding matters directly affecting their learning and curricular experiences.

8.8: Monitoring of Time Spent by Students in Required Curricular Activities (Table 8.8-1 G, Appendix 1):

Discussion:

It is important that medical schools communicate clear expectations regarding time spent on required curricular activities to enable students to organize other commitments in their lives outside of school. Further, medical schools must ensure that students can complete required learning tasks in the time allotted. This element evaluates the medical school's commitment to the aforementioned items. When asked if the medical school adequately informed students of the time commitments required for required learning experiences, >80% of students across all four years of medical school responded “Yes” (Table 8.8-1 G), which was deemed a “satisfactory” response. When asked on the latter item, >20% (negative question, so >20% was deemed unsatisfactory) of students in Years 2 and 4 reported disappointment in how often required learning experiences took more time than allotted. The response from students in year 1 and year 3 was deemed “satisfactory”, with <20% of students reporting disappointment.

For second-year medical students, it was felt by the ISA Steering Committee that the disappointment was influenced by the *Comprehensive Patient Assessments (CPA)* and “assigned studies” as part of modular courses, which required student self-studying. Firstly, CPA experiences are mandatory clinical skills sessions that take place throughout the year outside of regular clinical skills time. These sessions often require lengthy preparation from students. The preparation required often demands more time than that allotted. We recommend that the medical school reevaluate expectations of students to ensure that students are able to adequately prepare for their CPA sessions in the time allotted. Assigned studies were also noted to often take more student time to complete than expected by their schedule. Assigned study sessions often consisted of several learning tasks and documents which were unreasonable for students to complete in the time allotted.

For third year medical students, disappointment was likely influenced by those who exceeded their 26-hour limit for their call shifts. While this did not seem to be common theme amongst all students, the ISA Committee felt this may occur at times when preceptors and other team members are not aware of the 26-hour limit. It was noted that students were more likely to exceed this limit on Surgery and Internal Medicine rotations. We suggest that preceptors and

team members are encouraged to diligently check the call schedule and are informed of the 26-hour limit for medical students.

Strengths:

- The medical school adequately schedules students' responsibilities and allocates student time to required learning experiences.

Areas of improvement:

- Preparation required for the Comprehensive Patient Assessments often takes students more time than they are allotted.
- Assigned Study sessions often contain too large a quantity of learning tasks for students to appropriately complete within the allotted time.
- Clerks, especially those on their Surgery or Internal Medicine rotation, report exceeding the 26-hour call limit due to preceptors or other team members not realizing they are post-call.

Recommendations:

- The ISA Steering Committee recommends that the medical school reevaluate the quantity of materials within Assigned Study sessions to ensure students can appropriately fulfill sessions in the allotted time.
- The ISA Steering Committee recommends that the medical school ensure that students have time to adequately prepare for the Comprehensive Patient Assessment sessions.
- The ISA Steering Committee recommends that preceptors and team members are encouraged to check the call schedule, and ensure that students are dismissed prior to the 26-hour call shift limit.

Standard 9: Teaching, Supervision, Assessment, and Student and Patient Safety

9.3 Clinical Supervision of Medical Students (Table Table 9.3-1 C, Appendix 1):

Discussion:

A crucial component of the medical school curriculum is the time spent learning in clinical settings. Adequate supervision and support during these learning experiences are necessary, not only to ensure the highest quality of education, but also to prioritize the care and safety of patients in these settings. Item 73 assessed whether the level of supervision in clinical learning experiences involving patient care was appropriate, to which >80% of learners across all years responded "Yes" (Table 9.3-1 C), which was deemed "satisfactory". Similarly, when asked whether the level of supervision ensured, 1) student safety and 2) patient safety, 3) whether the level of responsibility delegated was appropriate within clinical settings, and 4) whether students were confident that concerns raised by them regarding adequate supervision would be adequately discussed and addressed by the medical school, >80% of Year 1 and 2 learners responded "Yes", which was deemed "satisfactory". While the agreement frequency was similar for most of the aforementioned areas across Years 3 and 4, there was some "unsatisfactory" responses. Specifically, <80% of Year 3 and 4 students felt confident that

concerns raised by them regarding adequate supervision would be adequately discussed and addressed by the medical school. While <80% of Year 4 medical students considered the level of supervision they received during clinical learning situations ensured patient safety. The ISA Steering Committee noted that the decrease in agreement frequency across Years 3 and 4 is likely due to the some of same factors as the concerns surrounding reporting of learner mistreatment (see Standards 3.4, 3.5, and 3.6). While the decrease in "satisfactory" responses regarding adequate supervision in the context of patient safety, across Year 4 students, may have been due to an increased perception of responsibility when compared to Year 3 learners.

Strengths:

- The medical school ensure that medical students of all levels receive sufficient supervision during all clinical learning experiences, while ensuring student and patient safety.

Areas of improvement:

- Clerkship students lacked confidence in the medical school's ability to adequately discuss and address concerns that they may have had regarding the level of responsibility that was delegated to them during clinical rotations.

Recommendations:

- The ISA Steering Committee recommends that medical schools strive to instill more confidence across clinical year students in their ability to adequately discuss and address any concerns that they may have regarding supervision during clinical experiences, through more active supervision policies and expectations.

<u>9.7: Timely Formative Assessment and Feedback (Table 9.7-1 C and Table 9.7-2 D; Appendix 1):</u>

Discussion:

Feedback and assessments are crucial in the ability for learners to improve in both academic and clinical settings. Ensuring that these assessments are done promptly ensures that learners are able to utilize the feedback when preparing for their final evaluations. >80% (Table 9.7-1 C) of students from Years 3 and 4 agree that the formative feedback they received was documented by the midpoint of each learning experience, and the timing in which they received it was adequate. The agreement frequency was lower amongst Pre-Clerkship students; the agreement frequency for the formative feedback being documented by the midpoint of the learning experience was 65% and 69% for Year 1 and Year 2, respectively. The agreement frequency for receiving formative feedback with enough time to demonstrate improvement among Pre-Clerkship students was 67% and 76% for Year 1 and Year 2, respectively. A common theme identified from Pre-Clerkship students on the ISA Steering Committee was the short timeframe between the release of the Formative OSCE feedback and the first OSCE in Year 1, as well as between the feedback from the first OSCE and the second exam in Year 2.

Strengths:

- Clerkship students receive formative assessments and feedback with enough time to demonstrate the improvements suggested in the feedback given to them.

Areas of improvement:

- Year 1 members of the ISA Steering committee indicated that the timing between the release of the Formative OSCE comments and their first OSCE made it difficult to fully implement the suggestions of evaluators

Recommendations:

- The ISA Steering Committee recommends, if possible, to release the comments from the Formative OSCE to Year 1 students earlier to allow for more time to utilize the suggestions given to them.

9.9: Student Advancement and Appeal Process (Table 9.9-2 C, Appendix 1):

Discussion:

In the case that a student has a concern or disagrees about the decision made on their ability to advance in their education, it is important that they are aware of the options available to them to appeal the decision made. >80% of respondents in each of the four years agreed that they are aware of the policies and procedures related to student advancement, and agreed that they can appeal any of these decisions.

Strengths:

- Students throughout all years feel informed about the policies and procedures on academic advancement and appeal.

Recommendations:

- The ISA Steering Committee recommends continuing to provide information about student advancement and appeal processes to students regularly.

9.10: Student Health and Patient Safety (Table 9.10-1 B, Appendix 1):

Discussion:

To ensure that both the learner as well as anyone in their care are as safe as possible, learners must be aware of any potential risk of harm to patients, including when their health may put patients at harm. >95% of students from all years who completed the ISA indicated that they know about their obligation to report situations in which their personal health may impact the safety and health of patients.

Strengths:

- Both the information sessions provided, as well as the physical reference cards, have been very effective in informing students about their obligation to report situations regarding their personal health.

Recommendations:

- The ISA Steering Committee recommends continuing to provide students with the information needed to be aware of the circumstances in which they are obligated to report their personal health.

Standard 11: Medical Student Academic Support, Career Advising, and Academic Records

11.1 Student Awareness of Academic Advising (Table 11.1-1 C, Appendix 1):

Discussion:

In a challenging field of study such as medicine, access to academic advising is an integral part of the success of learners, allowing them to navigate such a vast field of study and receive the resources needed to succeed in their studies. >80% of learners from all four years agreed that they are aware of the academic advising available to them through the medical school.

Strengths:

- Students from all years of medical school feel well-informed in their ability to receive academic advising.

Recommendations:

- The ISA Steering Committee recommends continuing to provide high-quality academic advising and continuing to inform students about its availability.

11.2 Student Awareness of Career Advising (Table 11.2-1 D and Table 11.2-2 D; Appendix 1):

Discussion:

As with Academic Advising, career planning plays a large role in both narrowing down future career ideas as well as discovering new avenues within medicine that were previously unknown to the learner. >80% of learners throughout all four years agreed that they are aware of the confidential career advising services offered to them. When assessing student awareness of the assistance available in choosing elective courses, evaluating career options, and applying to residency programs, the results reflected the medical school's timing in the delivery of these informational sessions, with medical student responses being increasingly "satisfactory" across the medical school years in an ascending fashion. With >80% of all medical learners in Years 2, 3, and 4 responding "Yes" (Table 11.2-2 D), which was deemed "satisfactory". While <80% of learners in Year 1 responded "Yes" to their awareness of these three items (counselling on electives, careers, and residency program), this was deemed "unsatisfactory". Students who had accessed these advising services, offered by the medical school, spoke highly of them, with one student commenting, expressing "Supports available for career planning and CaRMS process…" in response to what the medical school is doing well. Still, these "unsatisfactory"

responses across Year 1 students suggest that additional informational sessions may go a long way across this body of students.

Strengths:

- The medical school excels at making all students aware of the confidential career advising opportunities that are available to them, adequately informing those who will be affected the soonest.

Areas of improvement:

- Pre-Clerkship learners felt less informed about some of the advising services that the medical school has to offer.

Recommendations:

- The ISA Steering Committee recommends providing Pre-Clerkship learners with additional resources outlining the career advising services available to them throughout medical school.

11.4 and 11.6: Student Awareness to Review and Challenge Academic Records, Including the Medical Student Performance Record (Table 11.6-1 C, Appendix 1):

Discussion:

The College of Medicine has robust policies in place to allow learners to challenge their academic record if they disagree. To ensure that these policies and procedures are as effective as they can be, it is also imperative that learners are made aware of the option of appeal and the process that they must follow. When asked whether students were permitted to review and challenge their academic records, >80% of medical students from Years 1, 3, and 4, responded "Yes" (Table 11.6-1 C), which was deemed "satisfactory". However, when Year 2 students were asked the same, student response rates were deemed "unsatisfactory" (<80%). When considering why this may have been the case, it is important to recall that students in Year 1 have orientation fresh in mind, while those in Years 3 and 4 have requirements as part of CaRMS that require them to have a more meaningful understanding of their academic records. As a result, Year 2 students may have slipped between the cracks, warranting reiteration of academic record policies and procedures at the start of Year 2 as a reminder. When the same was asked of students in regards to their MSPR, >80% of medical students across all four years were aware that they were permitted to review their MSPR, which was deemed "satisfactory". However, only >80% of Year 4 medical students were aware that they could challenge their MSPR if they deemed it to be inaccurate. Discussion amongst the ISA Steering Committee identified that there are a lot of questions surrounding the MSPR among students. However, the committee would also like to recognize the medical school's work in the creation of the "Frequently Asked Questions" document that was created for medical students this year in an effort to bridge this gap– the timing of this survey may have missed the release of this document to the student body.

Strengths:

- Most of the medical learners felt well informed about the ability to review and challenge their academic records.

Areas of improvement:

- Preclerkship students' understanding of the MSPR, as well as the procedures for adding and reviewing their records, was not easily found before receiving the document of MSPR frequently asked questions.

Recommendations:

- The ISA Steering Committee recommends distributing the document with answers to frequently asked questions surrounding the MSPR earlier in the year for learners to review.
- The ISA Steering Committee recommends providing all learners more information regarding the remediation process, including procedures, support available to learners requiring remediation, and the visibility of remediation on their academic record.

11.5: Student Awareness of Medical School Procedures for the Collection, Storage, Disclosure, Disposal, and Retrieval of Academic Records (Table 11.5-2 C, Appendix 1):

Discussion:

Learners must be aware of the policies and procedures in place to protect the privacy of their academic information. When asked whether medical students were aware of medical school procedures as they pertain to the collection, storage, disclosure, disposal, and retrieval of their academic records, student responses across all four years were either “unsatisfactory” (<80%) or borderline.

Areas of improvement:

- Both Pre-clerkship and Clerkship students expressed that they were unaware of the policies and procedures in place regarding the handling of their academic records and were unable to actively find this information to reference.

Recommendations:

- The ISA Steering Committee recommends providing learners with an outline of how their academic record is handled by administrators regularly, such as annually.

Standard 12: Medical Student Health Services, Personal Counselling, and Financial Aid Services

12.8: Student Knowledge of Post-Exposure Policies/Procedures (Table 12.8-2 B, Appendix 1):

Discussion:

Accidents within learning environments may occur; students must be adequately equipped with the knowledge of post-exposure steps and procedures. When asked whether

students received instruction on steps to take following exposure to infectious or environmental hazards before their undertaking in any activities that may place them at risk, only 75% and 74% of Year 1 and 2 medical students, respectively, responded “Yes” (Table 12.8-2 B), which was deemed “unsatisfactory” (<80%). It is worth noting that the pre-clerkship curriculum is largely didactic, with few sessions that may pose any potential hazard to student safety. Still, Year 1 and 2 medical students on the ISA Steering Committee recalled receiving a “Post-Exposure” information card during their initial orientation and again, later on in the year. However, students reported being overwhelmed with a lot of handouts during orientation, making it easy for the initial card to have been overlooked. When the same question was posed to Years 3 and 4, 88% of students from both classes responded “Yes”, which was deemed “satisfactory”. However, Year 3 and 4 medical students on the ISA Steering Committee reported only receiving the same “Post-Exposure” card well into the academic year, with students stating that they would have preferred a session in addition to the card that outlined the protocol formally, as a similar session was not recalled by the clerkship students.

Strengths:

- The creation of a point-of-care “Post-Exposure” card streamlined the steps to take following the potential exposure to any infectious hazards, which was appreciated by students.

Areas of improvement:

- Students felt that a session outlining the post-exposure protocol would have greatly supplemented the “Post-Exposure” card that was made available to students.

Recommendations:

- The ISA Steering Committee recommends that the medical school implement sessions that can complement the “Post-Exposure” resource that is made available to students, to better synthesize information that may be critical to student health.

Open-Ended Questions

Question 95: What is the medical school doing well that should be maintained?

When approaching the interpretation of this open-ended question, which assessed the strengths of the medical school, the ISA Steering Committee sought to break responses down into themes as they pertain to pre-clerkship and clerkship years.

Pre-clerkship: Clinical Reasoning

Across the pre-clerkship years, several key areas of strength were identified. Notably, the Clinical Reasoning longitudinal course was consistently praised by students, with students reporting an appreciation for the timing of content delivery to concurrent modular courses, as well as the meaningful skills that students are challenged to develop, with one student reporting, “Clinical reasoning small group sessions, I think I learn a lot in that setting. Critical thinking,

problem solving, and understanding of complexity with each medical problem are some of the valuable things I have learned".

Pre-clerkship: Quality of educators, flexibility of learning, and early clinical exposures

Another strength identified by pre-clerkship students is the high quality of educators, from modular courses to individual tutorials. The "hybrid" model of courses was another highlight of student feedback, with students expressing their appreciation for lectures to be recorded to be viewed at their own convenience– whether fostering personal studying needs or accommodating flexibility for extra-curricular commitments. Early curricular clinical exposures were another strength identified by students, with one student expressing appreciation for the "offering [of] opportunities to early exposure to specialties and [encouragement] *(from the medical school)* that we do them".

Clerkship: Quality of Clerkship program and student independence

When assessing the responses of more senior medical students, the clerkship program was praised nearly unanimously, with one student reporting that the "clerkship program… fosters the development of competence in a challenging but appropriate manner… ultimately resulting in the acquisition of solid medical knowledge". Student reports also speak on the emphasis of independence and breadth of the clerkship program, "being able to see a diverse set of patient presentations and being given an appropriate amount of autonomy to practice our own clinical decision making".

Clerkship: Career advising/counselling and study resources are provided to clerkship students.

Furthermore, it is during clerkship that career advising may become more prudent for medical students, and those who sought support reported that "the school also does a good job providing accessible resources for academic/career counselling, as well as CV/Personal letter review that was helpful during CaRMS applications". Lastly, several students shared their satisfaction with the resources (namely, UWorld) provided by the medical school in preparation for the NBME exams, which, although challenging, were reported by students to foster the development of strong clinical skills.

<u>Question 96: What aspect(s) of the medical education program most need(s) improvement?</u>

Similar to the previous open-ended question, when students were asked what aspects of the medical school most needed improvement, the ISA Steering Committee sought to break down responses into themes as they pertained to the varying medical school years, as well as themes that came up across the college as a whole.

Pre-clerkship: Clinical Skills and Clinical Exposure

Across pre-clerkship responses, the Clinical Skills curriculum was one aspect of the medical school that was overwhelmingly identified as needing improvement. Students felt that the expectations of OSCEs, as a result, were unclear. One student reported that "the Clinical Skills course could have much more clarity in terms of what is expected on practical exams (OSCEs). I think there should be a standardized method for conducting history and physicals

that could be much more clearly laid out to students to set them up for success both on the OSCE and as they move into clerkship/residency". Granted, the ISA Steering Committee identified that similar concerns were raised in the previous iteration of the ISA Report, with the medical school incorporating changes to remedy these concerns– still, on this note, one medical student identified that they still "don't get great direction on how [to] perform skills". Furthermore, several students identified that they would like to see more point-of-care ultrasound (POCUS) teaching, as well as the incorporation of additional standardized teaching as part of the practice and skill development, and additional curricular opportunities for early clinical exposures to supplement their didactic learning.

Pre-clerkship: Population Health curriculum

Another area of improvement that was identified amongst pre-clerkship level responses was the Population Health curriculum. It was identified by the ISA Steering Committee that multiple students felt that the curriculum was "disorganized", "scattered", and "outdated", with several students even sharing the sentiment that the material presented in lectures did not correspond well with what was examined, "exams aren't very representative of emphasized content in the lectures". While many students found the Service Learning component to be meaningful, others felt that the didactic portion of the curriculum was "not very helpful", with students reporting that this impacted their attendance and that they would have preferred the material to be delivered in an *Assigned Study* format. Similar to the previous item, the medical school has already begun to take steps to ameliorate this; however, at the time of the delivery of this survey, this was still identified by students as an area requiring improvement.

Clerkship: Duty hour consistency and expectations

Across the clerkship years, one theme that was identified by the ISA Steering Committee pertained to clinical duty hours. Firstly, it was identified that dedicated/protected teaching was inconsistent between services and rotations, with students within the same cohort (or Track) receiving one teaching session per clinical day, while others received one dedicated teaching session per rotation (3-6 weeks), with further variability being identified across varying rotations. Granted, several rotations, such as Pediatrics and Gynecology, were identified to have better protected on-service teaching. Furthermore, it was identified by the ISA Steering Committee that certain services, namely those within General Surgery, required that students exceed their maximum clinical duty hours of 26 consecutive hours due to post-call rounding expectations. The ISA Steering Committee fears that such practices may put the safety of patients at risk while exposing medical students to potential errors while on service.

College-wide: Indigenous Health Curriculum

One theme identified by all years of medical student learners as in need of improvement was the Indigenous Health Curriculum. Several students identified that while the current curriculum excels at providing context to medical learners, about one of the largest populations that they will be serving as future physicians, another student reported that the current curriculum "... is delivered in a way that only focuses on the harms…" with little insight into "... traditional teachings and time with the community". Furthermore, it was identified by the ISA Steering Committee that several students expressed concerns that the few Indigenous Health

sessions that are scheduled are not classified as *Unique Learning Opportunities (or ULOs),* meaning that students can submit an absence for these sessions, which was reported to have occurred in excess– which was felt by students to be dismissing the value of these sessions. Lastly, several students expressed a desire for additional guidance on effective communication and the opportunity to practice cultural safety in standardized patient encounters.

College-wide: Student Lounge and Study space

Lastly, lounge and study spaces were identified by students across all four years as requiring improvement. While students have access to a lounge space, this space is shared with students across other healthcare faculties on campus, with the medical student lounge having been repurposed this past academic year. The ISA Steering Committee believes that the loss of this exclusive space served as a detriment to medical students' quality of life and wellness while on campus, as the other space was used by students to gather during lunch, with the shared space being too limited in size to accommodate the expanding medical classes. Furthermore, it was reported by clerkship students that there are no dedicated lounge spaces for medical students to use at any of the major clinical sites, which further hurts medical student wellness while on clinical rotations. Study space was another area of improvement identified by the ISA Steering Committee within this item. It is worth recognizing that the medical school had added additional individual study booths within the library space, but students still reported that the current studying facilities were not sufficient for their needs. This sentiment was echoed by medical students across clerkship years, with limited space being available for clerks to use while at clinical sites.

<u>Question 97: What is/are the most important recommendation(s) that you would like to see in the ISA Report?</u>

While the majority of the recommendations made within this section are in keeping with the areas of improvement identified in the previous item, there were several themes addressed within this section that were raised in other sections of this report.

Clinical Skills

Evident in the open-ended responses of the previous item, when students were asked to provide a recommendation within this report, an overhaul of the *Clinical Skills* curriculum was the majority of responses. While the ISA Steering Committee would like to acknowledge the ongoing work the medical school is currently undertaking, with input from students, the ISA Steering Committee identified the following key recommendations. The medical school should revaluate the delivery of clinical skills, with additional emphasis placed on ensuring that content delivery is done by instructors that are familiar with the expectations of OSCE examinations; at the least, the medical school should provide medical students with an explicit outline of expectations, such as in the form of a checklist, to guide student preparation and learning, “it would be nice to have a standardized approach (especially in first year), and then we can … find out own techniques and ways of doing physical skills as we beomce more comfortable”. Additionally, it was identified by medical students across this item that POCUS is beneficial and meaningful for student learning, and so, the ISA Steering Committee recommends that the

medical school seek to make POCUS skill development a more significant component of the *Clinical Skills* curriculum.

Indigenous Health Curriculum

The *Indigenous Health* curriculum is currently structured as a longitudinal course, meaning it is an ongoing course that spans all four years of medical school training. In its current stage, the majority of the content is delivered across the first two years of training, largely in a didactic style, with tutorials and unique exposures to supplement learning. However, it was identified in Item 97 that students feel that there is insufficient training done in the development of skills that make a culturally safe and competent physician. One student reported, “I would strongly recommend a comprehensive review and restructuring of the *Indigenous Health* curriculum… this should include embedding Indigenous health into core clinical training, such as through culturally safe patient encounters, communication strategies, and teachings on traditional medicines”. In keeping with this sentiment, the ISA Steering Committee recommends that the medical school implement additional sessions that focus on: the development of medical students' understanding of culturally safe practice in the context of Indigenous health care, communication strategies, and knowledge of traditional medicines. Additionally, the ISA Steering Committee recommends that the medical school consider reevaluating which *Indigenous Health* sessions are scheduled as ULOs to emphasize the importance of the content within these sessions.

Reporting of Mistreatment

Reporting of mistreatment was another recommendation that was identified by the ISA Steering Committee within question 96. A detailed discussion on this subject can be found in Sections 6: 3.4, 3.5, and 3.6; however, the ISA Steering Committee would like to reiterate some of the key points that were raised by students within this item and in the previous discussion. While the medical school does provide medical students with an understanding of the reporting system, the ISA Steering Committee would like to recommend that the medical school continue to reiterate the subsequent steps and proceedings, following a report, across all four years of training, as it was felt by students that this information was not presented outside of the medical school orientation. Additionally, the medical school should outline informal ways of reporting mistreatment, outline what happens after a report is placed, as well as take the necessary measures to ensure that medical student anonymity can be maintained through the process.

<u>Question 98: What can CACMS do to improve this questionnaire?</u>

This item sought to gauge student experience during the completion of this survey, feedback from which can have the potential to increase student accessibility and improve completion rates in future iterations of this survey. The following were some common themes that were identified by the ISA Steering Committee:

- Assessment for redundancy, with the hopes of truncating the survey and reducing the length

- Create separate surveys with questions tailored specifically for pre-clerks and clerks, as the current version created some confusion amongst students who may not have had exposure to the points different questions were assessing.\
- Ensuring wording of questions is specific to what is being assessed, one student reported confusion in one of the items, “comprehensive family medicine exposure” as opposed to “family medicine exposure”.
- Ensuring the “N/a” option is available everywhere where appropriate.
- Ensure that the platform used for survey delivery allows students to come back to the survey at a later point in time rather than having to complete it in one sitting.
- Consider the use of a Likert scale rather than a binary system.
- Consider assessing medical school culture.

Section 7: Limitations/Considerations

This report demonstrates the results of the 2024-2025 ISA Survey as interpreted by the MMSA ISA Steering Committee. However, this survey, its interpretation, and ensuing report are not without their limitations. The following limitations were identified through discussion by the ISA Steering Committee with reference to student accounts and Question 98:

1. Firstly, this iteration of the survey used “Not Applicable” logic to help guide students when navigating the survey. The intent of this was to facilitate the assessment of items and standards appropriately, such that questions about clinical experiences were not asked to pre-clerkship students. While this worked for some students, others found it unclear, resulting in mixed responses that proved interpretation to be difficult and often inaccurate.
    a. Recommendation: One approach that should be considered in future administrations of this survey is to sort the different responses into separate documents based on class year or if from the Brandon Longitudinal Integrated Clerkship Program (BLInC), to ensure that questions asked are appropriate to the audience being assessed. In addition to creating separate links for the previously mentioned cohorts.

2. Furthermore, while this year’s iteration of the ISA Steering Committee included more clerks and a Year 4 student (MF and RS, and EH, respectively), when compared to the previous iteration (ISA 2024-2025), the committee was largely represented by pre-clerkship students. As a result, questions assessing clerkship aspects of the survey were interpreted by three members, limiting the depth of the discussion.
    a. Recommendation: Future ISA Steering Committees should look to incorporate a broader variety of members.

3. Similarly, there were no members from the Brandon Longitudinal Integrated Clerkship Program (BLInC) on the ISA Steering Committee, which made it difficult to interpret and generalize the survey to members from this satellite clerkship program.
    a. Recommendation: Future ISA Steering Committees should look to incorporate members from the BLInC program to speak to the unique strengths and areas of improvement of this program.

4. Lastly, it was identified that the delivery of the survey occurred before the occurrence of a key clinical exposure of Year 1 medical students, *Rural Week*, which may have changed some of the responses in this survey. While future iterations of this survey may not be administered after this exposure, it is worth mentioning as a limitation, nevertheless.

Section 8: Summary/Recommendations

The findings and the above report represent the results of the 2024-2025 ISA Survey as interpreted by the MMSA ISA Steering Committee.

Overall, there are many strengths of the medical education program at the University of Manitoba Max Rady College of Medicine. However, there are several aspects of the program that were identified in this survey as areas for improvement, and the recommendations provided in this report represent the ISA Steering Committee's best attempt at suggesting solutions.

Please see below the key strengths, areas for improvement, and recommendations that arose during the analysis of the survey results *(previously found in Section 2: Executive Summary, Page 4).*

Key Strengths:

- The medical school excels at facilitating an environment that involves community-based learning by involving residents frequently throughout the undergraduate medical education.
- The medical school strives to encourage all medical learners to participate in scholarly learning, while providing them with an abundance of opportunities to do so.
- Medical learners found the medical school to foster an environment built on respect, one that frequently incorporates student feedback across all aspects of undergraduate training, while ensuring that learners have a thorough understanding of how to report mistreatment.
- Student safety is a core value of the medical school, with learners reporting an appreciation for the services in place both during and outside of regular classroom hours.
- The library and IT resources available to medical students were found to be exceptional, accessible to all learners both on- and off-campus.
- The curriculum offered at the medical school provides students with a strong foundation in generalist care across the various stages of the life cycle and within a broad range of clinical settings and environments, while developing strong clinical judgement and problem-solving that takes into account the importance of cultural competence and safety.
- The emphasis placed on the importance of reporting personal health and/or post-hazardous exposure by the medical school on medical learners was greatly appreciated by learners.
- The academic advising, career counselling, and elective exposures offered at the medical school were praised by medical students across all four years of training.
- The medical school was identified to boast a high quality of educators, while offering a flexible curriculum delivery model that is flexible to individual student learning needs and extra-curricular commitments.
- The clinical reasoning course was reported to be a strong component of the pre-clerkship curriculum.
- The clerkship program offered at the medical school was felt by learners to foster the development of a competent and independent medical learner, one who also recognizes

and values the unique learning needs and requests of clerkship students, providing learners with access to strong study resources

Key Areas for Improvement:

- While medical students expressed an abundance of research opportunities throughout pre-clerkship years, more senior students reported a desire for additional research opportunities during the latter half of medical school.
- Medical students across all four years expressed a strong understanding of how to report mistreatment and access support while doing so; however, it was identified that the subsequent steps following a reporting were often unclear– particularly, how they pertained to the protection of student anonymity throughout the process, as well as alternative informal ways of reporting mistreatment outside of “Speaking Up”.
- College-wide, students reported unclear expectations from clinical preceptors, as well as a lack of awareness of UGME policies and procedures amongst clinical preceptors– whether as Year 1 students during *Community Exposures* or as clerks during select rotations.
- Study and lounge spaces were expressed by students to be inadequate for their needs, both on- (with expanding class sizes) and off-campus (major teaching sites and facilities). Furthermore, students reported similar sentiments towards personal storage spaces, particularly amongst clinical year students, where locker space is often unavailable and the security of personal belongings is often not guaranteed.
- Pre-clerkship students reported that standardized patient encounters and clinical exposures were insufficient, expressing a desire for additional opportunities to explore career and specialty interests.
- Across all years, students reported multiple instances where the time required or expected of learners to complete certain clinical and didactic activities where inappropriate to the time allotted or outlined; notably, these inconsistencies were observed amongst select “Assigned studies”, *CPAs* for Year 2 students, and during “post-call” rounding for clerks.
- Pre-clerkship expressed a lack of awareness of some of the advising services that are made available to them. Similarly, the same students expressed an interest in additional sessions outlining CaRMs.
- Students across the college expressed a lack of awareness of the policies and procedures regarding the handling of their academic records.
- Year 1 and 2 learners unanimously identified the *Clinical Skills* curriculum as a major area requiring improvement; concerns pertained to OSCE expectations not aligning with the information or teaching students received, a desire for a document explicitly outlining expectations, as well as the formal addition of POCUS to the *Clinical Skills* curriculum.
- Similarly, Year 1 and 2 medical students identified the *Population Health* curriculum as in need of improvement, with concerns related to lecture content being outdated, disorganized, as well as a reference to a disconnect between materials covered within lectures and those examined.
- Lastly, the *Indigenous Health* curriculum was identified by multiple students as in need of revision. Namely, the material provided on traditional teaching is insufficient, there is

limited exposure to the community, and the few scheduled sessions are not designated as “Unique Learning Opportunities,” resulting in multiple students missing out on the important material delivered during this time. Students also expressed a desire for additional sessions on effective and culturally safe communication.

Key Recommendations:

- That additional scholarly research opportunities be implemented in the senior years of medical school.
- That the medical school provide additional information to learners on the subsequent steps and proceedings following the reporting of mistreatment, particularly as they pertain to student anonymity and alternative/informal ways of reporting mistreatment.
- That the medical school ensures that all clinical preceptors outline expectations of medical learners and are aware of the policies outlined by UGME.
- That the medical school explore additional study and lounge spaces for learners on- and off-campus, particularly at clinical sites and facilities. Similarly, the medical school ensure that learners have access to secure spaces to store personal belongings at all clinical sites.
- That the medical school provide junior medical students with additional standardized patient encounters and exposure opportunities/flexibility, to build confidence in learners while allowing them to have the opportunity to explore career options.
- That the time expectations are aligned with the allotted time for sessions and are in accordance with policies outlined by UGME, namely, during “Assigned studies”, *CPAs*, and during “post-call” rounding for clerks.
- That additional sessions outlining advising services and CaRMs be implemented for junior learners.
- That additional sessions are provided to all learners regarding the policies (access to and challenging of-) outlining the handling of student academic records.
- That the *Clinical Skills* curriculum be revised to ensure that OSCE expectations reflect the content delivered during clinical skills sessions, that students are provided with an explicit outline of OSCE expectations, and that POCUS be formally introduced into the *Clinical Skills* curriculum.
- That the *Population Health* curriculum be revised to ensure that lecture content is current and is reflected more appropriately on examinations.
- That the *Indigenous Health* curriculum be revised to provide students with a greater familiarity with traditional teachings, as well as greater confidence in culturally safe and competent communication. Furthermore, more tutorials are designated as “Unique Learning Opportunities” to ensure enhanced attendance by the student body.

On behalf of the ISA Steering Committee, we would like to thank all of those who were involved in assisting us with the process of administering the ISA Survey and writing the report. We would like to acknowledge the importance that the faculty and staff of the Max Rady College of Medicine place on student feedback, and hope that the contents of this report are considered to recognize the strengths of our program and to address areas for improvement to further improve the medical student experience here at the University of Manitoba. As medical learners,

we recognize that we are entering a largely self-regulated field, which to us means turning to peers and those in our collegial proximity for feedback to improve the quality and diligence of care we provide to those we serve. We hope that this report and all that it entails reflect this sentiment in the context of academic excellence. We, as students, recognize our privilege and feel fortunate to have had the opportunity to come together in collaboration to present an honest reflection of our medical school experience, and hope that this practice continues for years to come.