



Social Responsibility and Accountability of the UBC MD Undergraduate Program

A Renewal of Our Social Responsibility and Accountability Commitment

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Approved by: Undergraduate Medical Education Committee

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Executive Summary

The UBC Faculty of Medicine (FoM) Vision Statementⁱ, “*Transforming Health for Everyone*” affirms our vision for the MD Undergraduate Program (MDUP). We are the only medical school in British Columbia and as such we have a social responsibility and accountability to all peoples and populations in BC.

In 2010, a Working Group on Social Responsibility and Accountability was formed to inform the UBC MD Undergraduate Program’s curriculum renewalⁱⁱ. This working group identified the following social responsibility themes: Health Disparities; Diversity; Changing Demographics; Aboriginal People’s Health; Rural and Remote Health Care; Global Health; Generalist and Specialist Training; Collaborative Care; Research and Scholarship; Health Promotion and Disease Prevention; and Patient-Centred Care. This important document framed the Mission and Goals of the UBC MD Undergraduate Program (2013)ⁱⁱⁱ and the Exit Competencies (2016)^{iv} of the renewed curriculum.

In 2019, the Undergraduate Medical Education Committee formed the Curriculum Review Working Group (CRWG) to re-examine and refresh our Social Accountability and Responsibility framework with respect to the CACMS Accreditation Element^v 1.1.1 Social Responsibility:

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

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

This report of the CRWG outlines the activities and approach we undertook in renewing and refreshing our Social Responsibility and Accountability (SRA) framework, standing on the shoulders of the giants who designed our SRA framework one decade ago.

Our work comprised 7 stages:

1. Literature review of SRA for Medical Schools - annotated
2. Consultations with Community Stakeholders
3. Defining Priority Health Concerns of our Populations
4. Revising our SRA Themes
5. Reviewing our Mission Statement
6. Reviewing our Exit Competencies
7. Plan for the Review of the Curriculum as a Whole
8. Identifying our Outcome Measures



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Phase One: Literature Review of SRA for Medical Schools - Annotated

The CRWG Group identified a number of key papers in renewing our Social Responsibility and Accountability (SRA) framework. These papers were annotated by members of the CRWG.

[Social Accountability: A Vision for Canadian Medical Schools \(2001\)](#)^{vi}

This document addresses the social accountability concepts as they apply to Canadian medical schools. Many of the concepts are definitional and include the following highlights:

The definition of social accountability of medical schools is “the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.”

The four values of social accountability as they pertain to the activities or roles of medical schools (namely, education, research, and service) include

- *Relevance*: Medical schools should provide priority of health needs including access to services, determining and educating appropriate number and mix of physicians and facilitating the geographic distribution necessary to meet the needs of the community.
- *Quality*: High-quality health care should be evidence-based, comprehensive and culturally sensitive.
- *Cost-effectiveness*: The medical schools’ activities should return benefits to society that justify societal (initial) investment.
- *Equity*: Health care should be available to all people.

[Social Responsibility and Accountability Framework for UBC’s Undergraduate Medical Curriculum Renewal \(2012\)](#)ⁱⁱ

This document offers the definition of social responsibility and accountability and outlines specific recommendations to include in the mission of the UBC Faculty of Medicine. Some of the useful and practical statements are as follows:

- The terms social responsibility and social accountability are distinct. Their definitions are as follows: “The concepts of social responsibility suggest that faculties direct their education activities towards addressing the needs of the community, and social accountability directs that faculties should, in turn, report their efforts to address these priority health concerns to their stakeholders.” That is, faculty members, students, staff, and the medical curriculum “must accept and acknowledge being held to account by society.”
- Social responsibility and accountability framework of the medical curriculum should remain extremely dynamic.
- The medical school’s primary social responsibility is to train competent physicians who will meet the current and future health care needs of all BC, as well as those needs of national and international communities.
- Social responsibility goals need to originate within the community.



Four fundamental concepts to teach students and to evaluate them for professional competency, as they relate to social responsibility and accountability, were mentioned in the document and these are now components of the CanMEDS competency framework: collaborative care, research and scholarship, health promotion and disease prevention, and patient-centred care.

The social responsibility and accountability framework included 11 themes which the curriculum must address:

- Health disparities
- Diversity of students and faculty
- Changing demographics
- Aboriginal peoples' health
- Rural and remote health care
- Global health
- Generalist and specialist training
- Collaborative care
- Research and scholarship
- Health promotion and disease prevention
- Patient-centered care

The Social Mission in Medical School Mission Statements: Associations with Graduate Outcomes (2015)^{vii}

The mission statements of 167 U.S. medical schools were reviewed by 37 reviewers for their social mission content. The analysis indicated that “medical schools whose mission statements include a higher degree of content reflecting the social mission of medical education appear to have increased output of physicians working in underserved areas and in primary care. Of particular interest is the strong association of the social mission content scale to graduating physicians entering family medicine”.

This paper provides support, and to a certain extent guidance, for what the Curriculum Review Working Group is doing: updating the UGME mission statement and reviewing the Social Accountability and Responsibility mandate.

The results suggest the importance of including social mission content in our mission statement as a strategy to help increase the number of graduates who choose to work with underserved communities and populations

What was not looked at, and is not clear, is whether mission statements with high social mission content scores do a better job of selecting for and graduating physicians who have more highly developed relationship-based skills, such as empathy, compassion, patient humility, etc.

This is particularly important to UBC FOM, where we have a mandate to educate physicians who will serve a diversity of patient populations that includes people living in rural and remote communities, Indigenous Peoples, older adults living with complex health conditions; people who identify with diverse genders, gender expressions and/or sexual orientations; Black people,



People of Colour, people new to Canada, people who speak a language other than English; people, families and particularly children, living with a low income; people living with disabilities and/or chronic health needs, including people living with mental illness and people who use substances.

[Truth and Reconciliation Commission of Canada: Calls to Action \(2015\)^{xi}](#)

Recommendations for health care system: (that could be discussed within medical education) include:

- TRC19 (closing the gaps in health outcomes),
- TRC20 (recognize, respect and address unique needs of Inuit, Metis and off-reserve Aboriginal),
- TRC22 (Value of Aboriginal healing practices).

Recommendations for Health Care Education:

- TRC23 -increase number of Aboriginal Professionals in health professions (admissions), and cultural competency training for all Health care professionals (curriculum),
- TRC24 -a course in Aboriginal Health issues for all RN and MD students to include the history and legacy of residential schools, UN Declaration of Rights of Indigenous People Treaties and aboriginal rights^x, Indigenous teaching and practices. The course should be skills-based training in intercultural competency, conflict resolution, human rights and antiracism (curriculum).

[Producing a Socially Accountable Medical School \(2016\)^{viii}](#)

- The context of a medical school within a community and its mandate to be effective, relevant, impactful and equitable for that community.
- A medical school's social mission subsumes both a social responsibility and a social responsiveness and culminates in a social accountability which should achieve measurable results.
- Priority health needs should be addressed in partnership with the communities (plural), health service agencies and governments.
- Barriers to the social accountability mission include—the inherent 'silos' within the school; inter-silo differences; stakeholder opinion, funding and influence differences; current incentives (and disincentives) which may misdirect activities; role definitions, problems of defining a school's communities and their priority health needs; verification of effects of medical schools within its communities.
- The realization that social accountability is an ongoing responsibility.
- The backgrounds, investments, biases, perceptions and experiential contexts of a medical school's assessors will be widely variable as will be their social accountability assessments, all of which invoke the question of who should/will assess a medical school's performance in the social accountability realm?
- Definitions are of paramount importance.



- A “CPU” (Conceptualization-Production-Usability) system of social accountability evaluation is one model and there are others.
- So how can we proceed towards veritable and verifiable social accountability? The paper describes some scenarios for ‘benchmarking’ a school in this gradient towards the goal. Following a benchmarking, a change-management strategy is required.
- Proceeding towards this social mission and accountability is “likely to happen if the school’s original vision and strategy is based on strong foundations with a wider guiding coalition.”
- Clashes with real tension will occur in the process. Inertia and resistance will be mitigated if, among a number of things, there are authentic attempts at engagement, informed debate and a realization of the need.
- The vision should be excellence in all facets, including social accountability.
- Social accountability locally must also entwine global environmental accountability.

[Mandate Letter from Premier John Horgan to Adrian Dix, Minister of Health for BC \(2017\)^{ix}.](#)

In this letter, Premier Horgan outlines the priority health needs of British Columbians including but not limited to expanding team-based care, improving rural health services, providing dignified senior care, and implementing the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)^x, and the Calls to Action of the Truth and Reconciliation Commission^{xi}. He also highlights tackling poverty and inequality and addressing the opioid crisis.

[Mandate Letter from Premier John Horgan to Adrian Dix, Minister of Health for BC \(2020\)^{xii}.](#)

After winning a majority government in 2020, Premier Horgan advised all of his cabinet ministers that their mandate would include “Putting people first, Lasting and meaningful reconciliation, Equity and Anti-Racism, Fighting climate change, and a strong and sustainable economy”. In his letter to Adrian Dix, Premier Horgan also emphasized several COVID-19 related goals, better long-term care for seniors, delivering more Urgent and Primary Care Centres, working with rural and Indigenous communities to deliver more immediate and culturally safe care closer to home, building and modernizing hospitals, reducing wait times, leading cancer care, implementing a comprehensive health care human resources strategy, fighting for national Pharmacare, addressing systemic racism in the health care system, launching a second medical school to expand the health care workforce, improve BC’s response to the opioid crisis, increase support for mental health and addictions and addressing homelessness. This mandate letter has implications for our medical school and curriculum.

[Social Accountability of Medical Schools \(ASPIRE 2018\)^{xiii}](#)

The Association for Medical Education in Europe (AMEE) ASPIRE-to-Excellence Award for Social Accountability provides a useful framework for medical schools to consider when examining



their own social accountability. In 2018, Rourke published the major common themes among the 10 award-winning schools that included:

1. Social accountability being evident in the school's purpose and mandate and integrated into its planning and day- to-day management;
2. School admissions being focused on reflecting the demographic mix of the school's community, region, and nation;
3. The curriculum being relevant to the unique geographic, social, and cultural context and the priority health needs of the school's community, region, and nation;
4. The inclusion of clinical learning and service-learning experiences reflecting the diversity of the geographic, social, and cultural mix of the school's community, region, and nation;
5. The inclusion of extensive exposure to community-based learning experiences to understand and act on social determinants of health for vulnerable and underserved patients, communities, and populations;
6. Research being inspired by and responding to the priority health needs of the school's community, region, and nation and actively engaging the community in research, including developing the research agenda, partnering and participating in research, and taking part in knowledge translation/mobilization; and
7. The school's graduates and its health service partnerships having a positive impact on the health and the health care of its community, region, and nation with an emphasis on vulnerable and underserved populations.

[AFMC Joint Commitment to Action on Indigenous Health \(2019\)^{xviii}](#)

Action Statements

- Medical schools focus on the development of meaningful relationships with the Indigenous communities that they serve using rights-based approaches to the co-creation of the terms of the relationship.
- Indigenous communities are recognized as expert resources for the medical school and are provided with the opportunity and resources needed to participate in all aspects of the admissions process, teaching, hosting learners, research and scholarship, and faculty development.
- Medical schools respond to their social accountability mandate with respect to Indigenous communities by jointly developing specific Indigenous health goals and reporting regularly on progress within the medical school and to the Indigenous communities they serve.
- Medical schools invest in the development of a critical mass of Indigenous Faculty and Staff with the appropriate supportive infrastructure to lead all aspects of Indigenous medical education including admissions, student recruitment and retention, curriculum development and implementation, and with structured presence on key decision- making committees within the medical school.



- Medical schools dedicate sufficient resources to enable full implementation of its Indigenous health goals. The resource needs should be defined with the Indigenous communities, faculty, staff and students and should support action in all three domains of research, education and service.
- Medical schools commit to developing a safe work and learning environment for Indigenous learners, faculty and staff by supporting leadership and faculty change through focused and strategic professional development activities based in anti-racism, cultural safety and decolonization.

CanMEDS–Family Medicine Indigenous Health Supplement^{xiv}

This Indigenous supplement to the CanMEDS-FM 2017 competency framework was rigorously developed using a consensus-based and iterative approach, deeply grounded within Indigenous health research methods. This resource outlines critical knowledge and skills needed for effective therapeutic interactions and culturally safe care of Indigenous patients, families, and communities. Each competency reflects the basic format of CanMEDS-FM, focusing on Indigenous-relevant situations and foundational knowledge needed to develop these enabling competencies.

Key common themes emerged during the development process, which are reflected in each role. These themes highlight approaches for providing high quality and culturally safe health care to Indigenous patients:

- Working side-by-side with Indigenous patients, families, and communities, incorporating family and community perspectives and values within patient-centred care
- Addressing racism, discrimination, and inappropriate power differentials within the clinical context, starting with addressing physicians' and others' misconceptions and assumptions of Indigenous peoples
- Understanding the legacy effect of colonial history on current health outcomes and health care contexts
- Learning about and practising trauma- and violence-informed care and healing-centred engagement
- Respecting and valuing Indigenous knowledge and traditional ways for health, wellness, and healing
- Sustaining a healthy workforce within Indigenous communities, ensuring physician wellness

A helpful Glossary of terms is presented in this supplement:

Anti-racism – An active and consistent process of change to eliminate individual, institutional, and systemic racism.

Colonialism – The processes by which Indigenous peoples were dispossessed of their lands and resources, subjected to external control, and targeted for assimilation and extermination.¹⁰ It is



an ongoing phenomenon by settlers or the dominant society that continues to negatively affect Indigenous peoples in Canada politically, economically, and culturally.

Cultural competency – The alignment of knowing, behaving, and acting in a way that respects and honours the beliefs of others.

Cultural humility – A process of self-reflection to understand personal and systemic biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.

Cultural safety – A concept that may be considered as the rationale and goal in having good therapeutic interactions with Indigenous patients, families, and communities and becoming a Scholar in Indigenous health. According to the First Nations Health Authority, cultural safety is “an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.”

Decolonizing – To resist and undo the forces of colonialism and re-establish Indigenous nationhood. This approach is rooted in Indigenous values, philosophies, and knowledge systems. Decolonization is a way of doing things differently and challenging the colonial influence by making space for marginalized Indigenous perspectives.

Equity – The ability to provide everyone with the same opportunities while recognizing their unique situation and addressing systemic barriers.

Inclusiveness – The responsibility that health professionals have to engage patients and Indigenous communities in care decisions and support the development of patients' capacity to self-advocate.

Patient-centred approach – Patient-centredness is a core value in family medicine. This approach broadens the conventional medical approach to include the patient as an active participant in their care, and to promote the physician-patient partnership. This approach consists of three values: considering patients' needs, wants, perspectives, and experiences; offering opportunities for patients to provide input and participate in their care; and enhancing partnerships and understanding in the patient-physician relationship

Structural violence – Structures and social mechanisms that cause harm, deny human rights, constrain human agency, and/or prevent certain individuals and population groups from having the resources necessary to reach their full potential. Structural violence is insidious and silent, which causes it to be invisible to many and accepted as “the way things are.”²⁵

Systemic racism – The legacy of colonial policies that legitimized the idea that Indigenous peoples were a separate and inferior race. In Canada this is manifested as a society where one social group has disproportionate access to power and resources, leading to inequities and systemic racism against Indigenous peoples. This imbalance of power and resources is maintained through unequal treatment under the law; unfair policies, rules, and regulations; social exclusion and isolation that prevents political, social, and economic participation; and barriers to access and participate in other social systems such as education and health.

Interpersonal or relational racism and erroneous assumptions based on negative stereotypes, including in health care settings, fuels systemic racism.²⁶

Trauma-informed care – This approach recognizes how common trauma is and how it can affect all aspects of people’s lives, including their interactions with service providers. As family physicians, taking a trauma-informed care approach involves creating a safe space for Indigenous patients and acknowledging how colonization continues to impact their lived experiences and social determinants of health. Rather than reliving or reflecting on traumatic experiences, this approach to care emphasizes the strengths developed from surviving trauma and how that resiliency can foster healing. By not taking a trauma-informed care approach, patients may be re-traumatized and feel unsupported or blamed. This may discourage them from seeking health care and related services in the future.

Trauma and violence informed care – Expands the concept of trauma-informed care to underscore the connection between trauma and violence. This approach recognizes the connections between violence, trauma, negative health outcomes, and behaviours. The approach increases safety, control, and resilience for people who are seeking services related to experiences of violence and/or who have a history of experiencing violence. It is based on the following policy and practice principles: understand trauma and violence, and their impacts on peoples’ lives and behaviours; create emotionally and physically safe environments; foster opportunities for choice, collaboration, and connection; and provide a strengths-based and capacity building approach to support client coping and resilience.





Phase Two: Consultations with Community Stakeholders

Four community stakeholder groups were consulted: the BC Rural Health Network; Patient and Community Partnership for Education at UBC Health; the Centre for Excellence in Indigenous Health and the Black Physicians of British Columbia

BC Rural Health Network Summit 2019 (BC Rural Health Network)

In January 2019 over 250 leaders in BC participated in the 3-day BC Provincial Health Care Partners Retreat to reflect on and shape change to improve rural and First Nations health equity in BC. This retreat was facilitated by First Nations Health Authority and the Rural Coordination Centre of British Columbia to create a feedback loop into rural Primary Care Networks.

The following priority areas were identified in the Report^{xv}:

- Culturally safe and humble care; “Continue to resolve health disparities by implementing the Truth and Reconciliation Commission’s Calls to Action and the United Nations Declaration of the Rights of Indigenous Peoples principles. Support community led, culturally safe training and continuous learning, and Indigenous self-determination to fund and develop a holistic Patient Care Network and System,
- Team based care; (proposed priority area for consideration is rural maternity care); “Enhance both in-office and local teams through facilitation of team modelling sessions that apply community needs data with community members to match human resources with community care need”,
- Increasing citizen and community involvement in health care transformation processes.
- Improving access (Virtual Care) and transitions (Transport) for patients in rural and remote communities. “Work to improve the transport of patients with a view to decreasing the amount of time it takes from the moment of an accident/incident and the arrival of the patient at the first level of higher care (e.g., hospital)”; “Increase local capacity and support with resources and a linked provider network including IT virtual technologies to enhance outcomes across the continuum of patient wellness”.

BC Rural and First Nations Health and Wellness Summit 2020 (BC Rural Health Network)

In June 2020, 950 people with 57 community tables gathered for a virtual health and wellness Summit to build relationships and co-develop shared priorities for the future of health care re-design and transformation in BC. In the summary report^{xvi}, the following topic areas were discussed:

1. Virtually Enhanced Care: Advancing virtual technologies to enhance longitudinal relationship based and culturally appropriate care.
2. Transportation: Emergency transport (911 to ER), interfacility transport (ER to higher level of care), and transportation as a social determinant of health
3. Team-based Care: Moving toward the idea of team not being constrained by the people in the room but the people who need to be around the patient

4. Cultural Safety and Humility: Cultural Humility as a way of delivering healthcare and Cultural Safety in the way it is received
5. Addictions and Overdose: Designing and implementing new strategies for addressing the overdose crisis affecting our communities
6. COVID-19 gaps and Advances: Exploring the most important advance/programme in your community, or gap highlighted by COVID-19; that you don't want to lose.

Additionally, the ways in which the medical school could contribute to the rural vision were discussed. It was suggested that the medical school provide more opportunities for rural and remote placements beyond the integrated community clerkship and Year 3 rural rotation.





Patient and Community Partnership for Education (PCPE), UBC Health

The PCPE Executive (Angela Towle, Bill Godolphin and Cathy Kline) were consulted on October 8, 2019. The outcome of that meeting was to plan a community engagement exercise to pull together a diverse group of people; leaders in urban indigenous and health-concerned organizations, disability groups and others. The community engagement exercise was held on December 3, 2019 and is reported in the Consultation on Priority Health Concerns in BC (2020)^{xvii}. Community members, patients and caregivers participated.

Strengths of our current health care system and the roles of physicians in BC were identified: a publicly funded and accessible system; skilled health professionals; good services and models of care for particular populations and a system that is responsive to change.

Priority health needs and improvements included: better care for the under-privileged; better care for everyone.

The key issues and trends that will affect the role of the physician in the future were: an aging population; increase in addiction and mental health issues, climate change; need for team-based/shared care/holistic care; technology enhanced care; rising costs; rising diversity of culture and involving patients.

What patients want and need from their doctor-patient relationship: collaboration, trust, respect, doctor and patient as partners in care and attention to the wellness of the doctor.

Most important knowledge, skills and attitudes that should be emphasized in the medical school curriculum:

- Relationships with patients
- Cultural Safety
- Holistic approach to diagnosis and care
- Teamwork
- Primary and community care
- Students as “Change agents”; Healthcare Leaders
- Work-life Balance
- Attitudes: Curiosity, dedication, understanding, empathy, humility, accountability
- Knowledge - increased education around:
- Chronic health conditions
- Health concerns of underserved or stigmatized populations
- Diversity, disability and trauma-informed care
- Alternative care
- Staying up-to-date, ability to analyze “fake-news”

Implications of the consultation with the patients, care-givers and community members:

Improving the doctor-patient relationship was a major concern of all participants. Patients want to be treated as experts in their own lives and partners in care. Patients are concerned that fragmentation of care at both the systems and individual levels are exacerbated by the increase in complex chronic conditions in diverse populations. They are concerned for those who experience poor health care as a result of marginalization and stigma, including people who are

Indigenous, refugees and immigrants, youth, women, people experiencing homelessness, and living with mental health issues. Medical education has been slow to adopt culturally safe and trauma-informed approaches to care. They are concerned that doctors are over-worked and stressed and that many of the tasks that burden physicians could be better done by other health professions. They want teamwork to include the patient as part of the team. They want our medical students to be change agents; to change the system rather than be made to fit in with the medical status quo. They highlighted the need for a direct, separate and culturally appropriate and ongoing process of engagement with Indigenous individuals and communities to address the Truth and Reconciliation Commission Calls to Action⁹. Finally, they see engagement as a process; that we continue to find meaningful ways to engage with patients and community representatives as our curriculum review process unfolds.



UBC Centre For Excellence in Indigenous Health

A meeting was held between Co-Chairs of the Working group (Adrian Yee and Cheryl Holmes) and Dr. Nadine Caron, Leah Walker and Courtney Smith on November 26, 2019.

Subsequently, Dr. Caron organized a meeting with a larger group on April 8, 2020 that also included: Ray Markham - Executive Director Rural Coordination Centre, BC (RCCBC); Terri Aldred - outreach primary care doctor for Carrier Sekani Family Services and Indigenous Family Med Site Director; Megan Hunt – Director of Primary Care at FNHA; John Pawlovich – REAP coordinator and physician for Carrier Sekani Family Services; Leslie Carty – Executive Director Operations RCCBC; and Jean Allbuery, - e-Health planner for the First Nations Health Authority.

The following recommendations were made:

- Implement recommendations from AFMC Joint Commitment to Action on Indigenous Health (2019)^{xviii}
- Incorporate AFMC Indigenous Health Core Competencies (2019)^{xix} into the MDUP Exit Competencies
- Improve existing learning sessions on Indigenous Health
- Increase opportunities for authentic experiential learning in Indigenous Communities
- Ongoing dialogue is needed at each of the distributed sites of the MDUP to: increase the attachment of learners to their Indigenous communities; support learners to become physicians who are confident, competent and connected with physicians who are well connected to Indigenous communities; and resource Indigenous communities to support our students in a way that doesn't overburden them.

Subsequent to these discussions, the MD Undergraduate Program has developed a new education leadership position in Indigenous Health. The UGME Curriculum Lead, Indigenous Health provides leadership for integration, coordination, and quality of Indigenous Health curriculum across all four years and all four sites of the MD Undergraduate Program, enabling alignment with the program's exit competencies and course objectives. The Centre for Excellence in Indigenous Health (CEIH) will provide key guidance, mentorship, and pedagogical support.





Consultation with the Black Physicians of BC.

The Black Physicians of BC provided their recommendations to address Racial disparities and socioeconomic status directly related to health status. In their letter dated October 2020, they state, “In order to provide truly culturally-competent care, UBC’s curriculum and medical training must prepare its learners to be competent in identifying and dismantling structural inequality and racial biases to better serve our communities”. They made the following recommendations for UGME and PGME:

1. Collection of race-based data in medical school admissions and residency matching and annually sharing this information publicly.
2. Establishing a Black Student Application Program along with the creation of a Black Canadian Admissions Committee with Black physicians, trainees, as well as community members involved in MD interviews and the admission process.
3. Dedicating resources to fund mentorship efforts towards Black students at high school and undergraduate levels so that students can be introduced to the medical profession through tours, workshops, and virtual as well as in person events at the medical school.
4. Reviewing the medical school curriculum to ensure racial consciousness and incorporation of the impacts of racism on health, with input from Black community members, Black medical professionals, and experts in critical race theory and anti-racism. All participants involved should be appropriately compensated for their work.
5. Creating a well-funded office of equity and inclusion where there is a dedicated expert in anti-Blackness and anti-racist work to provide support for Black medical students at the undergraduate level, and for Black residents and fellows at the PGME level.
6. Dedicating resources to provide debriefing, mental health resources, and anti-racist expert support to Black staff physicians as they continue to face institutionalized racism.
7. Mandating anti-racist workshop(s) that explicitly addresses anti-Black racism for all clinical and academic supervisors, admissions committees, Office of Student Affairs, and incoming residents and fellows to create a safe environment in the classrooms and on the wards.
8. Increasing the representation of the Black instructors, and clinical supervisors through equitable recruitment and promotion with commitment to diversifying the Dean’s Executive Team.
9. Inclusion of Black physicians and trainees as active stakeholders in the Faculty’s equity initiatives.

In January 2021, the Black Physicians of BC contributed to a revision of the MDUP Exit Competencies and the MDUP Mission Statement.



Phase Three: Identifying our Priority Health Concerns and Populations

The CACMS Element 1.1.1^v requires us to articulate our social accountability commitment in our mission statement, identifying the priority health concerns of the populations we have a responsibility to serve.

Priority health needs and communities to consider and engage in the creation of the mission statement for our MDUP, based on our literature review and community stakeholder engagement include (updated using “people first” language):

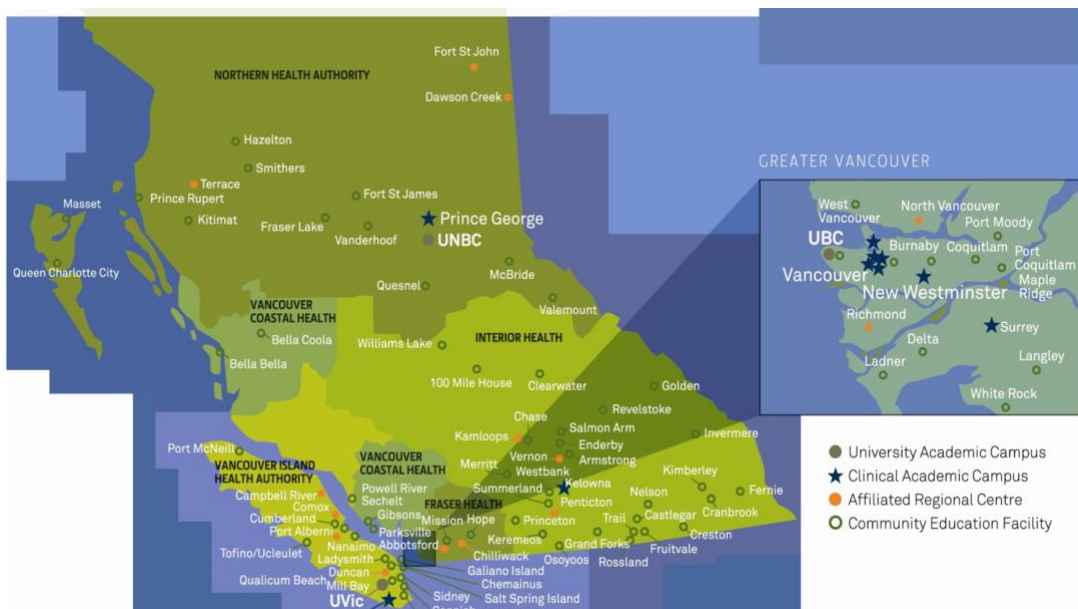
- Indigenous People in both rural and urban settings
- People living in rural and remote communities

People with unique healthcare experiences (who may experience health inequities)

- *Older adults living with complex health conditions;*
- *People who identify with diverse genders, gender expressions and/or sexual orientation;*

Black people, People of Colour, people new to Canada, people who speak a

- *language other than English;*
- *People, families and particularly children, living with a low income;*
- *People living with disabilities and/or chronic health needs including people living with mental illness and people who use substances.*





Phase Four: Revising our MDUP SRA Themes

SRA Theme 2020/21

Health Equity

Health inequities are differences in health linked to economic, social or environmental disadvantage and are caused by an uneven allocation of power, money and other resources. Health inequities disproportionately affect people and populations who systematically experience injustices and increased social or economic barriers to health based on factors known to be associated with discrimination or exclusion (e.g. gender, race or ethnicity, age, socioeconomic status, religion, ability/disability, sexual orientation, gender identity, geographic location, etc.)¹. A Medical school must be committed to reducing health inequities in the populations it serves. There is risk of further perpetuating health inequities if these issues are only addressed superficially or if learners are not equipped with the skills and attitudes to act on inequities, beyond lifestyle modification of individual patients². Physicians must understand not just what the social determinants of health are but also their historical roots; power and privilege and who benefits from the status quo; how oppression, racism, sexism and other 'isms' intersect to impact health; and how (and with whom) to challenge health inequities, at individual, organizational, community and societal levels.

Equity, Diversity and Inclusion

*Equity*³: Recognizing that everyone is not starting from the same place or history, deliberate measures must be taken to remove barriers to opportunities so as to ensure fair processes and outcomes. We need to achieve parity in policy, process and outcomes for historically and/or currently underrepresented and/or marginalized people and groups while accounting for diversity. Equity considers power, access, opportunities, treatment, impacts, and outcomes.

*Diversity*⁴: Differences in the lived experiences and perspectives of people that may include race, ethnicity, colour, ancestry, place of origin, language, political belief, religion, marital status, family status, physical disability, mental disability, sex, gender identity or expression, sexual orientation, age, class, and/or socioeconomic situations. Diversity of our students, staff and faculty should more closely align with the diversity of the people of BC on many diversity measures.

*Inclusion*⁴: An active, intentional, and continuous process to bring marginalized individuals and/or groups into processes, activities, and decision-making to address inequities in power and privilege, and build a respectful and diverse community that ensures welcoming spaces and opportunities to flourish

¹ World Health Organisation. (2008). Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Geneva: World Health Organization.

² Sharma M, Pinto A, Kumagai AK. Teaching the Social Determinants of Health: A Path to Equity or a Road to Nowhere? Academic Med. 2018; 93:25–30.

³ UBC Inclusion Action Plan <https://equity.ubc.ca/about/inclusion-action-plan/>



for all. Specifically related to curriculum, we need a critical approach to pedagogy⁴ to understand how the dominant discourse and hegemony influence curriculum development and delivery.

Indigenous Peoples' Health

For future physicians to address the significant health disparities amongst First Nations, Inuit, and Métis peoples in Canada, the medical curriculum needs to address Canada's history of colonialization, ongoing structural violence in the health system, as well as the social and structural determinants of health and wellness including racism, housing, employment, income, environment, language, land, culture, and education. Future physicians will require communication and advocacy skills that are culturally safe, strength-based, and resilience-informed. It is anticipated that educational priorities as identified by Indigenous communities, with an educational curriculum developed by Indigenous scholars, will be implemented throughout medical training in a safe and effective manner.

Key documents: TRC Report; UNDRIP; FNHA Declaration of Cultural Safety^{xx}

Rural and Remote Health Care

People living in rural and remote areas have the greatest difficulty in accessing health care services and as a consequence suffer the biggest health inequities in Canada. This also means that for marginalized and minority groups living in rural and remote areas the inequities that they suffer are magnified in comparison to similar groups that live in urban areas. Every learner and physician, no matter where they practice, may see rural patients as they can be referred to urban centres for diagnostic tests and treatments not available in their own communities. All medical students, therefore, need to appreciate the challenges of accessing health care services in these areas, and appreciate the wide scope of skills and abilities of rural practitioners, despite the low resource environments they live and work in. Students may also develop an appreciation of the enhanced health and wellness opportunities that present themselves in the rural setting. Understanding the varied health care contexts of BC is critical in reducing health inequities. To achieve this, all medical students need to have effective and authentic rural experiences⁵ during their time at medical school, and for those who are considering rural careers during much of their clinical training.

Planetary Health

Planetary Health is defined as “the achievement of the highest attainable standard of health, wellbeing, and equity worldwide through judicious attention to the human systems—political, economic, and social—that shape the future of humanity and the Earth's natural systems that define the safe environmental limits within which humanity can flourish. Put simply, planetary health is the health of human civilisation and the state of the natural systems on which it depends”⁶

Generalist Approach to Patient Care

⁴ Boelen C, Pearson D, Kaufman A, Rourke J, Woollard R, Marsh D, Gibbs T. Producing a socially accountable medical school: AMEE Guide No. 109, *Medical Teacher* (38), 1078-1091, 2016

⁵ CFPC Rural Road Map

https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Directories/Committees_List/Rural%20Road%20Map%20Directions%20ENG.pdf

⁶ Whitmee S. Safeguarding human health in the Anthropocene epoch: report of The Rockefeller Foundation—*Lancet* Commission on planetary health.

Lancet. 2015; [http://dx.doi.org/10.1016/S0140-6736\(15\)60901-1](http://dx.doi.org/10.1016/S0140-6736(15)60901-1)



Generalism⁷ is a philosophy of care wherein medical practitioners are committed to a wide breadth of practice and collaboration with the larger health care team in order to respond to patient and community needs; generalism is a remedy for fragmentation of care. Its principles include but are not limited to: treating the patient as a whole person, taking into account underlying complex chronic diseases, using adaptive expertise⁸ to manage clinical uncertainty, emphasizing health promotion and appreciating the importance of multidisciplinary care. Generalism is not in opposition with specialism; both are needed, and a generalist philosophy can be embraced in all specialties. While a generalism approach has a natural home within the specialty of family practice, a medical student who graduates with a solid grounding in generalism will be well-equipped to enter post-graduate training in any specialty.

Team-based care

Team-based care is "...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient - to accomplish shared goals within and across settings and achieve coordinated, high-quality care."⁹ Interprofessional teams, members of various health disciplines, can uphold the foundation of a strong health care system among increasingly complex health challenges. Intra-professional members within a given profession may have expertise or special interests in one or more areas as integrated parts of the broad scope of services they offer. A Medical school must be committed to reducing health costs and increase efficiencies and collaborations in the populations it serves. By providing patients with a comprehensive array of services that best meet their needs, team-based care can lead to increased access, higher patient and provider satisfaction, and better resource efficiency.

Medical education must not only equip learners with the breadth and depth of their role as a physician but also to equip learners with collaborative skills to work with their allied health professionals in both hospital and community settings, thus minimizing physician load and making use of the wealth of health knowledge among these health care providers. Benefits include: expanded access to and continuity of care, efficient use of resources, and improved chronic care management.

⁷ Royal College of Physicians and Surgeons of Canada. Report of the Generalism and Generalist Task Force. Ottawa, ON: Royal College of Physicians and Surgeons of Canada; 2013. Available from <http://www.royalcollege.ca/rcsite/educational-initiatives/generalism-medical-education-e>.

Postgraduate Medical Education Collaborative Governance Council. Report on Generalism in Postgraduate Medical Education. Ottawa, ON: Association of Faculties of Medicine of Canada; 2018. Available from: <https://pgme-cgc.ca/sites/default/files/news/Generalism%20Working%20Group%20Position%20Paper%20FINAL.pdf>

⁸ [Adaptive expertise: A situation during clinical reasoning where experts can adapt what they have learned in one context and/or for one problem to a novel context or problem; requires conceptual understanding that allows the expert to develop new solutions or new procedures for problem solving](#). Crosskerry, P, 2017. Medical Teacher 40(8):803-808.

⁹ Mitchell P, Wynia R, Golden B, et al. Core principles and values of effective team-based health care. Discussion Paper. Washington, DC: Institute of Medicine; 2012. http://thuvien.thanglong.edu.vn:8081/dspace/bitstream/DHTL_123456789/3976/1/Core%20principles%20%20values%20of%20effective%20team-based%20health%20care.pdf

College of Family Physicians in Canada. BEST ADVICE Team-Based Care in the Patient's Medical Home July 2017. <https://bccfp.bc.ca/wp-content/uploads/2015/06/Team-based-Care-in-PMH.pdf>



Knowledge Creation and Translation

“Knowledge creation, translation and exchange” invites us to nurture curiosity, to engage with our variable communities both locally and globally, as we equip our students with the necessary tools for discovery and innovation. We value and actively encourage scientific collaboration and we are sensitive to diversity, mindful of social contexts and passionate to improve the quality of health care as we ask and strive to answer the relevant, needful questions that aim to improve the well-being of the people we serve.

Health Promotion and Disease Prevention¹⁰ *Disease prevention* includes specific, population-based and individual-based interventions for primary and secondary prevention, aiming to minimize the burden of diseases and associated risk factors. *Primary prevention* refers to actions aimed at avoiding the manifestation of a disease. It involves screening for a disease before symptoms manifest and advising steps to prevent its onset. *Secondary prevention* (early detection) includes preventing complications from a disease and therefore improving the chances for positive health outcomes. *Health promotion* is the process of empowering people to increase control over their health and its determinants through health literacy efforts and multisectoral action to increase healthy behaviors. Health promotion usually addresses behavioral risk factors such as tobacco use, obesity, diet and physical inactivity, as well as the areas of mental health, injury prevention, drug abuse control, alcohol control, health behavior related to HIV, and sexual health.

Patient-centred care

Patient- or person- centred care takes into consideration the health needs of an individual, and is manifested when their desired health outcomes are the driving force during health encounters. Care is timely, patients are partners, health care providers are caring, skilled communicators, who consider the clinical perspective in light of the social, spiritual, financial, emotional and mental perspective of the patient.

¹⁰ WHO and Canadian Task Force on Preventive Health



Phase Five: Reviewing our Mission Statement

Process to Revise the MDUP Mission Statement

The Missions of Medical Schools: the pursuit of health in the service of society (2001)^{xxi}

Mission statements attempt to capture a medical school's unique and enduring purpose and practices, and as such serve a valuable purpose. The author of this publication identified 5 common themes which medical school mission statements typically include.

The mission statements of all medical schools in Canada, the US, the UK and Australia were reviewed by the author for common themes. Lewkonia (2001)^{xxi} identified 5 common themes which were present in most mission statements:

1. Tripartite responsibility of medical schools: Education; Research; Clinical Service
2. Tradition and historical perspective: Typically, longer-established medical schools tend to describe their reputation and achievements.
3. Service for specified communities or populations: these are more commonly seen in MS's from younger medical schools or those which serve areas of low population density.
4. Benchmarking to the templates or requirements of accrediting organizations or bodies: explicitly linking the MS to outside accreditors.
5. Mission statements often include descriptors for institutional performance and desirable behavioural attributes for graduates; Lewkonia provided multiple examples of each.

The value to a medical school of having a mission statement are multiple and include: sense of purpose (aspirational) for students, faculty, staff; recognize the interests of external stakeholders; motivates students, faculty, staff (inspirational); may provide an opportunity to evaluate the medical school in the context of performance outcome data.

Our current UBC MDUP Mission Statementⁱⁱⁱ states:

"The distributed MD Undergraduate Program admits and educates students who will graduate with demonstrated competencies and behaviours that will equip them to address the current and future health care needs of British Columbians. Our program and goals are grounded in the values of the University of British Columbia and its Faculty of Medicine and are aligned with the Liaison Committee on Medical Education (LCME) accreditation standards. The Program is committed to the following core principles and will foster these in its students and graduates: Collaboration and Partnerships; Scholarship and Innovation; Professionalism; Diversity and Equity; and Continuous Quality Improvement".

A revision would include (with examples):

- Who we are: A distributed MD Undergraduate Program
- What we do: Admit, educate and train students who will graduate with the demonstrated competencies and behaviours that will equip them to address the priority health concerns of British Columbians



- Our values: Our program and goals are grounded in the values of the University of British Columbia and its Faculty of Medicine Vision “Transforming Health for Everyone”.

Our Vision



The film Vision: Transforming Health for Everyone is the winner of two internationally-recognized platinum [MUSE Creative Awards for 2020](#).

As one of the world’s leading medical schools, UBC’s Faculty of Medicine has a bold vision: to transform health for everyone. When we say “for everyone” we mean it – regardless of age, ethnicity, gender or socioeconomic status. This is our contract with society in action: placing patients, their families and communities at the centre of everything we do.

Our Values



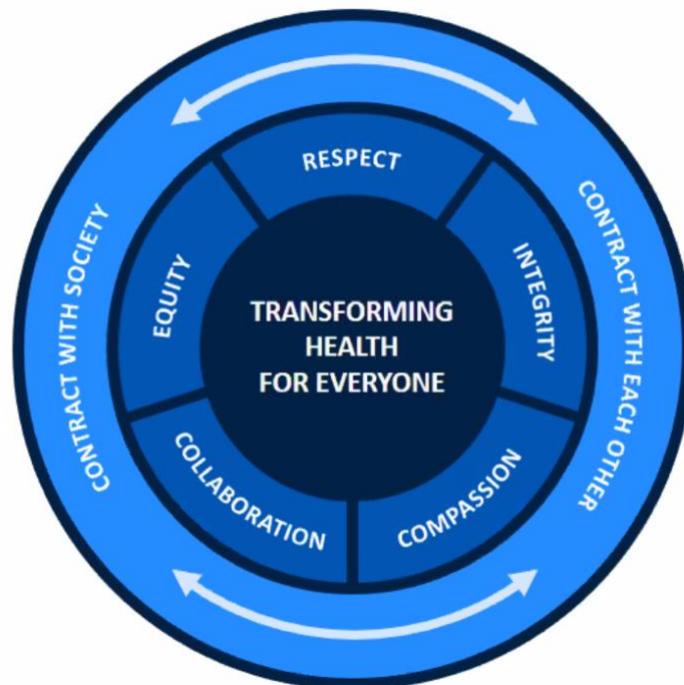
From December 2019 to February 2020, the Faculty of Medicine engaged over 700 faculty, staff, learners and alumni across the province of BC in a Vision^{xxii} and Values^{xxiii} exercise regarding the Faculty’s organizational culture and values.

From a [list of approximately 475 values](#) contributed by the Faculty community, the following five values emerged to the top as our core values:

- Respect: a regard felt or show towards different peoples, ideas and actions;
- Integrity: the quality of being honest, ethical and truthful;
- Compassion: the act of showing kindness and empathy to others

- Collaboration: working together with an individual or group of people towards achieving a common goal by sharing ideas, skills and actions;
- Equity: creating opportunities for equal access to education, programs and growth opportunities by recognizing and supporting individual and group needs.

Read the Faculty of Medicine [consultation report to](#) learn more about how we engaged, and how our values are helping us to move towards a people-centric desired culture that actively supports the achievement of the Faculty's vision



Who we serve and why: Our program is committed to addressing the health inequities of the diverse populations in British Columbia including our Indigenous populations, our rural and remote communities, the frail older adults living with complex health conditions; people who identify with diverse genders, gender expressions and/or sexual orientations; Black people, People of Colour, people new to Canada, people who speak a language other than English; people, families and particularly children, living with a low income; people living with disabilities and/or chronic health needs, including people living with mental illness and people who use substances.

Based on this we propose a Mission Statement using “people first” language with the assistance of the FoM Assistant Dean Equity Diversity and Inclusion. Our consultation process included: the UGME curriculum subcommittees, the Regional Site Administration and Leadership Teams, Patients and Community Partners for Education, the Black Physicians of BC, the Centre for Excellence in Indigenous Health and the BC Rural Health Network.



Revised MDUP Mission Statement

The University of British Columbia's MD Undergraduate Program strives to deliver exemplary distributed medical education that prepares future physicians to collaborate with patients and their circle of support in providing culturally safe, high-quality healthcare for the diverse and changing populations in BC and beyond, including Indigenous Peoples, people living in rural and remote communities, and people with unique healthcare needs*.

Our graduates are prepared to engage with diverse communities and to embrace generalist or specialist postgraduate training to further prepare them for medical practice.

The Program is grounded in the Faculty of Medicine's vision "Transforming Health for Everyone", and embodies the values of respect, integrity, compassion, collaboration and equity.

** People with unique healthcare needs include but are not limited to: older adults living with complex health conditions; people who identify with diverse genders, gender expressions and/or sexual orientations; Black people, People of Colour, people new to Canada, people who speak a language other than English; people, families and particularly children, living with a low income; people living with disabilities and/or chronic health needs, including people living with mental illness and people who use substances.*

Phase Six: Reviewing our Exit Competencies

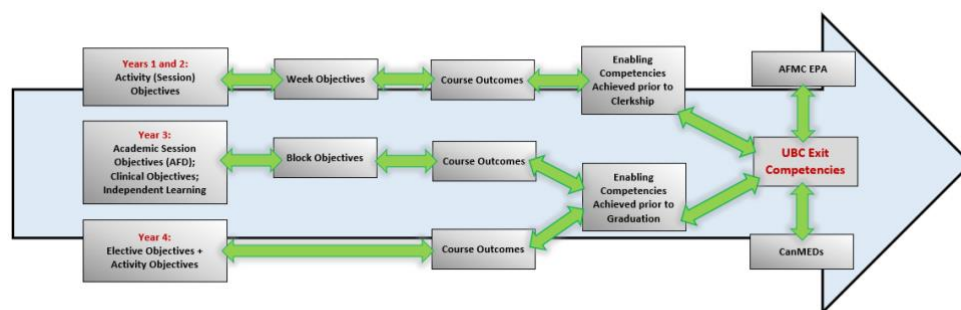
In reviewing and proposing revisions to our current exit competencies, members of the CRWG undertook the following process:

1. Reviewed the following documents:
 - a. UBC Exit Competencies^{iv} – November 2016
 - b. CanMEDS-Family Medicine Undergraduate 2019^{xxiv}
 - c. AFMC UGME Indigenous Competencies^{xix}
 - d. Consultation with External Stakeholders
 - e. The annotated literature review by the CRWG members
 - f. UBC SRA Framework 2012ⁱⁱ
 - g. Additional documents pertinent to the exit competency (references were tracked).
 - h. MCC Objectives Website - the relevant roles were reviewed:
<https://www.mcc.ca/objectives/>

Each Exit competency was initially reviewed and re-drafted by 2 members of the CRWG and subsequently reviewed by the member from the Centre for Health Education Scholarship (CHES).

A smaller working group was formed during COVID and Dr. Stephen McCarthy (MDUP FLEX student) was recruited and assisted along with Dr. Maria Hubinette, CHES Scholar and co-author of the CanMEDs-FMU 2019 Exit Competencies, in the review of our Exit Competencies. We held weekly meetings focusing on each exit competency until we achieved consensus in the proposed revision. The Leadership role underwent an extensive revision with input from the MDUP Leadership Theme Co-Leads and an extensive literature search, comparing and contrasting the various health professions education leadership frameworks. Finally, key competencies were then reviewed again with an EDI, Rural, Anti-racism and Indigenous cultural safety lens.

A table of current and proposed role definitions was provided to the CRWG for debate and review from September to January 2021. Year Milestones (part of the 2016 Exit Competencies) were replaced with enabling competencies “achieved prior to clerkship” and “achieved prior to graduation”.





Phase Seven: Plan for the Review of the Curriculum as a Whole

The Undergraduate MD Education Committee (UGMEC) is responsible for integrated oversight of the UGME curriculum. The committee oversees the process for curriculum design, review, revision, and for monitoring gaps and redundancies. The committee receives individual course evaluation report periodically, Canadian Graduate Questionnaires, Preparation for Clerkship, Preparation for Residency, and internal/external assessment outcomes. Curricular leadership uses the evaluation and assessment data to propose changes and improvements to the curriculum to UGMEC. UGMEC approves and monitors the progress.

Originally eight recommendations to set the direction for the renewed curriculum, in 2012:

1. **Social responsibility and accountability:** That the Faculty of Medicine renew its social responsibility and accountability framework for the MD Undergraduate Program so that UBC graduates are prepared to meet the current and future needs of society (provincially, nationally and internationally).
2. **Competency-based curriculum:** That the Faculty adopt an outcomes-based approach for the renewed undergraduate MD program that is derived from its social responsibility and accountability framework as well as the scientific basis of medicine, and that the competencies (knowledge, skills and attitudes) and standards that students must demonstrate in order to meet the exit outcomes be defined for each level of learner.
3. **Student assessment:** That the Faculty develop a comprehensive integrated student assessment system that aligns with both the curriculum and the outcomes.
4. **Flexibility:** That the curriculum will allow students to achieve the defined core competencies in an efficient and flexible manner.
5. **Scholarship:** That the curriculum will provide opportunities for all students to pursue excellence, innovation and new knowledge through scholarship.
6. **Integration:** That the Faculty develop a curriculum based on integration of basic biomedical, clinical and other disciplines with increasing complexity across the entire period of study so that students concurrently acquire and use knowledge and skills from different disciplines in a manner consistent with real-life patient care, population health activities and research.
7. **Continuity:** That the Faculty adopt a curriculum design promoting continuity of patient care, faculty interactions and curriculum content across all four years of the program. Continuity will be enabled by the establishment of an Academic Learning Community (ALC) system.
8. **Health care system:** That the Faculty adopt a curriculum that will prepare students for their roles as active participants in the current and future health care delivery system, including preparation for inter-professional collaborative practice as well as the enhancement of patient safety, quality of care and e-health.



A systems-oriented framework will be used to design an approach (Williams & Imam 2007; Parsons 2007) for evaluating how the original recommendations were implemented in the new curriculum

As the new curriculum is rolled out, the focus will shift to monitoring implementation and measuring outcomes. The primary questions that will be addressed include:

1. Is the current curriculum aligned with Curriculum Renewal principles?
2. Is the curriculum aligned with the MDUP exit competencies?
3. Are graduating students achieving exit competencies?
4. What is the process we employ to continuously improve the curriculum and ensure we meet societal needs?

Methodology

A mixed-method approach will be used to address the outcome questions described, including the use of administrative documents, interviews, surveys, assessment data, and data from external sources (e.g., Canadian Graduation Questionnaire, residency match data, Canadian post-graduate education registry data, Canadian licensing exam data, and accreditation documents). The outcomes of our community stakeholders' consultations will be included in any recommendations arising out of our deliberations.

The Faculty of Medicine Student Database, housed within the ESU, will be used as the source of outcome data. This database contains information about students from admissions into practice and is being maintained and updated on a continual basis. Qualitative data will be analyzed using standard protocols to identify meaning as appropriate to the evaluation questions. Quantitative data will be analyzed using appropriate statistical analyses. We will also use Geographic Information Systems to develop maps illustrating where UBC graduates are practicing medicine. As data are analyzed, evaluators will work interactively with faculty leaders and other stakeholders to review the findings to help provide insight into their meaning and to understand systemic influences that facilitate or hinder success.

Outcomes:

1. Make recommendations that reflect the findings of the UGME Curriculum Review Working Group to the UGME Committee (as a separate report).
2. Make further changes to the revised Exit Competencies based on the findings of the full review of the curriculum, as recommended to the UGME Committee.



Phase Eight: Identifying our Outcome Measures

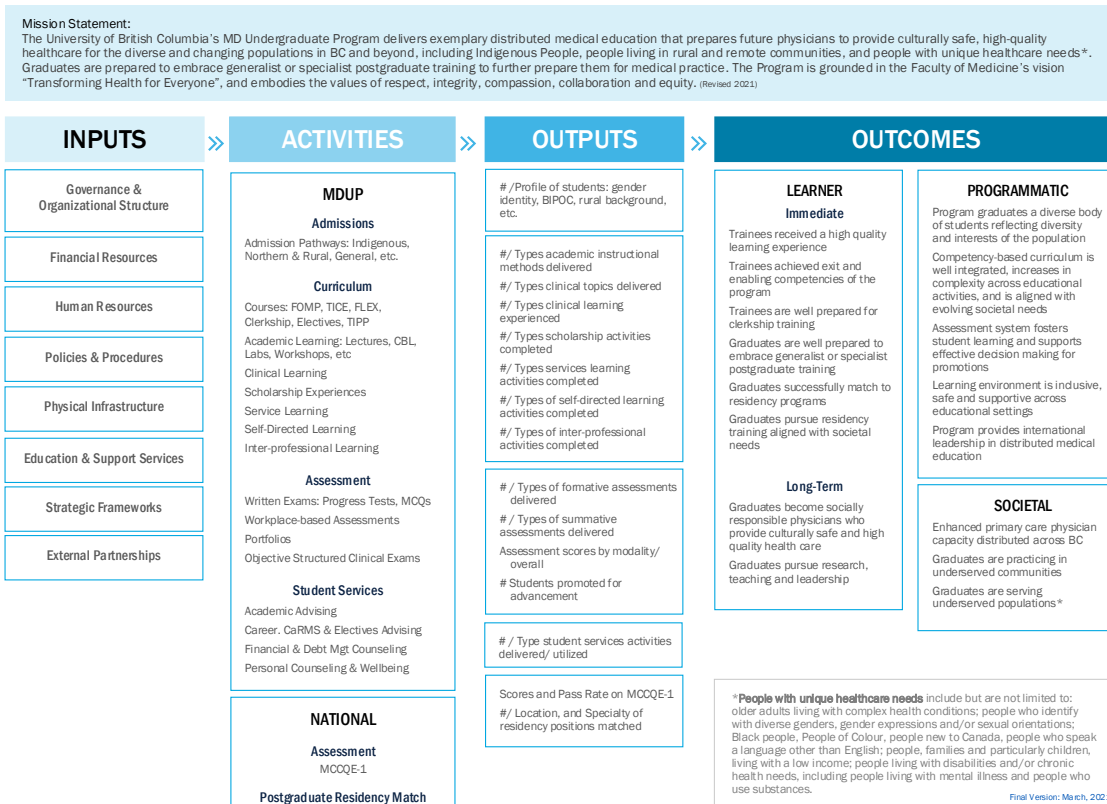
CACMS Element 1.1.1^v requires us to identify specific outcome measures of the populations that we have a responsibility to serve - both short-term and long-term. We must describe how the social accountability commitment of our medical school is fulfilled through the admissions process, curricular content and types and locations of educational experiences. We must describe how and how often the specific outcome measures are monitored and the groups or individuals who review the results.

MDUP Logic Model

The UBC MDUP logic model is a visual representation of how the MDUP has been designed to achieve the learner, programmatic, and societal outcomes which ultimately contribute to the mission of the program.

The purpose of this logic model is to serve as (1) a communication tool to ensure agreement on the logical flow of how the program contributes to its intended outcomes and (2) an integrated evaluation and monitoring framework for the program as a whole as well as for different components of the program (e.g., courses, assessment system, admissions, learning environment, and etc.)

UBC Faculty of Medicine MD Undergraduate Program Logic Model





Based on our literature search, community stakeholder consultations and our MDUP Mission statement we recommend the following populations and outcome measures (approved by the UGME Committee):

Table 1.1.1-1 | Populations that the Medical School has a Responsibility to Serve

List the populations that the medical school has a responsibility to serve. Provide a short title in Column 1 and a brief description (e.g., geographic, linguistic). Add rows as needed.	
School-identified population	Brief description
1. People living in rural and remote communities	Rural and remote communities are defined according to definitions developed by the federal or provincial governments. At the national level, communities are classified as rural/remote based on the Statistics Canada Rural and Small Town (RST) definition. At the provincial level, communities are classified as rural based on the BC Rural Subsidiary Agreement (RSA) definition.
2. Indigenous People in rural and urban settings	Indigenous peoples are defined as those who self-identify as First Nations, Metis or Inuk (Inuit).
3. People with unique healthcare needs (who may experience health inequities)	Older adults living with complex health conditions; people who identify with diverse genders, gender expressions and/or sexual orientations; Black people, People of Colour, people new to Canada, people who speak a language other than English; people, families and particularly children, living with a low income; people living with disabilities and/or chronic health needs including people living with mental illness and people who use substances. <i>*To be reviewed annually by UGME Committee</i>



Table 1.1.1-2 | Specific Outcome Measures

List the specific short-term and long-term outcome measures the school uses or will use as evidence that its social accountability is being fulfilled. Add rows as needed.		
School-identified social accountability measures	Short-term	Long-term
Input measures: <ul style="list-style-type: none"> a. Profile of learners b. Profile of faculty c. Diversity of learning settings 	<ul style="list-style-type: none"> a. Characteristics of learners on key diversity metrics <ul style="list-style-type: none"> - Gender, race/ethnicity (Indigenous), SES, language, disabilities, geographic background (rural/remote), etc. b. Characteristics of faculty on key diversity metrics <ul style="list-style-type: none"> - Gender, race/ethnicity (Indigenous), academic background (clinicians and basic scientists), etc. c. Characteristics of learning settings (type, number) 	<ul style="list-style-type: none"> a. Learners reflect the diversity of the populations they are expected to serve in BC and Canada b. Faculty and leadership reflect the diversity of the people of BC and beyond, who bring a wide range of perspectives to medical education c. Program delivers training in diverse settings with a broad representation of populations
Activity measures: <ul style="list-style-type: none"> a. Curriculum content b. Service-learning activities c. Educational/training experiences 	<ul style="list-style-type: none"> a. Curriculum dedicated to SRA themes and school-identified populations (type, number, and hours of curriculum) b. Service-learning activities with school-identified populations (type and number of activities) c. Clinical training experiences with school-identified populations (type and number of experiences) 	<ul style="list-style-type: none"> a. Curriculum addresses SRA themes and school-identified populations b. Learners participate in service-learning activities with school-identified populations c. Learners participate in clinical training experiences with school-identified populations
Outcome measures: <ul style="list-style-type: none"> a. Competencies of graduates b. Practice type of graduates c. Practice location of graduates 	<ul style="list-style-type: none"> a. Graduates competent in exit competencies related to SRA-themes, including advocating with and providing clinical care for school-identified populations b. Graduates matching to primary care (% match) c. Graduates practicing in diverse communities 	<ul style="list-style-type: none"> a. Graduates are practicing in primary care b. Graduates are practicing in rural and remote communities c. Graduates are practicing in underserved communities (e.g., areas with high concentration of school-identified populations)



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- ⁱⁱ UBC MDUP Social Responsibility and Accountability Framework 2010. UBC Medical Journal Volume 10 Issue 2 Spring 2019 <https://med-fom-ubcmj.sites.olt.ubc.ca/files/2019/03/Feature-3.pdf>
- ⁱⁱⁱ Mission and Goals of the UBC MD Undergraduate Program (2013) <https://mdprogram.med.ubc.ca/files/2015/08/Mission-and-Goals-of-the-UBC-MD-Undergraduate-Education-Program-January-15-2013.pdf>
- ^{iv} UBC Faculty of Medicine MD Undergraduate Program Exit Competencies (2016) <https://mednet.med.ubc.ca/Teaching/curriculum-management/mission-goals-competencies/Documents/UBC%20Exit%20Competencies%20-%20July%202017.pdf>
- ^v Committee on Accreditation of Canadian Medical Schools (CACMS) Standards and Elements https://cacms-cafmc.ca/sites/default/files/documents/CACMS_Standards_and_Elements_-_AY_2019-2020.pdf
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- ^{ix} Adrian Dix Mandate Letter from Premier John Horgan (2017) <https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/dix-mandate.pdf>
- ^x United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf
- ^{xi} Calls to Action of the Truth and Reconciliation Commission (2015) https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf
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- ^{xiv} CanMEDS Family Medicine Indigenous Health Supplement (2020) <https://www.cfpc.ca/CFPC/media/PDF/CanMEDS-IndigenousHS-ENG-web.pdf>

- ^{xv} Provincial Health Care Partners' Planning Retreat Summary Report (2019) <https://rccbc.ca/wp-content/uploads/2020/06/BC-Provincial-Health-Partners-Retreat-Final-Report.pdf>
- ^{xvi} BC Rural and First Nations Health and Wellness Summit 2020 <https://rccbc.ca/wp-content/uploads/2020/08/BC-Rural-and-First-Nations-Health-and-Wellness-Summit-Summary-Report.pdf>
- ^{xvii} Consultation on Priority Health Concerns in BC (Patient & Community Partnership for Education 2020) <https://meetingofexperts.org/programs-activities/priority-health-concerns-in-bc/>
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