EVALUATION OF THE MEDICAL SCHOOL AT THE BEN GURION UNIVERSITY FACULTY OF HEALTH SCIENCES

INTERNATIONAL QUALITY ASSURANCE REVIEW COMMITTEE ON HIGHER EDUCATION

NOVEMBER 2021

Background and Procedures

1.1 In the academic year 2020-2021, the Council for Higher Education (CHE) put in place arrangements for the evaluation of study programs in the field of Medicine in Israel.

1.2 The Higher Education Institutions [HEIs] participating in the evaluation process were:

Azrieli Faculty of Medicine at Bar Ilan University
Ben Gurion University Faculty of Health Sciences
Hebrew University Faculty of Medicine
Technion Faculty of Medicine
Sackler Faculty of Medicine at Tel Aviv University

1.3 To undertake the evaluation, the Vice Chair of the CHE appointed an International Quality Assurance Review Committee (IQARC; 'the evaluation committee'), under the auspices of the CHE's Committee for the Evaluation of Medical Education in Israel[1], consisting of:

- Prof. Mark Tykocinski (Chair)
- Prof. Haim Bitterman
- Prof. Adina Kalet
- Prof. Orit Karnieli-Miller
- Prof. Cees van der Vleuten

Ms. Pe'er Baris-Barnea served as the Coordinator of the IQARC evaluation committee on behalf of the CHE.

1.4 The first review took place from 7 to 14 June 2021, and it dealt with two of the five medical schools: Technion Faculty of Medicine and Azrieli Faculty of Medicine at Bar Ilan University. The second review took place from 2 to 11 November 2021, and it dealt with the remaining three medical schools: Sackler Faculty of Medicine at Tel Aviv University, Ben Gurion University Faculty of Health Sciences, and Hebrew University Faculty of Medicine.

1.5 The evaluation process was conducted in accordance with the CHE's *Standards for Medical Education (2021)*. Within this framework the evaluation committee was required to:

- examine the self-evaluation reports submitted by the medical schools in Israel
- conduct on-site visits (physical and/or virtual) at those institutions participating in the evaluation process
- draw conclusions vis-à-vis each of the 11 standards
- submit to the CHE an individual report on each of the medical schools participating in the evaluation
- set forth the committee's findings and recommendations for each school
- submit to the CHE a general report regarding the evaluated field of study within the Israeli system of higher education including recommendations for changes to the standards for Medical Education

1.6 The IQARC evaluation committee examined only the evidence provided by each participating institution — considering this alongside the distinctive mission set out by each institution in terms of its own aims and objectives. This material was further elaborated

[1] The committee's letter of appointment is attached as Appendix 1.

and explained in discussions with senior management, lecturers, students, and alumni in the course of the site visits to each of the institutions.

1.7 This report deals with the Ben Gurion University Faculty of Health Sciences (BGU-FOHS). While BGU-FOHS comprises degree program across several health professions, the present review was exclusively focused on the medical school (the *Joyce and Irving Goldman Medical School*—6-year track; and the *Medical School for International Health [MSIH]*—4-year track). Notwithstanding travel challenges associated with the coronavirus pandemic, the evaluation committee's site visits and associated deliberations were conducted in-person. Four of the committee members (Prof. Tykocinski, Prof. Haim Bitterman, Prof. Orit Karnieli-Miller, and Prof. Cees van der Vleuten) visited the medical school on November 3. Prof. Adina Kalet recused herself from this medical school evaluation.

1.8 The IQARC evaluation committee would like to thank the management of the Ben Gurion University Faculty of Health Sciences for their self-evaluation report, supportive interactions with the evaluation committee for the evaluation process, and hospitality towards the committee members who visited the institution.

Key findings

Executive Summary

Ben Gurion University's medical school was established in 1974 as Israel's fourth medical school, and four years later, it came together with several other departments (basic sciences, nursing, physiotherapy) to become the Ben Gurion University Faculty of Health Sciences (BGU-FOHS). Over the subsequent years, its health profession portfolio has expanded further into other fields. Located at the doorstep of the Negev, BGU-FOHS sees itself as serving Israel's diverse southern communities. Two medical education arms emerged at BGU—the *Joyce and Irving Goldman Medical School* and the *Medical School for International Health*—with 6-year and 4-year tracks, respectively. The education mission loomed large for BGU-FOHS at the beginning, as BGU-FOHS became known for its innovative approaches to medical education. Over time, the medical school's education focus has given way to a greater emphasis on research, in concert with the emergence of its parent university, along with Beer Sheva more broadly, as a significant R&D hub. In parallel, the BGU-FOHS collection of clinical affiliate training sites has grown, diversified, and geographically spread, in conjunction with Israel's largest health fund, Clalit. BGU-FOHS now sits at a critical juncture, as it maps its future, sets priorities across its multiple missions, and selects among a significant spectrum of opportunities before it.

The **International Quality Assurance Review Committee (IQARC)**, as charged by the **Council for Higher Education (CHE)**, met in November 2021 to assess BGU-FOHS, as part of the CHE's quality assurance assessment of Israel's medical schools.

The IQARC framed its deliberations around several core elements:

1) **CHE's directive to focus the evaluation around '*fitness for purpose*' |**
   In its quality assurance assessment, the IQARC looked to the medical school's own self-described *purpose*, as reflected in its mission and vision statements, along with its stated aspirations, as articulated in the self-study and IQARC interviews with university and medical school leadership.

2) **Evolving medical education models on the international scene |**
   In addition to considering the medical school's self-described purpose and the medical education ecosystem in which it operates, the IQARC also viewed BGU-FOHS through the lens of advances in medical education science and their translation across the world into medical school curricula and didactic modalities. This is relevant to the CHE's journey towards World Federation for Medical Education (WFME) accreditation status.

3) **Operating and budgetary constraints for Israel's medical schools |**
   Evaluation of medical school performance must *per force* factor in the operational environment. BGU-FOHS functions within a complex set of operating and budgetary constraints, including: a) national policies and practices vis-à-vis approval of, and budgetary allocations to, the medical school for educational programming, faculty staffing, new program development, and capital expenditures; b) tight university oversight of medical school educational curricula and programming, faculty appointments and promotions, and

operating and capital allocations; c) a complex interplay with its flagship hospital, Soroka University Medical Center in Beer Sheva, as well as the rest of its network of geographically-disbursed, functionally diverse clinical affiliates, now extending to Ashkelon and Ashdod; and d) the dynamic with Clalit. Navigating this matrix of operating and budgetary relationships is demanding on leadership, constrains degrees of freedom, and in turn, must factor into recommendations.

4) **First evaluation against a new set of CHE standards |**
Subsequent to the 2014 medical school review cycle, the CHE, in its journey to WFME status, set forth for the first time a structured set of standards for medical school quality assurance assessment in Israel. Further, there was a revision of these CHE standards within months of the June 2021 review cycle. Medical schools were given the option of revising their self-studies at this late stage, and BGU-FOHS did choose to do so.

5) BGU-FOHS' performance since the last CHE-directed accreditation review in 2014 |
Notwithstanding a changing medical education landscape in Israel, accompanied by evolving educational evaluation perspectives and the introduction of formal accreditation standards since the last accreditation review, the IQARC nonetheless looked back to that 2014 review and evaluated TFOM's progress in addressing the series of recommendations set forth in it, as well as in achieving internal objectives set forth in the medical school's subsequent strategic planning efforts.

The IQARC evaluated BGU-FOHS based upon 11 CHE-delineated standards for assessment of medical schools:

The CHE has modelled its standards after those of the United States Liaison Committee for Medical Education (LCME). The CHE adaptation encompasses assessment of:

Goals, Planning, and Organization (Standard 1)
Leadership and Management (Standard 2)
Academic and Educational Environment (Standard 3)
Teaching Staff (Standard 4)
Educational Resources and Infrastructure (Standard 5)
Skills, Learning Outcomes, and Curriculum Development (Standard 6)
Curriculum (Standard 7)
Curriculum Management and Evaluation (Standard 8)
Teaching, Guidance, Assessment and Safety of Students and Patients (Standard 9)
Admission Processes to the Program and Transition from Year to Year (Standard 10)
Student Support and Services (Standard 11)

The CEMEI evaluated BGU-FOHS compliance with these standards, and its top-level findings, commendations, and recommendations follow.

The IQARC's overarching findings are:

1) BGU has emerged as a premiere university on the Israel scene, with a campus undergoing dramatic expansion, a robust and wide-ranging research enterprise, a breadth of educational

offerings, and in recent years, a growing hi-tech, start-up ecosystem on its periphery. At once, the healthcare delivery system anchored in its flagship clinical affiliate, Soroka University Medical Center, has itself expanded and developed significant areas of clinical distinction. Together, these major developments in its parent university and anchor clinical affiliate provide BGU-FOHS, and its two component medical schools, with considerable opportunities for the future. They also demand critical decisions, and a pivotal one relates to the education mission. Over the years BGU-FOHS has cultivated its research prowess, in synch with the rest of the university's overarching priority in this area. As a by-product, the original '*Spirit of Beer Sheva'*-driven emphasis on pioneering medical education has faded, and in fact, the institution is now in a position of having to catch up in this realm. Ironically, the international student MSIH arm has tended to exhibit more innovation than the core 6-year program. Obviously, the dual research and education missions are not mutually exclusive, and they need not be approached as a zero-sum game, one having to displace the other. The opportunity remains to embrace medical education innovation once again, which can be powered by its outstanding faculty complement; the first-class assets that now envelop it (university, clinical, and start-up ecosystems); and the backdrop of its higher purpose social mission, regionally and globally. This will now demand a significant pivot, starting with better alignment of university and medical school leadership around budgetary, programmatic investment, and faculty investment priorities; understanding and support from Clalit; and reinfusion of a transformational spirit in all the medical education stakeholders.

2) As a prelude to reigniting the medical education ethos, BGU-FOHS must develop a comprehensive strategic plan—one that captures its newly configured, multi-dimensional mission; a vision of what it aspires to look like 5-10 years down the road; an articulation of its core values; and a detailing of key strategic goals and associated milestones and data-driven action plans, coupled to timelines. The booklet prepared by the prior dean, labelled as a *strategic plan* and distributed during the IQARC site visit, falls short of this kind of comprehensive analysis, and in any case, is by now dated. Clearly, a key focus for this new strategic plan should be the medical education component, with curricular transformation as a central theme. Further, a *bona fide* strategic plan should bring clarity to various entities that are within the BGU-FOHS orbit—for example, the *Goldman Committee (IARC)* and the *Moshe Prywes Center for Medical Education*—whose current roles seem blurred, whose recommendations lack diligent follow-up, and which thus appear more as organizational vestiges than substantive, guiding entities that inform concrete action.

3) Beyond mission clarification and an education mission deep-dive, the new strategic plan should chart a course for leveraging the dynamic surrounding ecosystems that BGU-FOHS can be tap into inside and outside the university as it looks to reassert its identity as a pioneer of 21st century medical education. A first step is to inventory the relevant academic assets of the parent university, as well as those of the rapidly expanding hi-tech start-up ecosystem in its home city. This would be followed by mapping these assets to initiatives that can leverage these various assets for co-curricular enrichment and unique educational programming and training pathways. By example, BGU-FOHS is ideally positioned to leverage Beer Sheva's world-class computational expertise (computer sciences, data

analytics, machine intelligence, cybersecurity, and others) to develop programming and educational offerings in areas such as computational medicine, digital health, and population health intelligence. This could include unique dual degree pathways, stackable certificates, and other transdisciplinary learning formats.

4) BGU-FOHS will need to embrace the CHE accreditation process in a more structured way, as it follows up on this IQARC review. Preparations for IQARC reviews cannot be dealt with as last-minute sprints to be orchestrated by an outside consultant. Instead, the CHE accreditation system must be viewed as a never-ending process of continuous self-improvement, overseen systematically and relentlessly by empowered senior faculty and administrative staff. Of particular concern, the findings of the 2014 accreditation review under the CHE's auspices were seemingly ignored in subsequent years, and the present DCI self-study fails to account for the thoughtful and comprehensive recommendations made back then. Of note, top-level recommendations of the prior accreditation review committee are still highly relevant—by example, the overarching need for a competency and outcomes-based curriculum; the call for a formal strategic plan; the requirement for ongoing, diligent assessment of the curriculum; the opportunity for the two component schools to share best practices; and the potential for assuming a forefront role on the national medical education scene. BGU-FOHS has, as a result, fallen behind, and it must now recommit to its education calling. At this stage, BGU-FOHS would benefit from gathering best-practice input from institutions around the world as it seeks to transform its medical curriculum, as well as bringing in external review teams at the midpoint of the accreditation cycle to critically review progress. A highly structured internal process must be in place for monitoring the medical school's progress over time in embracing external review panel recommendations and achieving its strategic goals and milestones. Such a structured internal process is particularly important for preserving continuity of objectives and programs in a system where deans transition on a relatively frequent basis, in the case of BGU-FOHS, every three years.

5) The BGU-FOHS DCI self-study has a bit of a disconnect, in that it is laced, on the one hand, with bold claims as to the excellence and achievements of its medical school programs, and on the other hand, with statements that transparently bare various critical weaknesses (in the dean's cover letter and some bulleted points within the respective standards). Ideally, the two should be meshed seamlessly within a DCI self-study, such that critical self-analysis and challenges identified are coupled to detailed action plans.

6) Given its location in the south of Israel, BGU-FOHS' oft stated mission of serving the populations of the Negev, including underserved communities such as the Bedouins, is compelling. This embrace of a regional social mission—to meet a spectrum of healthcare needs of the diverse communities of southern Israel—is coupled at BGU-FOHS to an equally laudable aspiration to cultivate physicians with social responsibility and provide its medical students with a global perspective on healthcare inequities. While this commitment is palpable at BGU-FOHS, from students and faculty alike, the associated programming would benefit from a more structured and less siloed approach. For example, while the global dimension is well-developed in the MSIH 4-year track, it is less so in the 6-year track; an

international elective could be introduced into the latter. Co-curricular and extra-curricular activities could be coordinated within individualized advanced study plans. Further, there is the potential for aligning outreach community service projects with other colleges at BGU, and even with students at other medical schools.

7) Given that BGU-FOHS comprises a range of health professions, it is well-positioned to build its interprofessional education (IPE), looking to cultivate effective members of the healthcare teams of tomorrow. Currently, IPE programming is limited, and the DCI self-study does not provide a concrete plan for advancing it. Here too, the social mission could factor in, with room for creative outreach programming that would foster joint experiential learning for students across the disciplines. Such groupings need not be limited to health profession students, as they could include students from other disciplines across the university, for example, psychology, sociology, and the design fields.

8) BGU-FOHS has been actively building a strong research infrastructure, with outstanding faculty steeped in the basic biomedical and population health sciences. These research faculty, along with those in the university more broadly, offer students considerable opportunities for research immersion. The dean has this opportunity in his sights, including building dual degree paths. In the meantime, the medical school should add rigor to the research experience of medical students, with protected time; revision of the research thesis requirement with more guidance and critical evaluation of deliverables; and introduction of didactic offerings that build students' grounding in fundamentals on the conduct of research that go beyond biostatistics.

9) As the medical school embraces its medical education transformation imperative, it will need deep faculty buy-in and engagement, by both its basic science and clinical faculty. There is a strong base of highly committed preclinical and clinical teaching staff in place on which to build. With concrete support and financial resourcing by the university, the medical school is advised to recruit a small cadre of faculty with education science expertise who can nucleate and drive the curricular reform process and serve as medical education champions. BGU-FOHS must also implement mandatory, longitudinal faculty preparation within *train-the-trainers* programming. This is important not only for an effective transition to more small group learning, e.g., case-based learning, which demands a broader range of didactic skillsets, but also equivalency of training by the diverse clinical faculty at BGI-FOHS' dispersed clinical affiliate sites, where this is currently a significant issue. Recognition of education-focused faculty in appointments and promotions is essential, and it will powerfully convey that the university and medical school alike value their faculty's educational contributions. To the extent that this requires upfront modifications of faculty tracks and promotion criteria, such change should be entertained. Importantly, there is a pressing need to address the issue of excessive teaching load, as faculty struggle to balance their clinical and research activities.

10) As BGU-FOHS recaptures its pioneering educational spirit, it will have to have a clear eye as to the scope of transformation that is now needed vis-à-vis curriculum and didactics. The medical school's current pre-clinical curriculum is traditional at its core—discipline-based,

lecture-intensive, passive in character, demanding in contact hours, limited in self-study, and modest in its clinical integration into the pre-clinical curriculum. The trend elsewhere has been for decades towards medical education that is characterized by integration among the foundational sciences and is competency-based, small group-intensive, rich in active learning, less demanding in contact hours, open to self-study, and robust in infusing clinical thinking into the pre-clinical years. The present IQARC review sets forth recommendations for achieving this end. The pace of implementation is also an issue. Cautious, stepwise evolution of the curriculum should give way to a more revolutionary gestalt, and the belief that curriculum transformation will be too costly must be replaced by a realization that the current curriculum is also costly in its time and resource intensiveness. Increased costs associated with running multiple small groups can be offset by decreasing other costs driven by the current unusually high load of contact hours. Various other curricular changes could be accomplished within the current financial envelope by simply shuffling resources and prioritizing programming. However, this is not to say that a small group-intensive curriculum will not have a higher baseline cost.

11) Beyond the core elements of a competency-based curriculum, there are other dimensions that are nowadays seen as essential for medical student education. These include communication skills; medical ethics; regional health disparities, cultural competence, and psychosocial matters; interprofessional education; and global health. These and other topics must be dealt with in a systematic way, with longitudinal threading and meaningful assessment, and for some of them, there is now an opportunity to align best practices where there are differences between the 6-year and 4-yeare tracks.

12) BGU-FOHS must increase student exposure to community medicine, both primary and specialty. This is in line with the institution's foundational commitment to serving its surrounding communities in the Negev and building a future healthcare workforce to serve them.

13) There has been an expansion of clinical affiliates over the years, translating into a richer set of clinical training opportunities. The constellation of BGU-FOHS affiliates now encompasses Soroka University Medical Center in Beer Sheva; Barzilai University Medical Center in Ashkelon; the Mental Health Center in Beer Sheva; and Assuta Medical Centers in Tel Aviv and most recently in Ashdod. While this now constitutes a significant institutional strength, the issue of equivalency of training across these BGU-FOHS clinical affiliates merits attention. While some effort has been made to foster such equivalency—for example, faculty site visits; collection of student feedback—the medical school should be more proactive in identifying and remediating deficiencies at specific sites and settings. An empowered educational coordinator should oversee all clinical affiliates and be further tasked with addressing unevenness in offerings and sharing of best practices.

14) There is a comprehensive assessment program in place. Yet, there is considerable opportunity to elevate assessment to a next level, moving away from a traditional summative program. This could include more integrated exams, with fewer of them; sub-score performance information; documented narrative data from feedback dialogues in the

clinical years; a system for tracking and sharing academic performance across clinical rotations; a mentoring student to monitor students' academic growth; OSCE's or work-based assessment methods, as opposed to patient-based orals; and pre-test quality control on item writing and post-test psychometric analysis and review.

15) The current admission process, with a robust admissions committee and associated training, brings in highly qualified and motivated medical students. That said, there is a need to diversify admitted student demographics. Increasing the number of endowed scholarships, in conjunction with university development officers, would be one way to pave the way for students from underprivileged backgrounds. Further, the level of sophistication of the admissions process could be elevated by incorporating alternative ways of assessing non-cognitive skills that go beyond personality assessments *per se*.

16) There is no prospective longitudinal assessment of outcomes and tracking of BGU-FOHS graduates. Among other things, this would provide a way of validating the effectiveness of educational programming across both medical school tracks. Given the prominence of BGU-FOHS in the Israeli medical education ecosystem, such an effort would additionally serve as a data resource outside of BGU in shaping national health manpower policy.

The IQARC's more specific findings related to the CHE standards are embodied within the series of commendations/good practices and 57 recommendations set forth in detail in the following section. This includes recent major changes and key challenges faced by BGU-FOHS, as well as the medical school's performance during the pandemic.

Each of the CHE standards was assessed on a scale of 1 to 6, wherein a score of 6 was deemed *Good Practice*; a score of 5 was deemed *Needs Minor Improvement*; scores of 3 and 4 were deemed *Needs Major Improvement*; and scores of 1 and 2 were deemed *Standard Not Met*. Based on this scoring system, the IQARC came to the overall conclusion that the Ben Gurion University Faculty of Health Sciences meets all 11 standards set forth by the Committee on Higher Education. That said, 10 of the 11 standards are categorized as *Needs Major Improvement* (4 'Score 3'; 6 'Score 4'), and 1 of the 11 standards as *Needs Minor Improvement* (1 'Score 5').

Conclusions about the Ben Gurion University Faculty of Health Sciences

The IQARC evaluation committee reached the following conclusions about the higher education provision at the medical school at the Ben Gurion University Faculty of Health Sciences.

Israeli Standards for Medical Education

The Ben Gurion University Faculty of Health Sciences meets 11 of the 11 Israeli Standards for Medical Education, with needs for improvement on each standard detailed below.

Commendations and Good Practice

The IQARC evaluation committee identified the following areas for commendation and features of good practice at the Ben Gurion University Faculty of Health Sciences:

1) BGU is clearly a university on the move, with an impressive campus undergoing dramatic expansion, and with this growth, many opportunities for inter-disciplinary educational experiences.

2) University leaders convey an ambitious vision for the university and express a willingness to embrace medical education reform and critical self-analysis.

3) BGU-FOHS' stated mission—to be socially accountable for health services to the population of the Negev—is compelling. The opportunities for cultivating physicians with a deep sense of social responsibility are thus considerable. The social mission is further reflected in the medical school's substantive global engagement.

4) BGU-FOHS is well-positioned to distinguish itself by leveraging the remarkable and growing IT environment and ecosystem of entrepreneurship that has been building up in Beer Sheva, including a biotech cluster at the periphery of the university campus.

5) The dean of BGU-HOFS is open to suggestions for advancing the medical school's curriculum.

6) BGU-FOHS affords its students a rich academic environment with wide representation of basic scientists and clinicians across the university and affiliated hospitals, with strong representation in all fields of clinical medicine. This is bolstered by an extensive milieu of other faculties and research departments across the broader university.

7) There is a strong research faculty, as part of a robust university academic landscape and credible resourcing. The current dean is himself an established biomedical scientist.

8) Residents are highly engaged in medical student teaching, and students are advantaged educationally from the physician assistant framework.

9) There is strong coordination of teaching content during the clinical years, especially in Internal Medicine and Pediatrics. Coordination and control of uniformity is achieved by pre-course meetings and mid-course visits.

10) Students convey satisfaction with what they perceive as a friendly teaching environment.

11) All relevant fields that are required for the preclinical and clinical course of studies are covered at BGU-FOHS and its clinical affiliates.

12) Clinical departments carry an exceptional load of clinical teaching, which is especially commendable given the lack of adequate support for protected time for teaching.

13) Exposure to community medicine begins at an early stage and continues throughout all teaching years.

14) Clear faculty appointment and promotion policies and procedures are in place and are exercised.

15) Early exposure to clinical practice is appreciated by students and reinforces their sense of institutional commitment to humanism.

16) *Global Health* programming within the 4-year MSIH track is exemplary, as it confers to students an appreciation for societal challenges with a global perspective.

17) A dedicated clinical faculty is deeply vested in the education and welfare of the medical students.

18) Various committees are in place to monitor student needs.

19) Every course/rotation is extensively, summatively assessed.

20) The system for admissions to both programs of the medical school comprises cognitive and non-cognitive elements. This translates into the enrollment at BGU-FOHS of highly qualified and motivated medical students that are ready to complete medical studies and who will become high quality physicians after training.

21) Attrition is minimal through good support of students, including a *Leave of Absence* set of regulations.

22) There is a commendable large admission committee with public representatives, and there is a strong training program in place for the admission committee.

23) Students have access to their course and clerkship data for review of the exam.

24) Funding is available for student electives abroad.

25) Psychological services are available for those students needing it.

Recommendations

The IQARC evaluation committee makes the following recommendations to the Ben Gurion University Faculty of Health Sciences.

Essential:

1) Reinvigorate BGU-FOHS' original commitment and energy to educational innovation, recognizing that the school's past status as a pioneer in medical education, dating to the early years after its founding, has faded over time. The medical school's prime aspiration has *de facto* morphed from educational innovation to research excellence, and there is a sense that the medical school has lost its way when it comes to excelling in, let alone pioneering, medical education. Over the years, there were apparently opportunities to recruit expert medical educators, but university and affiliate hospital funding was not forthcoming. BGU-FOHS leadership stated that the plan is to use the *Moshe Prywes Center for Medical Education* as a framework to drive medical education reform, with initiatives such as sending educators to forefront medical education hubs like Maastricht to learn best practices. However, the funding necessary for such initiatives is yet to be secured. In the meantime, an evolutionary approach is envisioned ('*if we can do 10 courses to the new method of teaching, perhaps in 5-6 years*'). The IQARC review team views this step-wise approach as unlikely to succeed and questions whether medical school leaders are overestimating the financial investment that will be required for significant curricular reform and are too locked into a view of budget as the primary barrier.

2) Develop a well-structured strategic plan that clearly articulates mission/vision/values/ strategic objectives and sets forth milestones/action plans/timelines. These various elements tend to be conflated in the DCI self-study. During the site visit, in response to questioning about strategic planning, the dean distributed to the review team members copies of a booklet entitled "*Shaping the Future Together—The Faculty of Health Sciences, Ben-Gurion University of the Negev, Strategic Plan 2016-2030*". The document reflects output of a strategic planning process launched in November 2015 in conjunction with a strategic consulting firm called TACK Growth Strategies. Of note, this document was not highlighted in the DCI self-study *per se*, nor were its findings set forth systematically in detailed fashion. The document itself is high level and superficial; lacks detailed milestones and metrics that would ground a concrete plan of action; is not medical school-specific, as it relates to all the college's professional training programs; and is dated by five years. Within a formal strategic plan, BGU-FOHS should also bring more rigor in addressing the recommendations of the *Goldman Committee (IARC)*, by more systematically cataloguing those recommendations and developing discrete action plans around them, assuming they are still relevant.

3) Articulate BGU-FOHS's mission priorities with clarity, as they relate to advancing medical education; serving the underserved of the Negev; pioneering biomedicine; nurturing global perspectives; and so on. At the site visit, the dean stated that the original primary overarching mission—to improve healthcare in southern communities and train excellent physicians who will stay in the south and serve those communities—continues to this day. This is reassuring. However, there is concern about other mission elements. Of most concern, the substantial commitment of financial and other resources for growing the research enterprise, while under-investing into the education side of the house, suggests a *de facto* evolution in focus away from the education mission. A shift in mission prioritization is apparent in the dean's stated priorities, e.g., launching programming that would connect

medicine and engineering faculties, and a 4-year track with an obligatory PhD. The primacy of the research agenda is also reflected in the "*Shaping the Future Together*" booklet, wherein the '*Focus 1*' is '*Groundbreaking Research*'. The primary mission has clearly evolved over time, and it is now multifaceted; '*Focus 2*' is '*Leadership in Education and Training of Tomorrow's Health Professionals*' and '*Focus 3*' is '*Strategic Partnerships to Impact the Health of Individuals and Communities*'. This begs the question: have these various missions been appropriately supported financially and have curriculum and co-curriculum been adapted to fulfill them? To what mid-21st century physician(s) does BGU-FOHS aspire and gear its educational programming?

4) Convey a more grounded view of the medical school's strengths and weaknesses, as a predicate for a meaningful call to action and a clear path forward. The DCI self-study is replete with a series of bold claims that simply lack substantiating evidence and are wanting in perspective and self-awareness, by example, *'the most student friendly campus in the country'* and *'only medical school in the world (whose) main focus is Global Health'*.

5) Embrace the CHE/IQARC medical school accreditation process in a deeper way, recognizing that DCI self-studies are not last-minute sprints. Instead, accreditation should be viewed as a never-ending process of continuous self-improvement, wherein internal and external quality assurance are aligned, and strategic plans are crafted and executed systematically, monitored continuously, allow for critical self-analysis, and importantly, survive dean transitions. Oversight of performance to accreditation standards should be overseen by active, empowered senior faculty and administrative staff, with due accountability. BGU-FOHS should identify a lead coordinator for overseeing this process who can visit exemplary medical schools in the world and observe first-hand how the re-accreditation journey is handled. BGU-FOHS might also consider inviting an external review team to the campus mid-way through the re-accreditation cycle to assess status and propose mid-course corrections. This recommendation is particularly pressing given that there was no diligent follow-up to the findings of the 2014 accreditation review under the CHE's auspices. The present DCI self-study fails to account for those previous recommendations, which remain as relevant today as they were back then.

6) Align financial decision-making between the university and the medical school to address critical educational imperatives in an effective way. Finances and funds flows are clearly stressors for BGU-FOHS, as the dean's cover letter within the DCI self-study lists as one of the '*major limitations'*: '*Lack of transparency from the BGU administration with respective to annual funding decisions hinders the FOHS ability to plan long term*'. This raises the core question of whether certain resource-demanding recommendations of an IQARC review panel can be implemented, and whether the dean will have the necessary budgetary latitude. Further, beyond finances per se, the dean at BGU-FOHS, as is the case for other Israeli medical school deans, is constrained in his authority around faculty appointments/promotion. This could hamper some of the faculty recruitment that will be required to drive curricular reform.

7) Address lack of continuity in dean leadership staff during dean transitions, as well as the pressing need to sustain commitment to longer-term strategic goals. This is particularly important given that dean terms at BGU-FOHS are three years. Of note, the current dean assumed his role in the summer of 2020 and was thus in a most challenging position, as it was on the threshold of the present IQARC medical school review and amidst a pandemic. The dean is a recognized scientist with international stature, but as a PhD, he will obviously require input on guiding the medical education continuum, particularly as it relates to the

clinical education component. The DCI self-study notes that the Vice Dean represents the dean's clinical complement, although Table 2.5-2 indicates that his administrative effort is only 30%.

8) Consider organizational restructuring steps to streamline curricular transformation, for example, within a restructured Department of Medical Education, that would additionally provide a home for faculty recruits who are experts in education science. This will entail reorganizing the various committees dealing with education into a more coordinated unit, that serves to integrate all aspects of curricular governance and streamlines the path towards significant curricular reform and co-curricular enrichment. This reorganization will require unwavering support from the dean and his senior administrative team, and it will call for an embrace of a broad transformation agenda and meticulous long-range planning, as opposed to the current approach of small incremental changes. In other words, a revolution mindset is required now, as opposed to one of evolution. On the positive side, both junior and senior faculty members express their openness to such transformation and recognize the need to rebuild the school's medical education expertise, and in the process, reignite a passion for medical education innovation. Assembling a cadre of faculty with education science expertise will be key. A solid departmental structure will serve to catalyze the meticulous preparation and implementation that is now required for profound curricular transformation.

9) Commit to and implement a fully competency-based medical curriculum (CBME), which at this stage must viewed as a pressing imperative. While the DCI self-study does identify competencies, this is set forth in an isolated table (Table 6.1.1, p. 57), which neither specifies how competencies are taught nor how they are assessed. When moving to a CBME, there should be a comprehensive system of work-based assessment, with documented feedback.

10) Map curricular content against competencies in a systematic and comprehensive fashion across the pre-clinical and clinical continuum.

11) Reduce contact hours and implement a more comprehensive approach to active learning. A significant portion of students' time should be freed up to promote self-directed, active learning. Currently, small group learning represents a small proportion of the learning experience, and self-directed learning is rarely used. Time devoted to self-directed learning should be systematically monitored

12) Consider transitioning from a semester-based to a block-based system as early as possible in the curriculum.

13) Introduce more horizontal and vertical integration in the pre-clinical years to balance the department-centric culture.

14) Revise the compendium of evaluation parameters for clinical rotations by adding key indicators that are missing, such as ones related to whether students receive feedback, are observed during different interactions with patients, engage in team-based learning, and are treated with respect.

15) Develop a portfolio for continuous and longitudinal dialogue between learners and teachers.

16) Add educational programming to address, develop and assess reflective abilities. Reflective practice, which is essential for contemporary medical education, is not mentioned in the DCI

self-study.

17) Develop communication skills longitudinally, with attention to how communication skills, along with clinical skills and clinical reasoning, are observed (how many, by whom), developed (who provides feedback, when), and assessed. Longitudinal follow-up of students should be well-organized and span years to help students continuously grow their abilities. To this end, BGU-FOHS can leverage its early exposure to practice-with-intention, with focus on communication skills and professionalism in the pre-clinical years. Overarching objectives of communication skills training and the approach to longitudinal threading of this competency should be clearly articulated. Though the DCI self-study states that BGU-FOHS has spent many years developing programming on communication skills within medicine, it does not offer clear design, goals, and processes. Principals and the behaviors taught should be set forth, as how they will be subject to longitudinal formative and summative assessment.

18) Invest in formal faculty development and require all clinical faculty to engage in a longitudinal, rigorous faculty development process that leads to certification and becomes a promotion criterion. Over time, this will build clinical education capacity for the whole system. Of note, currently available activities are poorly attended. Single 'workshops' and episodic programming are ineffective. More structured *teach-the-teachers* will foster equivalency of training across the various clinical affiliate sites. Mandatory faculty development of clinical instructors should focus on the clerkship educational goals, bedside teaching, active learning, observation skills, work-based assessment, feedback, communication skills, and aligning clinical instructors with what students were taught in the pre-clinical years. Faculty recognize that this is lacking. Structured faculty development will cultivate over time a sense that their educational contributions are appreciated by the medical school and that their teaching is more than '*volunteering*', as they juggle this role with their substantial clinical obligations.

19) Establish a promotion track for clinical educators and ensure that it meets the needs of a range of faculty stakeholders.

20) Recruit more faculty with a medical education focus, as well as some with an understanding of contemporary education science. A core group of such faculty will convey medical education literacy across the faculty and serve as catalysts for educational innovation. Without such faculty, who can additionally solicit insights from institutions abroad who have successfully implemented competency-based curricula, it is hard to see how BGU-FOHS can effectively orchestrate a comprehensive curricular transformation agenda in all its dimensions.

21) Increase the ambulatory/community component of clinical training, given that outpatient medicine is under-represented in the curriculum. While some clerkships do have ambulatory/community experiences, the percentage is low. This will require a well-developed plan. The DCI self-study alludes to this issue, referring to it as a '*lacuna*' and alluding to a role for the curriculum committee, class representatives and clerkship instructors in monitoring time students spend in both ambulatory and inpatient settings, but a meaningful plan to achieve this goal is not set forth.

22) Align best practices between the 6- and 4-year tracks, and where there are differences, account for them. For example, the 4-year track, but not the 6-year one, offers two days of simulations related to cross-cultural issues and psychosocial matters. Interprofessional

education experiences are there for the 6-year, but apparently not for the 4-year track. There are major differences between the two tracks on the way societal matters are addressed. For example, while disparities in healthcare is taught in the 6-year track's *Ethics* and *Physician and Society* courses, the 4-year track addresses the subject in the *On Being a Doctor* course and in various global health offerings. This difference is of particular interest since 4-year program students apparently want more exposure and understanding of regional population needs, while 6-year program students would like more global learning. Yet another example are the subjects of nutrition and treating the elderly which are apparently addressed only in the 4-year track as core curricular elements (albeit treating the elderly is there as an elective for the 6-year program). Key subjects should be addressed in both tracks, with translation of best practices between the two.

23) Expand training in research methods that goes beyond biostatistics. Students feel there is limited guidance for their research endeavors. Revise the research thesis requirement to better articulate and elevate expectations of scholarly inquiry and provide protected time for the students' research activity. There is a general sense among the 6-year students of little encouragement for their research activities. Rigor should be added to the MD thesis so that it is not perceived as small and insignificant. A structured approach for instilling a research component in the 4-year program should also be developed.

24) Rethink the approach to inter-professional education (IPE), including timing within the curriculum, the number of encounters, and their relevance for working inter-professionally. Only two experiences are mentioned in the DCI self-study, and while some initiatives are contemplated for enhancing IPE, there is no clear plan set forth for overcoming problems to-date in implementing them and addressing students complaints. A comprehensive IPE plan should be developed and consider adding social workers and occupational therapists to IPE processes.

25) Coordinate education across all clinical affiliate sites to ensure equivalency of training. While some effort has been made to foster such equivalency (e.g., faculty site visits, collection of student feedback), BGU-FOHS should be more active in identifying deficiencies at specific sites/settings and taking appropriate corrective action in a timely fashion. Differences are noted in the DCI self-study—for instance, only one department has an exceptional journal club, and another is mentioned for its thorough syllabi—yet no clear plan is offered to share best practices across sites, instead vaguely stating that there is a plan to '*assist in sharpening this matter*. There should be a designated and empowered educational coordinator overseeing all the clinical affiliates, along with a more systematic approach to site visiting clinical clerkships. Clarity should be brought to how academic issues and unevenness in offerings (e.g., quality of grand rounds) at the various clinical sites are handled.

26) Establish clear and systematic processes for monitoring students with difficulties and develop clear approaches for remediation. Best practice for remediation identifies underlying causes of the difficulty and configures individualized remediation with timelines and accountability plans.

27) Develop a process to review medical education program objectives, ensure the horizontal and vertical integration of curriculum content, and monitor the overall quality and outcomes of all required learning. This cannot be done through student evaluations alone.

28) Ensure that there is a systematic approach for internal quality assurance, with PDSA (Plan, Do, Study, Act) cycles closing the loop of evaluation and addressing the requirements of

external quality assurance.

29) Clarify and verify the different ways medical knowledge is assessed. As part of this, reconsider the assessment *of* learning program and shift it more of an assessment *for* learning program. The assessment program is a traditional summative program with many hurdles. Adopt a competency framework and map all assessment activities to these competencies. Copy some of the diversity of assessment methods from the 4-year MSIH program to the 6-year program (e.g., narratives).

30) Create more integrated exams and significantly reduce the number of exams. In the preclinical phase of the curriculum, 54 exams are counted.

31) Increase meaningful feedback to students for better learning from assessments (grades are a poor form of feedback). For example, provide sub-score performance information on blueprints of individual tests, where the individual performance is related to the performance of the cohort.

32) Use documented narrative data from feedback dialogues in the clinical years to inform complex skills such as professionalism, communication, teamwork, leadership, and so on. Try not to merely capture clinical skills in checklists.

33) Implement a system for tracking and sharing academic performance across clinical rotations. Monitoring growth of competencies in clinical years requires carrying over information from one rotation to the other to improve continued learning.

34) Consider introducing a mentoring system to monitor student's academic growth and enhance reflective and self-directive learning.

35) Replace older methods of assessment (patient-based orals) with more modern ones, such as OSCEs or work-based assessment methods. In particular, the latter would fit best to a CBME approach to assessment.

36) Introduce pretest quality control on item writing and post-test psychometric analysis and review.

37) Work with CHE to develop paths for diversifying admitted student demographics, including minority groups and those from underprivileged backgrounds.

38) Incorporate into the admission process alternative ways of assessing non-cognitive skills that go beyond personality assessments *per se*, e.g., written Situational Judgment Tests (SJT) and replace the current interviewing with *Multiple Mini Interviews (MMIs)*.

<u>Important</u>:

39) Inventory the extensive academic assets of the parent university and the home city's hi-tech infrastructure and then develop a plan for leveraging these assets for co-curricular enrichment and unique educational programming and training pathways. There is untapped potential for significant, even world-class educational innovation.

40) Address the lack of current MOU's and affiliation agreements with some of BGU-FOHS's clinical teaching hospitals.

41) Establish a structured committee that develops comprehensive conflict-of-interest and conflict-of-commitment policies and then oversees them within BGU-FOHS.

42) Implement a system for longitudinal tracking of BGU-FOHS graduates and educational outcomes. Given that a national goal is to build Israel's physician workforce, medical school-specific data as to numbers of graduates practicing in Israel, types of medicine practiced, and kinds of clinical settings and institutions at which they work are crucial for proper assessment and planning.

43) Introduce a more structured mechanism to evaluate performance of administrative leaders within BGU-FOHS.

44) Add rigor to the research experience of medical students, with protected time.

45) Broaden exposure to primary and specialty clinical teaching in the community and explore ways to increase time spent in primary care and specialty care clinics in the community. This would have the added dividend of lessening the load of teaching carried by a relatively small number of clinical teaching departments.

46) Reintroduce basic scientists in advanced stages of the clinical years, so that it mirrors the participation of clinicians in some of the pre-clinical courses. This will serve to reinforce the basic science-clinical science nexus.

47) Monitor and deal with Clalit's stated plan to reduce the size of the library.

48) Increase the number of electives in the 6-year track, including international elective opportunities. There are currently too few electives in that track and no requirement for diversity within them. There are lessons to be learned in this regard from the 4-year MSIH program.

49) Address student concerns about curricular overloading, for example, in the 2nd year of the 6-year program.

50) Commit to teach critical issues related to regional health disparities and cultural competence and develop a well-coordinated approach to this end. The DCI self-study does not describe with sufficient clarity the various offerings dealing with this subject area. Titles of important topics are set forth (e.g., societal problems, caring for the disabled, population-based medicine, wellness, determinants of health), but there is no detailing of how they are taught or assessed. Other important topics, such as professionalism, humanistic values, and leadership are not mentioned at all. Some of these are referred to in the context of the clinical years, but it is unclear whether they are discrete courses or simply topics that should be touched on in clinical rotations. If the latter, how is it verified that they are indeed being taught? A clear articulation of overarching goals and specific topics is needed upfront.

Desirable:

51) Address inadequacies of devoted student spaces at clinical sites.

52) Partner with university-level development officers to create a meaningful number of endowed scholarships.

53) Permit students to review their narrative assessments.

54) Consider motivation to be a key criterion for admission to foreign electives instead of grades.

55) Copy the 4-year MSIH track's career advising for the 6-year track.

56) Provide an explanation for the 10% dropout rate and take actions accordingly.

57) Translate from Hebrew to English key documents in DCI self-studies. By example, the bylaws and conflict-of-interest policy documents in the appendix were in Hebrew only.

Explanation of the findings about the Ben Gurion University Faculty of Medicine

This section expands upon some of the review findings set forth within the recommendations set forth above.

Standard 1: Mission, Planning, Organization, and Integrity

A medical school has a written statement of mission and goals for the medical education program, conducts ongoing planning, and has written bylaws that describe an effective organizational structure and governance process. In the conduct of all internal and external activities, the medical school demonstrates integrity through its consistent and documented adherence to fair, impartial, and effective processes, policies, and practices.

Provide summary of the commendations and good practices relevant to this standard

- BGU is clearly a university on the move, with an impressive campus undergoing dramatic expansion, and with this growth, many opportunities for inter-disciplinary educational experiences.

- University leaders convey an ambitious vision for the university and express a willingness to embrace medical education reform and critical self-analysis.

- BGU-FOHS's stated mission—to be socially accountable for health services to the population of the Negev—is compelling. The opportunities for cultivating physicians with a deep sense of social responsibility are thus considerable. The social mission is further reflected in the medical school's substantive global engagement.

- BGU-FOHS is well-positioned to distinguish itself by leveraging the remarkable and growing IT environment and ecosystem of entrepreneurship that has been building up in Beer Sheva, including a biotech cluster at the periphery of the university campus.

Provide summary of the recommendations relevant to this standard

- Reinvigorate BGU-FOHS' original commitment and energy to educational innovation, recognizing that the school's past status as a pioneer in medical education, dating to the early years after its founding, has faded over time. The medical school's prime aspiration has *de facto* morphed from educational innovation to research excellence, and there is a sense that the medical school has lost its way when it comes to excelling in, let alone pioneering, medical education. Over the years, there were apparently opportunities to recruit expert medical educators, but university and affiliate hospital funding was not forthcoming. BGU-FOHS leadership stated that the plan is to use the *Moshe Prywes Center for Medical Education* as a framework to drive medical education reform, with initiatives such as sending educators to forefront medical education hubs like Maastricht to learn best practices. However, the funding necessary for such initiatives is yet to be secured. In the meantime, an evolutionary approach is envisioned ('*if we can do 10 courses to the new method of teaching, perhaps in 5-6 years*'). The IQARC review team views this step-wise approach as unlikely to succeed and questions whether medical school leaders are overestimating the financial investment that will be required for significant curricular reform and are too locked

into a view of budget as the primary barrier.

- Develop a well-structured strategic plan that clearly articulates mission/vision/values/ strategic objectives and sets forth milestones/action plans/timelines. These various elements tend to be conflated in the DCI self-study. During the site visit, in response to questioning about strategic planning, the dean distributed to the review team members copies of a booklet entitled "*Shaping the Future Together—The Faculty of Health Sciences, Ben-Gurion University of the Negev, Strategic Plan 2016-2030*". The document reflects output of a strategic planning process launched in November 2015 in conjunction with a strategic consulting firm called TACK Growth Strategies. Of note, this document was not highlighted in the DCI self-study *per se*, nor were its findings set forth systematically in detailed fashion. The document itself is high level and superficial; lacks detailed milestones and metrics that would ground a concrete plan of action; is not medical school-specific, as it relates to all the college's professional training programs; and is dated by five years. Within a formal strategic plan, BGU-FOHS should also bring more rigor in addressing the recommendations of the *Goldman Committee (IARC)*, by more systematically cataloguing those recommendations and developing discrete action plans around them, assuming they are still relevant.

- Articulate BGU-FOHS' mission priorities with clarity, as they relate to advancing medical education; serving the underserved of the Negev; pioneering biomedicine; nurturing global perspectives; and so on. At the site visit, the dean stated that the original primary overarching mission—to improve healthcare in southern communities and train excellent physicians who will stay in the south and serve those communities—continues to this day. This is reassuring. However, there is concern about other mission elements. Of most concern, the substantial commitment of financial and other resources for growing the research enterprise, while under-investing into the education side of the house, suggests a *de facto* evolution in focus away from the education mission. A shift in mission prioritization is apparent in the dean's stated priorities, e.g., launching programming that would connect medicine and engineering faculties, and a 4-year track with an obligatory PhD. The primacy of the research agenda is also reflected in the "*Shaping the Future Together*" booklet, wherein the '*Focus 1*' is '*Groundbreaking Research*'. The primary mission has clearly evolved over time, and it is now multifaceted; '*Focus 2*' is '*Leadership in Education and Training of Tomorrow's Health Professionals*' and '*Focus 3*' is '*Strategic Partnerships to Impact the Health of Individuals and Communities*'. This begs the question: have these various missions been appropriately supported financially and have curriculum and co-curriculum been adapted to fulfill them? To what mid-21st century physician(s) does BGU-FOHS aspire and gear its educational programming?

- Convey a more grounded view of the medical school's strengths and weaknesses, as a predicate for a meaningful call to action and a clear path forward. The DCI self-study is replete with a series of bold claims that simply lack substantiating evidence and are wanting in perspective and self-awareness, by example, *'the most student friendly campus in the country'* and *'only medical school in the world (whose) main focus is Global Health'*.

- Embrace the CHE/IQARC medical school accreditation process in a deeper way, recognizing that DCI self-studies are not last-minute sprints. Instead, accreditation should be viewed as a never-ending process of continuous self-improvement, wherein internal and external quality assurance are aligned, and strategic plans are crafted and executed systematically, monitored continuously, allow for critical self-analysis, and importantly, survive dean transitions. Oversight of performance to accreditation standards should be overseen by

active, empowered senior faculty and administrative staff, with due accountability. BGU-FOHS should identify a lead coordinator for overseeing this process who can visit exemplary medical schools in the world and observe first-hand how the re-accreditation journey is handled. BGU-FOHS might also consider inviting an external review team to the campus mid-way through the re-accreditation cycle to assess status and propose mid-course corrections. This recommendation is particularly pressing given that there was no diligent follow-up to the findings of the 2014 accreditation review under the CHE's auspices. The present DCI self-study fails to account for those previous recommendations, which remain as relevant today as they were back then.

- Inventory the extensive academic assets of the parent university and the home city's hi-tech infrastructure and then develop a plan for leveraging these assets for co-curricular enrichment and unique educational programming and training pathways. There is untapped potential for significant, even world-class educational innovation.

- Address the lack of current MOU's and affiliation agreements with some of BGU-FOHS's clinical teaching hospitals.

- Establish a structured committee that develops comprehensive conflict-of-interest and conflict-of-commitment policies and then oversees them within BGU-FOHS.

- Implement a system for longitudinal tracking of BGU-FOHS graduates and educational outcomes. Given that a national goal is to build Israel's physician workforce, medical school-specific data as to numbers of graduates practicing in Israel, types of medicine practiced, and kinds of clinical settings and institutions at which they work are crucial for proper assessment and planning.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 1 is met, albeit *needs major improvement* (Score 4).

❖ The score that the institution gave itself in this standard:

Unsatisfactory				Satisfactory	
1	2	3	4	**5**	6

❖ The score that the committee gives the institution in this standard:

Unsatisfactory				Satisfactory	
1	2	3	**4**	5	6

Standard 2: Leadership and Administration

A medical school has a sufficient number of faculty in leadership roles and of senior administrative staff with the skills, time, and administrative support necessary to achieve the goals of the medical education program and to ensure the functional integration of all programmatic components.

Provide summary of the commendations and good practices relevant to this standard

- The dean of BGU-FOHS is open to suggestions for advancing the medical school's curriculum.

Provide summary of the recommendations relevant to this standard

- Align financial decision-making between the university and the medical school to address critical educational imperatives in an effective way. Finances and funds flow is clearly a stressor for BGU-FOHS, as the dean's cover letter within the DCI self-study lists as one of the '*major limitations*': '*Lack of transparency from the BGU administration with respective to annual funding decisions hinders the FOHS ability to plan long term*'. This raises the core question of whether certain resource-demanding recommendations of an IQARC review panel can be implemented, and whether the dean will have the necessary budgetary latitude. Further, beyond finances per se, the dean at BGU-FOHS, as is the case for other Israeli medical school deans, is constrained in his authority around faculty appointments/promotion. This could hamper some of the faculty recruitment that will be required to drive curricular reform.

- Address lack of continuity in dean leadership staff during dean transitions, as well as the pressing need to sustain commitment to longer-term strategic goals. This is particularly important given that dean terms at BGU-FOHS are three years. Of note, the current dean assumed his role in the summer of 2020 and was thus in a most challenging position, as it was on the threshold of the present IQARC medical school review and amidst a pandemic. The dean is a recognized scientist with international stature, but as a PhD, he will obviously require input on guiding the medical education continuum, particularly as it relates to the clinical education component. The DCI self-study notes that the Vice Dean represents the dean's clinical complement, although Table 2.5-2 indicates that his administrative effort is only 30%.

- Introduce a more structured mechanism to evaluate performance of administrative leaders within BGU-FOHS.

- Consider organizational restructuring steps to streamline curricular transformation, for example, within a restructured Department of Medical Education, that would additionally provide a home for faculty recruits who are expert in education science.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 2 is met, albeit *needs major improvement* (Score 4).

❖ The score that the institution gave itself in this standard:

Unsatisfactory				Satisfactory	
1	2	3	4	**5**	6

❖ The score that the committee gives the institution in this standard:

Unsatisfactory				Satisfactory	
1	2	3	**4**	5	6

Standard 3: Academic and Learning Environments

A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments, recognizes the benefits of diversity, and promotes students' attainment of competencies required of future physicians.

Provide summary of the commendations and good practices relevant to this standard

- BGU-FOHS affords its students a rich academic environment with wide representation of basic scientists and clinicians across the university and affiliated hospitals, with strong representation in all fields of clinical medicine. This is bolstered by an extensive milieu of other faculties and research departments across the broader university.

- There is a strong research faculty, as part of a robust university academic landscape and credible resourcing. The current dean himself is an established biomedical scientist.

- Residents are highly engaged in medical student teaching, and students are advantaged educationally from the physician assistant framework.

- There is strong coordination of teaching content during the clinical years, especially in Internal Medicine and Pediatrics. Coordination and control of uniformity is achieved by pre-course meetings and mid-course visits.

- Students convey satisfaction with what they perceive as a friendly teaching environment.

Provide summary of the recommendations relevant to this standard

- Regain a leading position in medical education by reviving the Department of Medical Education and addressing educational faculty needs. This will require unwavering support from the dean and his senior administrative team, and it will call for an embrace of a broad transformation agenda and meticulous long-range planning, as opposed to the current approach of small incremental changes. In other words, a revolution mindset is required now, as opposed to one of evolution. On the positive side, both junior and senior faculty members express their openness to such transformation and recognize the need to rebuild the school's medical education expertise, and in the process, reignite a passion for medical education innovation. Assembling a cadre of faculty with education science expertise will be key. A solid departmental structure will serve to catalyze the meticulous preparation and implementation that is now required for profound curricular transformation.

- Add rigor to the research experience of medical students, with protected time.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 3 is met, albeit *needs major improvement* (Score 4).

❖ The score that the institution gave itself in this standard:

Unsatisfactory					Satisfactory
1	2	3	**4**	5	6

❖ The score that the committee gives the institution in this standard:

Unsatisfactory					Satisfactory
1	2	3	**4**	5	6

Standard 4: Faculty Preparation, Productivity, Participation, and Policies

The faculty members of a medical school are qualified through their education, training, experience, and continuing professional development, to provide the leadership and support necessary to attain the institutions educational, research, and service goals.

Provide summary of the commendations and good practices relevant to this standard

- All relevant fields that are required for the preclinical and clinical course of studies are covered at BGU-FOHS and its clinical affiliates.
- Clinical departments carry an exceptional load of clinical teaching, which is especially commendable given the lack of adequate support for protected time for teaching.
- Exposure to community medicine begins at an early stage and continues throughout all teaching years.
- Clear faculty appointment and promotion policies and procedures are in place and are exercised.

Provide summary of the recommendations relevant to this standard

- Implement mandatory, longitudinal faculty preparation and train-the-trainer activities. Of note, currently available activities are poorly attended.
- Establish a promotion track for clinical educators and ensure that it meets the needs of a range of faculty stakeholders.
- Increase student exposure to community medicine.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 4 is met, albeit *needs major improvement* (Score 4).

- The score that the institution gave itself in this standard:

Unsatisfactory					Satisfactory
1	2	3	**4**	5	6

- The score that the committee gives the institution in this standard:

Unsatisfactory					Satisfactory
1	2	3	**4**	5	6

Standard 5: Educational Resources and Infrastructure

A medical school has sufficient personnel, financial resources, physical facilities, equipment, and clinical, instructional, informational, technological, and other resources readily available and accessible across all locations to meet its needs and to achieve its goals.

Provide summary of the commendations and good practices relevant to this standard

- An exceptional effort is exerted by the relatively small number of clinical departments to enable all required clinical clerkships.
- There is a highly committed pre-clinical and clinical teaching staff, who are deeply engaged with, and show significant caring for, the professional and personal development of BGU-FOHS' medical students.

Provide summary of the recommendations relevant to this standard

- Broaden exposure to primary and specialty clinical teaching in the community.
- Explore ways to increase time spent in primary care and specialty care clinics in the community. This would have the added dividend of lessening the load of teaching carried by a relatively small number of clinical teaching departments.
- Reintroduce basic scientists in advanced stages of the clinical years, so that it mirrors the participation of clinicians in some of the pre-clinical courses. This will serve to reinforce the basic science-clinical science nexus.
- Address inadequacies of devoted student spaces at clinical sites.
- Monitor and deal with Clalit's stated plan to reduce the size of the library.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 5 is met, albeit *needs major improvement* (Score 4).

- ❖ The score that the institution gave itself in this standard:

Unsatisfactory				Satisfactory	
1	2	**3**	4	5	6

❖ The score that the committee gives the institution in this standard:

Unsatisfactory				Satisfactory	
1	2	3	**4**	5	6

Standard 6: Competencies, Curricular Objectives, and Curricular Design

The faculty of a medical school define the competencies to be achieved by its medical students through medical education program objectives and is responsible for the detailed design and implementation of the components of a medical curriculum that enable its medical students to achieve those competencies and objectives. Medical education program objectives are statements of the knowledge, skills, behaviours, and attitudes that medical students are expected to exhibit as evidence of their achievement by completion of the program.

Provide summary of the commendations and good practices relevant to this standard

- Early exposure to clinical practice is appreciated by students and reinforces their sense of institutional commitment to humanism.

Provide summary of the recommendations relevant to this standard

- Commit to and implement a fully competency-based medical curriculum (CBME), which at this stage must viewed as a pressing imperative. While the DCI self-study does identify competencies, this is set forth in an isolated table (Table 6.1.1, p. 57), which neither specifies how competencies are taught nor how they are assessed. When moving to a CBME, there should be a comprehensive system of work-based assessment, with documented feedback.

- Map curricular content against competencies in a systematic and comprehensive fashion across the pre-clinical and clinical continuum.

- Reduce contact hours and implement a more comprehensive approach to active learning. A significant portion of students' time should be freed up to promote self-directed, active learning. Currently, small group learning represents a small proportion of the learning experience, and self-directed learning is rarely used. Time devoted to self-directed learning should be systematically monitored

- Consider transitioning from a semester-based to a block-based system as early as possible in the curriculum.

- Introduce more horizontal and vertical integration in the pre-clinical years to balance the department-centric culture.

- Revise the compendium of evaluation parameters for clinical rotations by adding key indicators that are missing, such as ones related to whether students receive feedback, are observed during different interactions with patients, engage in team-based learning, and are treated with respect.

- Develop a portfolio for continuous and longitudinal dialogue between learners and teachers.

- Add educational programming to address, develop and assess reflective abilities. Reflective practice, which is essential for contemporary medical education, is not mentioned in the DCI self-study.

- Develop communication skills longitudinally, with attention to how communication skills, along with clinical skills and clinical reasoning, are observed (how many, by whom), developed (who provides feedback, when), and evaluated. Longitudinal follow-up of students should be well-organized and span years to help students continuously grow their abilities. To this end, BGU-FOHS can leverage its early exposure to practice-with-intention, with focus on communication skills and professionalism in the pre-clinical years. Overarching objectives of communication skills training and the approach to longitudinal threading of this competency should be clearly articulated. Though the DCI self-study states that BGUFOHS has spent many years developing programming on communication skills within medicine, it does not offer clear design, goals, and processes. Principals and the behaviors taught should be set forth, as how they will be subject to longitudinal formative and summative assessment.

- Reorganize the various committees dealing with education into a more coordinated unit, perhaps as a formal Department of Medical Education, that serves to integrate all aspects of curricular governance and streamlines the path towards significant curricular reform and co-curricular enrichment.

- Invest in formal faculty development and require all clinical faculty to engage in a longitudinal, rigorous faculty development process that leads to certification and becomes a promotion criterion. Over time, this will build clinical education capacity for the whole system. Single 'workshops' and episodic programming are ineffective. More structured *teach-the-teachers* will foster equivalency of training across the various clinical affiliate sites. Mandatory faculty development of clinical instructors should focus on the clerkship educational goals, bedside teaching, active learning, observation skills, work-based assessment, feedback, communication skills, and aligning clinical instructors with what students were taught in the pre-clinical years. Faculty recognize that this is lacking. Structured faculty development will cultivate over time a sense that their educational contributions are appreciated by the medical school and that their teaching is more than '*volunteering*', as they juggle this role with their substantial clinical obligations.

- Recruit more faculty with a medical education focus, as well as some with an understanding of contemporary education science. A core group of such faculty will convey medical education literacy across the faculty and serve as catalysts for educational innovation. Without such faculty, who can additionally solicit insights from institutions abroad who have successfully implemented competency-based curricula, it is hard to see how BGUFOHS can effectively orchestrate a comprehensive curricular transformation agenda in all its dimensions.

- Increase the ambulatory/community component of clinical training, given that outpatient medicine is under-represented in the curriculum. While some clerkships do have ambulatory/community experiences, the percentage is low. This will require a well-developed plan. The DCI self-study alludes to this issue, referring to it as a '*lacuna*' and alluding to a role for the curriculum committee, class representatives and clerkship instructors in monitoring time students spend in both ambulatory and inpatient settings, but a meaningful plan to achieve this goal is not set forth.

- Increase the number of electives in the 6-year track, including international elective opportunities. There are currently too few electives in that track and no requirement for diversity within them. There are lessons to be learned in this regard from the 4-year MSIH program.

- Address student concerns about curricular overloading, for example, in the 2nd year of the 6-year program.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 6 is met, albeit *needs major improvement* (Score 3).

❖ The score that the institution gave itself in this standard:

Unsatisfactory					Satisfactory
1	2	3	**4**	5	6

❖ The score that the committee gives the institution in this standard:

Unsatisfactory					Satisfactory
1	2	**3**	4	5	6

Standard 7: Curricular Content

The faculty of a medical school ensures that the medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine.

Provide summary of the commendations and good practices relevant to this standard

- *Global Health* programming within the 4-year MSIH track is exemplary, as it confers to students an appreciation for societal challenges with a global perspective.

Provide summary of the recommendations relevant to this standard

- Introduce basic science content into the clinical years, deploying basic scientists where appropriate. Engagement of basic scientists in this way would mirror and nicely complement the current contributions of clinicians in some of the pre-clinical courses.

- Commit to teach critical issues related to regional health disparities and cultural competence and develop a well-coordinated approach to this end. The DCI self-study does not describe with sufficient clarity the various offerings dealing with this subject area. Titles of important topics are set forth (e.g., societal problems, caring for the disabled, population-based medicine, wellness, determinants of health), but there is no detailing of how they are taught or assessed. Other important topics, such as professionalism, humanistic values, and leadership are not mentioned at all. Some of these are referred to in the context of the clinical years, but it is unclear whether they are discrete courses or simply topics that should be touched on in clinical rotations. If the latter, how is it verified that they are indeed being taught. A clear articulation of overarching goals and specific topics is needed upfront.

- Align best practices between the 6- and 4-year tracks, and where there are differences, account for them. For example, the 4-year track, but not the 6-year one, offers two days of simulations related to cross-cultural issues and psychosocial matters. Interprofessional education experiences are there for the 6-year, but apparently for the 4-year track. There are major differences between the two tracks on the way societal matters are addressed. For example, while disparities in healthcare is taught in the 6-year track's *Ethics* and *Physician and Society* courses, the 4-year track addresses the subject in the *On Being a Doctor* course and in various global health offerings. This difference is of particular interest since 4-year program students apparently want more exposure and understanding of regional population needs, while 6-year program students would like more global learning. Yet other examples are the subjects of nutrition and treating the elderly which are apparently addressed only in the 4-year track as core curricular elements (albeit treating the elderly is there as an elective for the 6-year program). Key subjects should be addressed in both tracks, with translation of best practices between the two.

- Expand training in research methods that goes beyond biostatistics. Students feel there is limited guidance for their research endeavors. Revise the research thesis requirement to better articulate and elevate expectations of scholarly inquiry and provide protected time for the students' research activity. There is a general sense among the 6-year students of little encouragement for their research activities, and that the MD thesis is small and insignificant.

Why is the research thesis graded only fail, pass and honors? A structured approach for instilling a research component in the 4-year program should also be developed.

- Rethink the approach to inter-professional education (IPE), including timing within the curriculum, the number of encounters, and their relevance for working inter-professionally. Only two experiences are mentioned in the DCI self-study, and while some initiatives are contemplated for enhancing IPE, there is no clear plan set forth for overcoming problems to-date in implementing them and addressing students complaints. A comprehensive IPE plan should be developed and consider adding social workers and occupational therapists to IPE processes.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 7 is met, albeit *needs major improvement* (Score 3).

❖ The score that the institution gave itself in this standard:

Unsatisfactory					Satisfactory
1	2	3	**4**	5	6

❖ The score that the committee gives the institution in this standard:

Unsatisfactory					Satisfactory
1	2	**3**	4	5	6

Standard 8: Curricular Management, Evaluation, and Enhancement

The faculty of a medical school engages in curricular revision and program evaluation activities to ensure that the medical education program quality is maintained and enhanced and that medical students achieve all medical education program objectives and participate in required clinical experiences and settings.

Provide summary of the commendations and good practices relevant to this standard

- A dedicated clinical faculty is deeply vested in the education and welfare of the medical students.
- Various committees are in place to monitor student needs.

Provide summary of the recommendations relevant to this standard

- Coordinate education across all clinical affiliate sites to ensure equivalency of training. While some effort has been made to foster such equivalency (e.g., faculty site visits, collection of student feedback), BGU-FOHS should be more active in identifying deficiencies at specific sites/settings and taking appropriate corrective action in a timely fashion. Differences are noted in the DCI self-study—for instance, only one department has an exceptional journal club, and another is mentioned for its thorough syllabi—yet no clear plan is offered to share best practices across sites, instead vaguely stating that there is a plan to '*assist in sharpening this matter*. There should be a designated and empowered educational coordinator overseeing all the clinical affiliates, along with a more systematic approach to site visiting clinical clerkships. Clarity should be brought to how academic issues and unevenness in offerings (e.g., quality of grand rounds) at the various clinical sites are handled.
- Establish clear and systematic processes for monitoring students with difficulties and develop clear approaches for remediation. Best practice for remediation identifies underlying causes of the difficulty and configures individualized remediation with timelines and accountability plans.
- Develop a process to review medical education program objectives, ensure the horizontal and vertical integration of curriculum content, and monitor the overall quality and outcomes of all required learning. This cannot be done through student evaluations alone.
- Ensure that there is a systematic approach for internal quality assurance, with PDSA (Plan, Do, Study, Act) cycles closing the loop of evaluation and addressing the requirements of external quality assurance.
- Clarify and verify the different ways medical knowledge is assessed.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 8 is met, albeit *needs major improvement* (Score 3).

The score that the institution gave itself in this standard:

Unsatisfactory					Satisfactory
1	2	3	**4**	5	6

- The score that the committee gives the institution in this standard:

Unsatisfactory					Satisfactory
1	2	**3**	4	5	6

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

A medical school ensures that its medical education program includes a comprehensive, fair, and uniform system of formative and summative medical student assessment and protects medical students' and patients' safety by ensuring that all persons who teach, supervise, and/or assess medical students are adequately prepared for those responsibilities.

Provide summary of the commendations and good practices relevant to this standard

- The assessment program is comprehensive and deals with all elements of the curriculum content.
- Every course/rotation is extensively, summatively assessed.

Provide summary of the recommendations relevant to this standard

- Reconsider the assessment *of* learning program and shift it more of an assessment *for* learning program. The assessment program is a traditional summative program with many hurdles.
- Create more integrated exams and significantly reduce the number of exams. In the preclinical phase of the curriculum, 54 exams are counted.
- Increase meaningful feedback to students for better learning from assessments (grades are a poor form of feedback). For example, provide sub-score performance information on blueprints of individual tests, where the individual performance is related to the performance of the cohort.
- Use documented narrative data from feedback dialogues in the clinical years to inform complex skills such as professionalism, communication, teamwork, leadership, and so on. Try not to merely capture clinical skills in checklists.
- Adopt a competency framework and map all assessment activities to these competencies.
- Implement a system for tracking and sharing academic performance across clinical rotations. Monitoring growth of competencies in clinical years requires carrying over information from one rotation to the other to improve continued learning.
- Consider introducing a mentoring system to monitor student's academic growth and enhance reflective and self-directive learning.
- Replace older methods of assessment (patient-based orals) with more modern ones, such as OSCEs or work-based assessment methods. In particular, the latter would fit best to a CBME approach to assessment.

- Copy some of the diversity of assessment methods from the 4-year MSIH program to the 6-year program (e.g., narratives).

- Introduce pretest quality control on item writing and post-test psychometric analysis and review.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 9 is met, albeit *needs major improvement* (Score 3).

❖ The score that the institution gave itself in this standard:

Unsatisfactory				Satisfactory	
1	2	3	4	**5**	6

❖ The score that the committee gives the institution in this standard:

Unsatisfactory				Satisfactory	
1	2	**3**	4	5	6

Standard 10: Medical Student Selection, Assignment, and Progress

A medical school establishes and publishes admission requirements for potential applicants to the medical education program and uses effective policies and procedures for medical student selection, enrolment, and assignment.

Provide summary of the commendations and good practices relevant to this standard

- There exists a comprehensive system of admission to both programs of the medical school, which comprise cognitive and non-cognitive elements. This translates into the enrollment at BGUFOHS of highly qualified and motivated medical students that are ready to complete medical studies and who will become high quality physicians after training.
- Attrition is minimal though good support of students, including a *Leave of Absence* set of regulations.
- There is a commendable large admission committee with public representatives, and there is a strong training program for the admission committee in place.

Provide summary of the recommendations relevant to this standard

- Work with CHE to develop paths for diversifying admitted student demographics, including minority groups and those from underprivileged backgrounds.
- Partner with university-level development officers to create a meaningful number of endowed scholarships.
- Incorporate into the admission process alternative ways of assessing non-cognitive skills that go beyond personality assessments *per se*, e.g., written Situational Judgment Tests (SJT) and replace the current interviewing with *Multiple Mini Interviews (MMIs)*.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 10 is met, albeit *needs minor improvement* (Score 5).

- The score that the institution gave itself in this standard:

Unsatisfactory				Satisfactory	
1	2	3	4	**5**	6

- The score that the committee gives the institution in this standard:

Unsatisfactory				Satisfactory	
1	2	3	4	**5**	6

Standard 11: Medical Student Academic Support, Career Advising, Educational Records, Financial Aid, and Access to Personal Counselling

A medical school provides effective academic support, student services, financial aid counselling, and career advising to all medical students to assist them in achieving their career goals and the school's medical education program objectives. All medical students have the same rights and receive comparable services.

Provide summary of the commendations and good practices relevant to this standard

- Students have access to their course and clerkship data for review of the exam.
- Funding is available for student electives abroad.
- Psychological services are available for those students needing it.

Provide summary of the recommendations relevant to this standard

- Permit students to review their narrative assessments.
- Consider motivation to be a key criterion for admission to foreign electives instead of grades.
- Copy the 4-year MSIH track's career advising for the 6-year track.
- Provide an explanation for the 10% dropout rate and take actions accordingly.

Conclude whether the standard is 'met' or 'not met', and if met, briefly explain reason for score

Standard 11 is met, albeit *needs minor improvement* (Score 5).

- The score that the institution gave itself in this standard:

Unsatisfactory				Satisfactory	
1	2	3	**4**	5	6

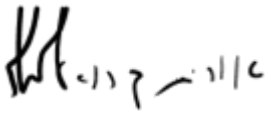
- The score that the committee gives the institution in this standard:

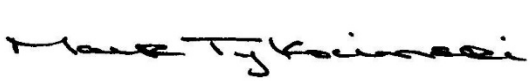
Unsatisfactory				Satisfactory	
1	2	3	**4**	5	6

Signed by:

Prof. Haim Bitterman: 

Prof. Adina Kalet: 

Prof. Orit Karnieli-Miller: 

Prof. Mark Tykocinski: 

Prof. Cees Van der Vleuten: 

Appendix 1 – the Committee's Letter of Appointment

Prof. Mark Tykocinski
Provost and Executive Vice President for Academic Affairs
Thomas Jefferson University
USA

Dear Professor,

The Israeli Council for Higher Education (CHE) strives to ensure the continuing excellence and quality of Israeli higher education through a systematic evaluation process. By engaging upon this mission, the CHE seeks: to enhance and ensure the quality of academic studies, to provide the public with information regarding the quality of study programs in institutions of higher education throughout Israel, and to ensure the continued integration of the Israeli system of higher education in the international academic arena.

As part of this important endeavor we reach out to world renowned academicians to help us meet the challenges that confront the Israeli higher education by accepting our invitation to participate in our international evaluation committees. This process establishes a structure for an ongoing consultative process around the globe on common academic dilemmas and prospects.

I therefore deeply appreciate your willingness to join us in this crucial enterprise.

It is with great pleasure that I hereby appoint you to serve as chair of the Council for Higher Education's Committee for the Evaluation of **Faculties of Medicine and Medical Schools in Israel**. In addition to yourself, the composition of the Committee will be as follows: Prof. Haim Bitterman, Prof. Adina Kalet, Prof. Orit Karnieli-Miller and Prof. Cees van der Vlueten.

Ms. Pe'er Baris-Barnea will be the coordinator of the Committee.

Details regarding the operation of the committee and its mandate are provided in the enclosed appendix.

I wish you much success in your role as a member of this most important committee.

Sincerely,

Prof. Ido Perlman
Vice Chair,
The Council for Higher Education (CHE)

Appendix 2 – Visit Schedule

BGU Schedule of site visit Wednesday, November 3rd		
09:00-10:00	Meeting with the Dean of the Faculty of Medicine	Dean, FOHS- Prof. Angel Porgador Vice Dean- Prof. Ilan Shelef
10:15-10:45	Opening session with Heads of the Institution	President, BGU - Prof. Daniel Chaimovich Vice Rector and Head of the Office of Academic Assessment and Evaluation - Prof. Gal Debuton
10:45-11:00	**Break – at the meeting room**	**Closed-door meeting of the committee**
11:00-11:45	Meeting with the QA Report Commissioner*	Prof. A. Mark Clarfield and Mr Roi Hillcohen
11:45-12:30	Meeting with senior academic staff *	Head of 6 year track- Prof. Yael Refaely Head of 4-year track- Prof. Alan Jotkowitz Vice dean of Students Affairs - Dr. Idit Liberti Vice Head of the 6-year track- Dr. Eli Rosenberg
12:30-13:15	Meeting with Adjunct academic staff*	Prof. Shaul Sofer, Paediatrics and previous dean Prof. Deb Lebman, Immunology Prof. Emanuel Sikuler, Internal Medicine Prof. Eli Lewis, Assoc Dean, Medical Education Dr. David Geffen, Oncology Dr. Shimon-David Amar, Family Medicine Mr. Tal Michael
13:15-13:45	**Lunch**	**Closed-door meeting of the committee**
13:45-15:30	Meeting with Clinical instructors*	Prof. Gali Pariente, Ob/Gyn Dr. Lior Nesher, Internal medicine (will arrive at 14:00) Dr. Anton Osintsov, Surgery (will arrive at 14:00) Dr. Aviva Levitess, Paediatrics (will leave at 15:00) Dr. Orna Staretz-Haham, - Paediatrics Dr. Shimrit Yaniv- Ob/Gyn
15:30-16:00	Tour of the School	By Prof. Alan Jotkowitz
16:00-16:45	Meeting with pre-clinical students**	**6-year track:** Aviv Dor Omri Ashkenazi Ofek Ben Dahan **4-year track:** Raquel Weinberg Samuel Francis

16:45-17:30	Meeting clinical students**	**6-year track:** Guy Tal Lior Hassan Rotem Givoli Shahar Feiglin **4-year track:** Binil Jacob Yael Fruchter
17:30-18:15	Meeting with Alumni**	**6-year track:** Dr. Roy Dayan Dr. Mierav Attias Dr. Gal Tzaban **4-year track:** Dr. Benzion Samueli Dr. Elissa Freedman
18:15-18:30	**Break– at the meeting room**	**Closed-door meeting of the committee**
18:30-19:00	Closing meeting with the Dean	Dean - Prof. Angel Porgador Vice Dean - Prof. Ilan Shelef