EVALUATION OF THE MEDICAL SCHOOL AT THE AZRIELI FACULTY OF MEDICINE AT BAR ILAN UNIVERSITY

INTERNATIONAL QUALITY ASSURANCE REVIEW COMMITTEE
COMMITTEE ON HIGHER EDUCATION

JUNE 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 Medicine
Hebrew University Faculty of Medicine
Technion Faculty of Medicine
Tel Aviv University Faculty of Medicine

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 Committee on behalf of the CHE.

1.4 The review took place from 7 to 14 June 2021, and it dealt with two of the five medical schools: Azrieli Faculty of Medicine at Bar Ilan University and Technion 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 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 and explained

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

in discussions with senior management, lecturers, students, and alumni during the course of each visit to each of the institutions.

1.7 This report deals with the Medical School at Bar Ilan University. Due to travel limitations associated with the coronavirus pandemic, the Committee's deliberations were conducted online, supplemented by an in-person visit of three of the Committee members (Prof. Tykocinski, Prof. Haim Bitterman, and Prof. Orit Karenieli-Miller) to the medical school in Tzfat on June 13. The schedule of the visit is attached as **Appendix 2**.

1.8 The Committee would like to thank the management of the Azrieli Faculty of Medicine at Bar Ilan University for their self-evaluation report and for their supportive interactions with the Committee during the evaluation process and for their hospitality towards the Committee members who visited the institution.

Key findings

Executive Summary

Azrieli Faculty of Medicine at Bar Ilan University (AFOM-BIU) was established in 2011 as Israel's fifth medical school with a well-defined, primary goal in mind: to address the significant health disparities among the underserved populations of the Galilee. An additional goal was to increase the physician workforce in that region, and in Israel more generally. Location in the northern reaches of the country translated into three geographic challenges for this new medical school. First, recruiting top-tier faculty to that area is difficult, especially faculty with spouses who must seek employment. Second, attracting students who will stay on in the north after graduating is not straightforward. Third, distance from AFOM-BIU's parent university in Ramat Gan, a 2+ hour drive away, inherently creates barriers to programmatic integration. Yet, in its first decade, AFOM-BIU has demonstrated a willingness to tackle these challenges head on and press forward in its mission to serve the underserved.

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

The IQARC framed its deliberations around several core elements:

1) **AFOM-BIU's status as a new medical school |**
   Launching a new medical school represents a major undertaking, especially a medical school that is geographically isolated and operates in a region where healthcare resources are limiting. AFOM-BIU is only a decade into its creative journey, which must factor into any review committee evaluation.

2) **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 Data Collection Instrument (DCI) self-study, along with its stated aspirations, as articulated in the self-study and IQARC interviews with university and medical school leadership.

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

4) **Operating and budgetary constraints for Israel's medical schools |**
   Evaluation of medical school performance must *per force* consider its operational environment. AFOM-BIU 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; and c) a complex interplay with its geographically-disbursed, functionally-diverse clinical training sites—hospitals and community clinics spread across the Galilee. Navigating this matrix of operating and budgetary relationships is demanding on leadership, constrains degrees of freedom, and in turn, must factor into recommendations.

5) **First accreditation review for AFOM-BIU |**
This is the first accreditation review for AFOM-BIU. As it happens, the CHE, in its journey to WFME status, recently set forth, for the first time, a structured set of standards for medical school quality assurance assessment in Israel. Hence, this first review is occurring in the backdrop of a new national review process—one that is structured by formal standards and still evolving in its early phases. Of note, 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 AFOM-BIU elected to do so, as it faced the coronavirus pandemic.

The IQARC evaluated AFOM-BIU 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 IQARC evaluated AFOM-BIU's compliance with these standards, and its top-level findings, commendations, and recommendations follow.

The IQARC's overarching findings are:

1) AFOM-BIU has articulated a primary goal geared to physician workforce development in the northern region of Israel. While this represents a compelling objective, there is another one equally compelling: elevating the calibre and quality of healthcare delivered to the diverse, underserved populations of that region. In some respects, the latter goal is more tractable in the near-term. While the medical school can take concrete steps to develop specific programs to motivate graduates to stay on in the Galilee, ultimate success demands a multi-

dimensional approach, with key solution sets out of its direct control and dependent on external entities (e.g., quality of life determinants; employment opportunities for spouses; schooling options for children). In contrast, by working in lockstep with its clinical affiliates, the medical school can move the needle on regional healthcare right from the start. Indeed, there is already evidence that this has been the case during the AFOM-BIU's first decade. While the lofty stated goal of turning the clinical affiliates into *university-like hospitals* certainly requires a long runway, medical school-catalyzed clinician recruitment, along with the establishment of labs and upgrading of facilities, is already making a tangible difference. Stated in other terms, AFOM-BIU would help itself by broadening its narrative and highlighting impact metrics linked to quality of regional healthcare alongside workforce impact metrics.

2) As AFOM-BIU positions itself for its second decade, a key fork in the road is how to balance its social mission with the ambition of many of its stakeholders to build critical mass in biomedical sciences. There may be lessons to be learned from the Ben Gurion Faculty of Medicine, another upstart medical school situated in a developing region that faced the tension between a regional social mission and the ambition to expand hard-core lab-based science. Without doubt, AFOM-BIU should strive for research excellence, but the question is one of research emphasis. A compelling option is for AFOM-BIU to position itself as the premier medical school in the country in the health services science space. In fact, AFOM-BIU has already started to build strength in population health, and this can be leveraged not just to drive health services research, but also to position the medical school as a prime destination for medical students interested in pursuing careers in this field of the future. Building basic science, clinical and health services research are not mutually exclusive, and the question here is simply one of attending to the balance such that the social mission is not lost.

3) University leadership categorically stated that geographical distance will not be allowed to pose a barrier to the success of AFOM-BIU. During the interviews, they pointed to efforts by administrative leaders to meet with faculty in Tzfat, university teaching awards to medical school faculty, and the leveraging of digital communication tools to bridge the distance. There is also the stated intention to *'give a lot of discretion to heads of departments, within certain limits'*. While this is all encouraging and in the right direction, facts on the ground do matter, and this positive intention will have to be reified in faculty appointments and promotions; approval of new programs and courses; and true engagement of AFOM-BIU faculty in the life and rhythm of the university (e.g., conferences, planning committees).

4) Being a new medical school affords greater flexibility in reaching for a forefront medical curriculum and state-of-the-art didactics. While AFOM-BIU's trajectory is strong, even impressive, there is considerably more that needs to be accomplished vis-à-vis attaining a true competency-based curriculum, infusing active learning, and dynamic tracking of educational outcomes in the service of continuous quality improvement. The current high contact-hour curriculum constrains self-study and exemplifies the medical school's challenges ahead in advancing its educational agenda.

5) An overarching challenge for AFOM-BIU is its dependence on a network of clinical affiliate hospitals that vary in their clinical resources and technologies, spectrum of specialties, and structured academic training environments. As is often the case in remote areas, maldistribution of medical and surgical subspecialties can pose challenges to breadth of medical students' clinical experience. In the case of AFOM-BIU, this raises several issues. There is a pressing need to teach the teachers, and robust and mandatory faculty development will be of paramount importance across the clinical sites. There is also the clinical rotation site question. For largely logistical reasons (e.g., commuting realities), AFOM-BIU has adopted a self-described *homing* model, wherein clinical rotations for each student are concentrated at a single affiliated hospital. On the one hand, there are strong arguments to be made for this approach, as it enables students a highly integrated continuity experience even as they rotate across the disciplines. This structure enables AFOM-BIU to experiment with versions of longitudinally integrated clerkships (LIC) and fosters continuity with teachers, mentors, and patients alike. However, given the unevenness among the hospitals, flexibility in this hospital anchoring approach may be appropriate, to accommodate specific specialty interests of students. Some of this is reportedly already taking place.

6) As a follow-up to the present IQARC review, AFOM-BIU should put in place a structured internal process for tracking its progress over time in embracing the review panel's recommendations and achieving its stated strategic goals. Such a process will be particularly important for ensuring continuity in a system where deans transition on a relatively frequent basis.

7) There are opportunities for deepening evaluation of both the pre-clinical and clinical educational components. Further, as a new medical school and particularly given its unique mission, AFOM-BIU should create a first-class comprehensive database for tracking AFOM-BIU graduates as their careers unfold and longitudinally assessing educational outcomes over time. Beyond informing continuous quality improvement internally, this database would additionally serve as a data resource outside the medical school's walls in shaping national physician manpower policy.

The IQARC's more specific findings related to the standards are embodied within the series of commendations/good practices and recommendations set forth in detail in the following section. This covers recent major changes and key challenges faced by AFOM-BIU, 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 Azrieli Faculty of Medicine at Bar Ilan University meets all 11 standards set forth by the Committee on Higher Education. That said, 7 of the 11 standards are categorized as *Needs Major Improvement* (Score 4) and 4 of the 11 standards as *Needs Minor Improvement* (Score 5).

There are substantial areas of commendation/good practice, and yet there is significant opportunity for elevating AFOM-BIU's administrative structures and educational programming, which are captured in the 50 recommendations set forth in the section below.

Conclusions about the Azrieli Faculty of Medicine at Bar Ilan University

The International Quality Assurance Review Committee (IQARC) reached the following conclusions about the higher education provision at the medical school at the Azrieli Faculty of Medicine at Bar Ilan University.

Israeli Standards for Medical Education

The Azrieli Faculty of Medicine at Bar Ilan University 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 identified the following areas for commendation and features of good practice at the Azrieli Faculty of Medicine at Bar Ilan University (AFOM-BIU):

1) AFOM-BIU benefits from the palpable esprit and pioneering spirit of a highly motivated, mission-driven faculty and leadership team, who see their medical school as playing a unique and higher purpose role within the Israel medical school landscape. The faculty are deeply committed to and aligned with the mission, and many were founding members of the school. They have been able to establish relationships with the communities they serve and attract a group of young and passionate full-time and volunteer faculty. Notwithstanding their clear appreciation for the geographic and clinical affiliate challenges, they are buoyed by a pervasive sense of purpose, which in turn, cascades down to the student body. A refrain during the interviews was that they see their location in the geographical and economic periphery as not just as a hurdle, but also as an opportunity (e.g., ethnic diversity; wide variety of pathology; serving the underserved).

2) The current dean is very charismatic, optimistic, and energetic, with seemingly excellent alignment and relationships with both the central university leadership in Ramat Gan and his local team. He inherited a new medical school with an inspiring and clear social mission. This dean aptly conveys and supports his aspirations for the medical school and respects the contributions of his predecessors in establishing it. He came to this role with relevant, practical experience from the University of Toronto and the Technion Israel Institute of Technology. He has led by example by choosing to live in Tzfat himself. The head of management, who has been with the school since the beginning, has effectively deployed his military logistic training to materially advance the objectives of the medical school.

3) There is a strategic planning process underway, and through it, AFOM-BIU leadership aspires to set a course towards excellence in medical education, areas of research distinction, and elevated clinical care for their surrounding communities. Achievements in its first decade, along with its willingness to bring focus to its plans, speak to the credibility to its strategic ambitions. The funding apparently in hand for two new building (education and research) adds further credibility. In crafting the strategic plan, the leadership team is appropriately engaging its diverse set of stakeholders, including its parent university and its network of clinical affiliates.

4) AFOM-BIU has started to define unique assets it can leverage towards distinctive programming and national visibility. One example is its program development around diabetes (SPHERE) which is intended as an initial foray into chronic disease management in underserved populations. This focus on the chronic disease angle of population health is part-and-parcel of a wider intention to develop population health science as an area of emphasis. The recent recruitment of a faculty member with expertise in this field represents an important step towards developing relevant faculty depth. The IQARC wholeheartedly encourages this direction since AFOM-BIU can now position itself as a preferred destination for medical students interested in career paths linked to population health.

5) AFOM-BIU is planning a significant expansion of space which will apparently double the size of the facility and accommodate the recruitment of more research faculty and a larger class, including launch of a 6-year track to complement the current 3- and 4-year tracks. There is a large philanthropic gift towards this expansion. The medical school is also making other capital investments, for example, two *Anatomage* digital dissection set-ups (to supplement its cadaver dissection), and impressive core facilities to support its basic scientists with high-end state-of-the-art equipment for proteomics, genomics, and high-resolution imaging, with appropriate technical staffing.

6) AFOM-BIU was founded on a base of strong philanthropic support, and notably, it appears that this philanthropy is continuing forward as a critical financial enabler for the school's ambitious growth plans.

7) Relationships with the clinical affiliates and community partners are perceived as mutually beneficial, and this cooperative spirit has already begun to foster higher quality care in the region, for example, in oncology, specialty medicine, and neurosurgery services. It is also garnering grant support linked to regional health disparities, which in turn, is setting the stage for building a research presence at the various clinical affiliates, and ultimately launching research institutes in each regional hospital. The cultivation of translational research collaboration among the clinical affiliates is viewed with optimism. This strong partnership will further serve to elevate their clinical practice, bringing them closer to their downstream vision of them becoming more *'university hospital-like'*.

8) Students and alumni are passionate about the school's mission, recognize the value of active learning, and particularly value AFOM-BIU's *beyond book learning* approach that makes them self-directed learners. Despite the challenges inherent in attending a medical school in the periphery, AFOM-BIU students convey enthusiasm and seem satisfied with their choice of medical school. The students emphasized the empathic and friendly environment they experience throughout their studies and feel supported by teaching staff, both formally and informally. They especially emphasized the effectiveness of the HILA course (in Years 1 and 2 of the 4-year program) in which the students are taught basic clinical and communication skills and ethics, and are being tutored one-on-one and in groups, by a designated senior teacher throughout the first two years. The 'Year Parents' program is a strength. All of this speaks to an interest in student wellbeing and what is reported as a nurturing atmosphere from day one. The students are also provided a rich set of volunteering opportunities.

Alumni express satisfaction with their preparation for postgraduate clinical training. Of note, most graduates do not proceed to residencies in the affiliated hospitals and do not establish their careers in the Galilee.

9) The curriculum is impressively evidence-based, fit for purpose, and designed to achieve the school's mission. By virtue of being a new medical school, AFOM-BIU is advantaged by not being entrenched in a conventional curriculum and not having to deal with a faculty that is vested in longstanding ways of doing business.

10) Clinical teachers are integrated into many pre-clinical courses, where they shed light on the clinical relevance of the fundamental science being taught. While this evolved by default to address lack of faculty depth, it is now accepted by both heads of courses and students as advantageous as an effective integrated approach for the pre-clinical years.

11) The research requirement for all students, as well as an MD-PhD program (typically 2 students per cohort), signal the medical school's commitment to nurturing a spirit of discovery in its students. It is also significant that the school supports a scholarship for graduate students in faculty labs.

12) Students and faculty partner in co-producing the curriculum—a cutting-edge gestalt exemplified by *Near Peer Tutoring*. Students have been empowered in other ways as well. For example, the students, via their student union, were recently instrumental in revising the methodology and implementing clinical rotation assignments.

13) AFOM-BUI managed to secure approval for a Vice Dean for Graduate Medical Education, apparently the first in Israel. This is of obvious importance given that residents play a critical role in medical student education.

14) The two current curriculum tracks, 3 and 4 years, are well described in the DCI self-study as to prerequisites, intended student recruits, and differences in pre-clinical course structure. The pre-clinical content is delivered in integrated blocks. There are two longitudinal curricula in which students learn core clinical skills, receive feedback, and are monitored for academic and psychological struggles. Scientists and clinicians collaborate in teaching on a regular basis.

15) As reflected in knowledge test scores, AFOM-BIU graduates perform as well as students from other Israeli medical schools. This is suggesting that there is *no harm done* by this evidence based, modern medical school curriculum, as a minimum standard. However, it is also clear that they meet some higher standards of preparing the students for contemporary medical practice—a much higher bar.

16) The HILA *Professional Foundations for the Future Doctor and the Medical Ethics* course is longitudinal across the pre-clinical years, and it is followed by the *Imparting the Basics of Clinical Medicine* course (a 6-week course, combining case-based learning and team-based learning, lectures, and case discussions). This course is described as integrated with, and

timed to reinforce, material being taught in the pre-clerkship blocks. A few detailed examples are provided in the DCI self-study.

17) The communication skills curriculum engages students actively in a staged, skills-based set of learning activities. Communication skills are conceptualized in a set of principles (rather than behaviour-specified skills – perhaps a better alternative) and undergo both formative and summative assessment. This is high stakes given that the communication skills assessment is 50% of the final grade of the HILA course.

18) Imaging (including POCUS), Pathology and EM curricula are integrated longitudinally.

19) The *Societal Problems* thread was carefully crafted to comport with the mission of the medical school, and they describe four "spiral curricula": 1) a population health small-group course; 2) a community placement course (4 hours/week for 8 weeks); 3) a preventive medicine course (embedded in the internal medicine clerkship); and 4) *ETGAR Challenge* (a patient-based transition from hospital to community- experience). This is an exemplar for other medical schools.

20) There is monitoring of students with difficulties. For example, the *Student Achievement and Professionalism Committee* monitors the students' academic achievements and development in the field of professionalism during their training towards the practice of medicine. The committee actively works to identify students who are having difficulty meeting academic requirements and/or standards of professional conduct.

21) AFOM-BIU introduced effective innovations in its pre-clinical and clinical training in coping with the COVID-19 pandemic, and these innovations can now serve as springboard for hybrid flexible innovations in the medical school's didactic methodologies.

Recommendations

The IQARC makes the following recommendations to the Azrieli Faculty of Medicine at Bar Ilan University (AFOM-BIU):

<u>Essential</u>:

1) **Complete the strategic plan.**
   Strategic planning is still underway, after a pause during the pandemic. While the DCI self-study targets completion by summer of 2021, it is unclear at the time of the present review if this deadline will be met. This represents the first strategic plan for the medical school, and it is surprising that one was not developed at the time of founding. From the dean's slide deck at the time of the site visit, the strategic plan will have 5 elements: *1) mission vision update; 2) strengthening medical centers and community health connections: 3) research faculty and development recruitment; 4) strategic planning of educational tracks and outcomes; and 5) Galilee student and staff experience*.

2) **Formal mission, vision, and value statements should be formulated.**
A vision statement was offered in the DCI, but of note, it was approved only at the end of December 2020, just in time for the review. This 'vision statement' is not really a vision, but rather a cataloguing of goals (*Research faculty recruitment and development; Strengthening the connection with the medical centers and community health; Strategic planning of educational tracks and outcomes; Faculty's contribution to the strengthening of the Galilee*), which overlap with the aforementioned strategic plan elements. There is no mission statement *per se*. Hence, mission, vision, and goals are being conflated, and there is no formal statement around values. All of this should be addressed. A *mission* statement should concisely set forth the medical school's primary purpose. A *vision* statement should convey what the medical school aspires to be and what it intends to look like several years down road. A *values* statement should crisply express the core principles that frame all that medical school does. In turn, specific goals and action plans follow from, and give life to, the mission/vision/values statements.

3) **Develop a unique identity for the medical school that distinguishes it in the Israel medical school landscape.**
The dean is appropriately thinking in terms of focused areas of AFOM-BIU strength and distinction. With respect to research, areas of emphasis include genetics of isolated populations; diabetes; population health sciences; infection, immunity, and microbiome; data sciences; and AI medicine. The diabetes-focused *SPHERE (Social Precision Medicine Health Equity Research Endeavor)* exemplifies the types of initiatives that tie into such areas of focus. To reinforce the medial school's unique identification with these areas, they should be translated into educational offerings and experiences for the students in a deliberate fashion.

4) **Translate the university bylaws into a medical school handbook that codifies policies and procedures.**
AFOM-BIU operates under the university bylaws, but this has not been translated into a medical school handbook that codifies its school-specific policies, guidelines, and procedures relating to faculty, student, alumni, and administrative affairs.

5) **Clarify governance within the medical school.**
The DCI self-study states that the governing body is *Faculty Leadership*, which must be approved by the university. Specifics around it are entirely lacking (e.g., membership; operational details; relationship to the dean and other administrative entities). There is also reference to a *Faculty Council*, and it is unclear if this is the same one. How are junior and mid-career faculty represented and engaged? The medical school's governance structure must be crisply developed and then made clear to all stakeholders.

6) **Establish a formal *Department of Medical Education*.**
The DCI self-study mentions several entities that touch on medical education at AFOM-BIU. These include directorates (a *Directorate for Medical Education*, paired with a Directorate for Research); units (the *Medical Education Research and Development Unit* and the *Education and Evaluation Unit*) and committees (*Teaching/Curriculum Committee*). While an

organizational chart containing these entities was offered, their respective domains of authority and responsibility were vague, as was their membership, governing principles, and operational specifics (e.g., how often they meet; how they relate to each other). Further complicating the picture are the pre-clinical and clinical components under the *Directorate for Medical Education*. The relationship of these various entities to the Vice Dean for Medical Education is also not clearly defined. The IQARC recommends the establishment of a formal *Department of Medical Education*, powered by trained professionals with *bona fide* educational science expertise, and simplification of the matrix of directorates, units, and committees under the umbrella of this department. University leadership expressed an intention to create a *Faculty of Education*, and a *Department of Medical Education* within the medical school would provide a home for its professional educators.

7) **Invest in faculty development.**
Many of the volunteer faculty in the community hospitals have little specific expertise in evidence-based medical education. Faculty development training is not mandatory and appears to be episodic. Require all clinical faculty to engage in a longitudinal, rigorous faculty development process that leads to certification (e.g., as a promotion criterion). Over time, this will build clinical education capacity for the whole system. Single 'workshops' are not effective. More structured *teaching-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.

8) Invest in, test, and rapidly expand a community-based model for clinical medical education.
The community sites are not yet adequate to the current or future need for community-based clinical training. Many clerkships do seem to have ambulatory/community experiences, but the percentage is low. This will require a well-developed plan.
The barriers within the purview of the medical school should be addressed (e.g., curriculum and faculty development) while advocating with the relevant ministries for resources needed. This represents a national challenge, and AFOM-BIU should take the lead, thinking in terms of a community-based campus. With only three major hospitals, it should be considered as a way forward.

9) **Build *home-grown* capacity for medical education scholarship and innovation.**
For starters, invest in 3-5 junior faculty with interest and focus on medical education, including giving them the opportunity to obtain a master's or PhD in *Health Professions Education* from one of the premier international centers. This investment would enable AFOM-BIU to position itself as a leader in medical education. *{Standard 2}*

10) **Strengthen the pathway toward academic promotion for medical educators.**
Support and maintain an educator's portfolio for all faculty. Advocacy for medical educators during central university deliberations on tracks, promotion, resourcing, and compensation

will be essential.

11) **Address faculty diversity in the pre-clinical years and ensure gender equity in appointments, promotions, and compensation.**
The dean has taken steps to address such diversity and equity issues, and these must be carried forward. Aggressively recruit faculty and students from underrepresented ethnic, racial, religious, and nation-of-origin groups in the region. Diversity is critical to achieving the school's mission. A particular concern relates to possible inequities at the university level vis-à-vis faculty title and rank for women faculty. AFOM-BIU should implement a requirement that all faculty be discussed on an annual basis by the school's appointments and promotions committee, with regular assessment and consideration of appropriateness of track and rank, readiness for promotion, and status of regular mentoring by assigned senior faculty mentors.

12) **Introduce a formal rating system of faculty by students.**
There is apparently a *flagging system* to identify faculty with low rating scores, purportedly in real-time. AFOM-BIU might consider an expanded rating system that would also identify high-performers.

13) **Build the 6-year program to both expand the number of physicians and enhance the attractiveness of a career in medicine for regional students.**
A plan is being developed for a new 6-year track which it is thought might attract more students from local communities and potentially increase the number who choose to stay and practice in the north.

14) **Commit to and implement a fully competency/outcomes-based curriculum.**
Such a curriculum would build on and integrate the many solid components AFOM-BIU already has in place. The DCI self-study does identify the need to move toward a genuine competency-based medical education (CBME) curriculum, but much needs to be done towards this end. By example, efforts need to be invested in assessing outcomes and providing feedback in the clinical years. *Task-pad* or *skills* notes, though clear, only include the medical procedures a student should observe, but do not encompass professionalism or communication issues (e.g., whether a clinical faculty observed them in different professional tasks; the quality of their patient interviews). Further, they are mainly checking if the student observed or participated in specific procedures/situations, but not how they have done it nor feedback on how to improve in the future (e.g., how to organize KABALA better). When moving to more CBME, assessment should entail a system of work-based assessment in the clinical phase assessing broad outcomes, while providing documented feedback and to more and diverse assessment approaches in the preclinical. With representation on the national committee to set CBME outcomes, this has the potential to transform medical education in the country. Consider contributing towards an Israeli Competency Framework (e.g., see CanMeds, Scottish Doctor, ACGME Outcomes).

15) **Clarify the overarching curricular framework and justification for the pre-clerkship "block" structure.**

It seems to be a combination of discipline-based (e.g., anatomy, bioenergetics) and disease/pathology-based (oncology) curricula.

16) **Reduce contact hours and implement a more comprehensive approach to active learning.**
It is evident that students are exposed to a dense weekly program of direct contact/exposure. A significant part of this time should be freed up to promote self-directed, active learning. There have been some steps in this direction in both the pre-clinical and clinical years, as well as in integrating team-based learning. However, it remains unclear precisely what has been done, how many hours are invested in it, its success thus far, and the barriers.

17) **Coordinate education across the various clinical affiliate sites to ensure equivalency of training.**
The distributed nature of the clinical campus has many inherent challenges. There should be a clearly designated and empowered educational coordinator at each of the clinical affiliate sites, and these coordinators should meet regularly under the auspices of the central administrative educational leaders. There should be a more systematic approach to site visits in clerkships, rather than their being done in *"intervals as seem fit"*. It is unclear how academic issues at the various clinical sites are handled, with the general statement that *"findings are reported in the relevant forums and acted upon as required"*. While it is encouraging that there seems to be substantial department (specialty)-specific crosstalk among the various affiliates, the interplay of academic department and central medical school administrative entities in these matters must be clearly defined. All of this must come together to ensure equivalency of training across the affiliate network.

18) **Add more structure to educational assessment, including an integrated database.**
Various ways of assessment have been implemented, including *"a combination of written examinations, OSCE-style clinical examinations, written and practice assignments and clerkship performance assessments".* However, students are not observed in a systematic way, and it is unclear when and how they receive feedback. A more integrative and inclusive database should be developed that tracks each student's progress and challenges. The current assessment system follows the block design. Therefore, the assessment volume is high in the preclinical curriculum, but not present in the clinical years. By moving to vertical and horizontal integration, the assessment frequency could be more easily distributed.

19) **Amplify structured student assessment forms.**
Students do fill out assessment forms after each clerkship, but questions should be added relating to ongoing feedback and their opportunity to learn from it; whether they were observed during different interactions with patients; whether they were treated with respect; and how much of the teaching was team-based learning. Observation of performance, including interaction with the patient, and feedback on this in the clinical years is critical to students' development. Furthermore, the feedback should be guided to focus on specific items, not, as one faculty member mentioned, based on *"personal impression"*.

20) **Explore new models for the clinical clerkships.**
Given that the homing model has students spending most of their required clerkships at single clinical affiliates, such continuity of experience and associated mentoring lends itself to *Longitudinal Integrated Clerkship* models. This could be developed more formally. Other options such as advanced clerkship and *incremental increases in authority* models can be grafted onto the clinical training schema to better prepare students for their transition to residency and beyond.

21) **Implement an inter-professional education (IPE) curricular thread.**
While students claimed to be learning how to work on inter-professional teams, they could not cite specific examples of having ever trained alongside another health professions student. A single such experience (with nursing students) is described in the DCI self-study. It would be reasonably straightforward to incorporate IPE competencies into a curriculum structured such as that of AFOM-BIU, and assessment of IPE could be added to *OSCE's* and *Direct Workplace Observation*.

22) **Further develop the curriculum around cultural competence and healthcare disparities.**
The content for these elements is spread throughout the HILA course, clerkships, and active learning experiences exploring personal biases. An explicit conceptual framework for this material would be valuable in tying the material together for both educators and students. For instance, while there is reference to a *Social Determinants of Health* curriculum and communication skills practice, cultural humility is only hinted at in the description of students exploring their own biases.

23) **Develop a well-structured process for continuous quality improvement.**
A detailed process for orchestrating quality improvement activities should be developed. Two examples of quality improvement actions are offered in the DCI self-study by example (in Surgery and OB/GYN), but it is unclear if they were simply handled at the departmental level and how this tied to school-wide quality improvement processes.

24) **Create a database for longitudinal tracking of graduates.**
As a new school, AFOM-BIU has a unique opportunity to track long-term outcomes of its graduates right from its founding. This could be part of comprehensive, prospective program evaluation that provides guidance for continuous quality improvement and mission monitoring. Correlations with career choice, location of practice, communication skills, cultural competence, inter-professional teamwork, teaching evaluations, and academic success would become possible.

25) **Create continuity of student mentoring across the pre-clerkship and clerkship curriculum.**
A longitudinal mentoring program is briefly described in the DCI self-study. It is not clear if all students are mentored in a consistent way.

26) **Address processes for academic remediation.**
While there is an early intervention attitude towards academic remediation and a professional educator who works with students, there is a need for a dean of students who

coordinates disciplinary and ethics issues in conjunction with the rest of the university.

27) **Grow scholarship support, especially for students with families to support.**

<u>Important</u>:

28) **Develop a formal multi-year faculty recruitment plan.**
As noted by the dean, at its founding, faculty recruitment was per force largely opportunistic. A more deliberate approach is now envisioned under the strategic plan. Given the competing interests of recruiting health science v. basic science v. education science faculty, faculty recruitment objectives should be developed framed by a multi-year horizon, so that faculty build does not devolve into opportunistic recruiting. Of note, faculty search committees are headed by the Associate Dean for Research; input of educators is obviously essential.

29) **Supplement pre-clinical didactics with online teaching.**
Online teaching by best teachers (potentially from other faculties of medicine as well) could solve some of the issues related to lack of faculty in some pre-clinical courses.

30) **Address the need for simulation training.**
There is an intention to access a simulation center to be opened at a college in Tzfat. This plan must be executed, as access to simulation is now viewed as foundational for any contemporary medical education system.

31) **Augment reflections and communication skills development, longitudinally.**
The DCI self-study mentions the use of reflections and feedback, but it remains unclear how reflective practice is actually taught, as well as the assessment used to guide feedback on it. A guiding assessment tool would be useful. It is essential to have longitudinal follow-up of the student in a more organized way throughout the years (perhaps more integration between the important HILA course and mentoring). This longitudinal follow-up should help students maintain and develop their reflective abilities and communication skills. Currently, the competency skills of reflections and communication are formally taught and assessed only in the pre-clinical years and are missing in the clinical years. More direct observation, feedback, and work-based assessments or OSCE's are needed.

32) **Make routine psychometric testing of exams available.**
Improve the pre- and post-test quality control around item and test development, including a psychometric analysis.

33) **Establish a dedicated committee to deal with conflict-of-interest.**
There is not a dedicated individual or committee dealing with conflict of interest. Instead, the dean steers each conflict-of-interest matter, as it arises, to whomever he believes should handle it (medical education committee; student affairs; and so on). This is inappropriate.

34) **Develop a conflict-of-commitment policy.**

35) **Ensure clinical affiliation agreements are updated.**
Clinical affiliation agreements have been signed. However, given that most date back to 2010 and 2011, end-dates of these agreements should be monitored, and they should be updated as appropriate.

36) **Explore collaborative opportunities with the Technion Faculty of Medicine in addressing the healthcare needs of the underserved in the north.**
Given that AFOM-BIU and the Technion Faculty of Medicine are both situated in the north, the two institutions should find ways to collaborate on defined projects, both clinical and research—particularly projects geared to the health needs of the underserved of that region. Such inter-institutional collaboration could attract government and philanthropic support, and it would model the type of collaborative spirit that would benefit many of the academic institutions within the country. The notion of *coopetition* has become mainstream elsewhere.

37) **Formalize assessment in key educational threads.**
Assessment should be better developed as it relates to *Ethics and Human Values*, the HILA program, professionalism, humanistic values, and leadership, among others.

38) **Implement a *Resident-as-Teacher* training program and recognize/award residents for their contributions to the teaching of medical students.**

39) **Sustain the curricular innovations introduced during the COVID-19 pandemic.**

40) **Address student life issues.**
The current facilities are acknowledged as limited, but adequate for the current size of the faculty and student body. Student feedback suggested basic satisfaction with almost everything except the quality and cost of food on campus. Survey students on these issues regularly (consider a random sample of students quarterly) to monitor their experience as administration makes changes. Delegate student surveys to student council and include them in the interpretation of survey results and the development of solutions. Whenever reporting any survey data, share the response rates, means/modes, and standard deviations in a table that makes it easier to interpret the meaning of the results. Also, when monitoring these issues, share change over time.

41) **Proceed with implementation of the *North Star* program.**
This program is designed to sway more students to stay and practice in the north.

Desirable:

42) **Assess the impact of admission procedures on student diversity.**
There are rigorous and comprehensive admission procedures, covering both cognitive and non-cognitive domains, common to both programs. The result is a highly selective outcome with very bright students entering the program. However, a risk might be that the student

population is not representative for the population in the country.

43) **Revise the Multiple-Mini-Interview (MMI).**
A genuine MMI would have many more oral stations and examiners.

44) **Strengthen career counseling.**
Adding career counselling to the mentorship program in the clinical years would help students decide on electives.

45) **Develop an ethics code for the faculty.**
AFOM-BIU developed an important and clear ethics code for students. However, it is worth adding a similar code for faculty.

46) **Remedy the mold issue in the library.**

Recommendations Related to the International QA Review Process

47) **Make assessment of performance vis-à-vis CHE standards part of the medical school's operational rhythm.**
Preparation for re-accreditation should be viewed as a continuous process, as opposed to a last-minute sprint as the site visit approaches. AFOM-BIU should identify a lead coordinator for overseeing this process—perhaps the Vice Dean for Academics, or else another empowered individual—who can visit exemplary medical schools in other countries and observe first-hand how the re-accreditation journey is handled. They might also consider inviting an external review team in mid-way through the re-accreditation cycle to assess status and propose mid-course corrections.

48) **Prepare future DCI self-studies with more attention to detail.**
There should be a better process for writing the DCI self-study, with a view towards clarity, unity, and accuracy. The dean's slide presentation to the review committee was impressive and conveyed a comprehensive perspective that was lacking in the DCI self-study.

49) **Provide English translations for key supporting documents in the DCI self-study.**
Organizational charts were in Hebrew, as was much of the documentation. At the very least, there should be descriptors/titles in English for key documentary evidence.

50) **Provide a table of contents in the DCI self-study.**

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

1. Azrieli Faculty of Medicine at Bar Ilan University (AFOM-BIU) was established in 2011 as Israel's fifth medical school with a well-defined, primary purpose in mind: to address the significant health disparities among the underserved populations of the Galilee. An additional purpose was to increase the physician workforce in that region, and in Israel more generally.

2. There is a strategic planning process underway, and through it, AFOM-BIU leadership aspires to set a course towards excellence in medical education, areas of research distinction, and elevated clinical care for their surrounding communities. Achievements in its first decade, along with its willingness to bring focus to its plans, speak to the credibility to its strategic ambitions. The funding apparently in hand for two new building (education and research) adds further credibility.

3. AFOM-BIU has started to define unique assets it can leverage towards distinctive programming and national visibility. One example is its program development around diabetes (SPHERE) which is intended as an initial foray into chronic disease management in underserved populations. This focus on the chronic disease angle of population health is part-and-parcel of a wider intention to develop population health science as an area of emphasis.

4. AFOM-BIU is planning a significant expansion of space which will apparently double the size of the facility and accommodate the recruitment of more research faculty and a larger class, including launch of a 6-year track to complement the current 3- and 4-year tracks. There is a large philanthropic gift towards this expansion. The medical school is also making other capital investments, for example, two *Anatomage* digital dissection set-ups (to supplement its cadaver dissection), and impressive core facilities to support its basic scientists with high-end state-of-the-art equipment for proteomics, genomics, and high-resolution imaging, with appropriate technical staffing.

5. AFOM-BIU was founded on a base of strong philanthropic support, and notably, it appears that this philanthropy is continuing forward as a critical financial enabler for the school's ambitious growth plans.

6. Relationships with the clinical affiliates and community partners are perceived as mutually beneficial, and this cooperative spirit has already begun to foster higher quality care in the

region, for example, in oncology, specialty medicine, and neurosurgery services. It is also garnering grant support linked to regional health disparities, which in turn, is setting the stage for building a research presence at the various clinical affiliates, and ultimately formalized institutes. The cultivation of translational research collaboration among the clinical affiliates is viewed with optimism. This strong partnership will further serve to elevate their clinical practice, bringing them closer to their downstream vision of them becoming more *'university hospital-like'*.

Provide summary of the recommendations relevant to this standard

1. **Complete the strategic plan.** Strategic planning is still underway, after a pause during the pandemic. While the DCI self-study targets completion by summer of 2021, it is unclear at the time of the present review if this deadline will be met. This represents the first strategic plan for the medical school, and it is surprising that one was not developed at the time of founding. Of note, responses to several key questions are not in the DCI self-study and are instead relegated to '*pending the strategic plan*' (e.g., plans for monitoring), and in one place, the self-study indicates that the strategic plan is '*N/A'*.

2. **Formal mission, vision, and value statements should be formulated.** A vision statement was offered in the DCI, but of note, it was approved only at the end of December 2020, just in time for the review. This 'vision statement' is not really a vision, but rather a cataloguing of goals, which overlap with strategic plan elements that are offered elsewhere. There is no mission statement *per se*. Hence, mission, vision, and goals are being conflated, and there is no formal statement around values. All of this should be addressed. A *mission* statement should concisely set forth the medical school's primary purpose. A *vision* statement should convey what the medical school aspires to be and what it intends to look like several years down road. A *values* statement should crisply express the core principles that frame all that medical school does. In turn, specific goals and action plans follow from, and give life to, the mission/vision/values statements.

3. **Translate the university bylaws into a medical school handbook that codifies policies and procedures.** AFOM-BIU operates under the university bylaws, but this has not been translated into a medical school handbook that codifies its school-specific policies, guidelines, and procedures relating to faculty, student, alumni, and administrative affairs.

4. **Clarify governance within the medical school.** The DCI self-study states that the governing body is *Faculty Leadership*, which must be approved by the university. Specifics around it are entirely lacking (e.g., membership; operational details; relationship to the dean and other administrative entities). There is also reference to a *Faculty Council*, and it is unclear if this is one and the same. How are junior and mid-career faculty represented and engaged? The medical school's governance structure must be crisply developed and then made clear to all stakeholders.

5. **Establish a dedicated committee to deal with conflicts of interest.** There is no dedicated individual or committee dealing with conflict of interest. Instead, the dean steers each conflict-of-interest matter, as it arises, to whomever he believes should handle it (medical education committee; student affairs; and so on). This is inappropriate. There is simply an asterisk next to '*Conflict of private interest of faculty with academic/teaching responsibilities*', and in any case, conflict-of-interest should go beyond faculty to encompass administrative leaders as well.

6. **Develop a conflict-of-commitment policy.**

7. **Ensure clinical affiliation agreements are updated.** Clinical affiliation agreements have been signed. However, given that most date back to 2010 and 2011, end-dates of these agreements should be monitored, and they should be updated as appropriate.

8. **Develop an ethics code for the faculty.** AFOM-BIU developed an important and clear ethics code for students. However, it is worth adding a similar code for faculty.

9. **Develop a well-structured process for continuous quality improvement.** A detailed process for orchestrating quality improvement activities should be developed. Two examples of quality improvement actions are offered in the DCI self-study by example (in Surgery and OB/GYN), but it is unclear if they were simply handled at the departmental level and how this tied to school-wide quality improvement processes.

10. **Create a database for longitudinal tracking of graduates.** As a new school, AFOM-BIU has a unique opportunity to track long-term outcomes of its graduates right from its founding. This could be part of comprehensive, prospective program evaluation that provides guidance for continuous quality improvement and mission monitoring. Correlations with career choice, location of practice, communication skills, cultural competence, inter-professional teamwork, teaching evaluations, and academic success would become possible.

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). This needed improvement relates to lack of a strategic plan (despite having launched a decade ago); lack of well-formulated mission/vision/value statements (though admittedly these may be understood implicitly); lack of structured action plans that flow from mission/vision/value statements; lack of a compilation of formal medical school policies and procedures, in the form of a handbook, that comport with, and derive from, the parent university bylaws; lack of clarity in medical school governance, e.g., the relationship of various education directorates/units/committees to each other and to central administration; inadequacies in conflict-of-interest management procedures; lack of a conflict-of-commitment policy; lack of a well-defined, formal process for continuous quality improvement; and lack of a database for longitudinal tracking of graduates to inform continuous quality improvement. That said, AFOM-BIU is credited, under Standard 1, with a compelling sense of purpose; strong medical school leadership; significant progress in defining areas of education and research

distinction; strong and sustained philanthropic support; and efforts to elevate the academic status and clinical offerings of its clinical affiliates.

- 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

1. AFOM-BIU benefits from the palpable esprit and pioneering spirit of a highly motivated, mission-driven faculty and leadership team, who see their medical school as playing a unique and higher purpose role within the Israel medical school landscape. The current dean is charismatic, optimistic, and energetic, with seemingly excellent alignment and relationships with both the central university leadership in Ramat Gan and his local team. He inherited a new medical school with an inspiring and clear social mission. This dean ably conveys and supports his aspirations for the medical school and duly respects the contributions of his predecessors.

2. At the time of the site visit, IQARC was informed that the current dean was approved for a 2-year extension. This is a positive development and provides reassurance that the strategic plan will be completed under his leadership, and that he will be in place to start implementation of the ICARC's recommendations. That said, two years is not long, and it will be incumbent upon the dean to work towards a smooth transition that ensures continuity in action plans.

3. The dean is surrounded by a solid management team, many of whom have been there since the school's founding. That includes the head of management, who has effectively deployed his military logistic training to materially advance the objectives of the medical school.

4. Through strong administrative leadership, AFOM-BIU introduced effective innovations in its pre-clinical and clinical training in coping with the COVID-19 pandemic. These innovations can now serve as springboard for hybrid flexible innovations in the medical school's didactic methodologies.

Provide summary of the recommendations relevant to this standard

1. **Establish a formal *Department of Medical Education*.** The DCI self-study mentions several entities that touch on medical education at AFOM-BIU. These include directorates (a *Directorate for Medical Education*, paired with a Directorate for Research); units (the *Medical Education Research and Development Unit* and the *Education and Evaluation Unit*) and committees (*Teaching/Curriculum Committee*). While an organizational chart containing these entities was offered, their respective domains of authority and responsibility were vague, as was their membership, governing principles, and operational specifics (e.g., how often they meet; how they relate to each other). Further complicating the picture are the pre-clinical and clinical components under the *Directorate for Medical Education*. The

relationship of these various entities to the Vice Dean for Medical Education is also not clearly defined. The IQARC recommends the establishment of a formal *Department of Medical Education*, powered by trained professionals with *bona fide* educational science expertise, and simplification of the matrix of directorates, units, and committees under the umbrella of this department. University leadership expressed an intention to create a *Faculty of Education*, and a *Department of Medical Education* within the medical school would provide a home for its professional educators.

2. **Build *home-grown* capacity for medical education scholarship and innovation, and in turn, administrative leaders with domain expertise in medical education.** For starters, invest in 3-5 junior faculty with interest and focus on medical education, including giving them the opportunity to obtain a master's or PhD in *Health Professions Education* from one of the premier international centers (e.g., University of Maastricht). This investment will serve to cultivate a next cadre of future administrative leaders for the medical school with a deep foundation in medical education. In turn, this would enable AFOM-BIU to position itself as a leader in medical education on the national science.

3. **Coordinate education across the various clinical affiliate sites, through an empowered educational coordinator at each site, to ensure equivalency of training.** The distributed nature of the clinical campus has many inherent challenges. There should be a clearly designated and empowered educational coordinator at each of the clinical affiliate sites, and these coordinators should meet regularly under the auspices of the central administrative educational leaders. There should be a more systematic approach to site visits in clerkships, rather than their being done in *"intervals as seem fit"*. It is unclear how academic issues at the various clinical sites are handled, with the general statement that *"findings are reported in the relevant forums and acted upon as required"*. While it is encouraging that there seems to be substantial department (specialty)-specific crosstalk among the various affiliates, the interplay of academic department and central medical school administrative entities in these matters must be clearly defined. All of this must come together to ensure equivalency of training across the affiliate network.

4. **Develop a formal multi-year faculty recruitment plan.** As noted by the dean, at its founding, faculty recruitment was per force largely opportunistic. A more deliberate approach is now envisioned under the strategic plan. Given the competing interests of recruiting health science v. basic science v. education science faculty, faculty recruitment objectives should be developed framed by a multi-year horizon, so that faculty build does not devolve into opportunistic recruiting. Of note, faculty search committees are headed by the Associate Dean for Research; input of educators is obviously essential. Clearly, a well-conceived, deliberate approach to faculty build will translate, down the road, into a multi-talented pool of future administrative leaders for the medical school.

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

Standard 2 is met, albeit *needs minor improvement* (Score 5). This needed improvement relates to a need for clearer definition of the administrative interplay among its various educational oversight

entities, which would benefit from coordination through a Department of Medical Education; the opportunity to build a strong cadre of medical educators steeped in education science; need for clearly designated educational coordinators at all sites, who come together regularly under the oversight of central administrative leaders; and the need for a formal multi-year faculty recruitment plan, with a view towards cultivating the next generation of medical school leaders. That said, AFOM-BIU is credited, under Standard 2, with a strong and galvanized management team; and strong performance in seeing the medical school through the pandemic.

- 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

1. AFOM-BIU was established with well-defined, primary goals: to address the significant health disparities among the underserved populations of the Galilee and to increase the physician workforce in that region, and in Israel. Throughout the first 10 years of its existence AFOM-BIU has demonstrated continuous willingness and effort to tackle these challenges with an already demonstrable effect on the quality and enthusiasm of the basic and clinical staff functioning both in its main campus and affiliated medical institutions. This, as well as the general continuous enthusiastic atmosphere created and radiated by the AFOM-BIU leadership translates into a respectful and stimulating learning and research environment.

2. The students feel supported by the teaching staff, both formally and informally. They emphasize the effectiveness of the HILA course which covers basic clinical and communication skills and ethics and provides personal as well as group tutorship by a designated teacher throughout the first two years.

Provide summary of the recommendations relevant to this standard

1. The ability to maintain and enhance the initial success in creating the current stimulating learning and clinical environment depends to a large extent on success in attracting AFOM-BIU graduates to residencies and ongoing career in affiliated medical institutions. Specific programs aimed at this purpose (scholarships, personal grants for fellowships in Israel and abroad etc.) should be formulated, initiated, and supported on a long-term basis.

2. Competency-based curriculum – Initial steps in this direction have already been undertaken. Yet this approach should be broadened and supported by appropriate mandatory faculty development and longitudinal assessment of both students and teachers.

3. Enhancement of learning exposure in the community combined with well-directed and longitudinally supervised and assessed attainment of competencies that are generally required and specifically meet special needs of underserved Galilee communities would greatly serve the key missions of the AFOM-BIU.

4. It is suggested that formal longitudinal tutorship by a senior teacher should be designed for the students throughout the 3rd And 4th year. The "homing" of student groups mostly to one affiliated hospital makes this suggestion feasible.

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

Standard 3 is met; however, it needs major improvement (Score 4). Key steps for improvement relate to the issues of longitudinal tutoring of students; assessment of their attainment of well-defined required competencies; and a significant effort to encourage their direction to local Galilee residencies and specialties. Mandatory faculty development is needed mostly due to the diverse clinical environments in which teaching occurs.

- 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

1. The committee was impressed by the adequately trained teachers in the basic science courses. The combination of well-suited, highly motivated teachers with clinical teachers in the basic sciences courses helps bridge an inherent lack of teachers, but at the same time, serves the purpose of clinical relevance and is accepted both by teachers and students as extremely valuable.

2. Clinical teachers were selected from the different institutions that are affiliated with the AFOM-BIU. In general, they share an enthusiastic pioneering attitude. The general enthusiastic approach is reflected in significant additional efforts exerted by many of them without a clear benefit—in many cases, even without a partial academic appointment.

Provide summary of the recommendations relevant to this standard

1. The diverse professional backgrounds of clinical teachers, many of them without previous experience in currently accepted approaches to training of medical students, necessitates a well-designed and compulsory scheme of continuing faculty development programs. The fact that many of the clinical teachers are residents (some of them 1st or 2nd year residents) emphasizes this need even further.

2. It is advised to develop a system, possibly separate, for academic promotion based on excellence in teaching.

3. Special efforts should be directed towards training and development of community-based teachers.

4. Founding a department for medical education will enhance the possibility to plan and maintain a clear mandatory plan of faculty development directed towards competency-based, longitudinally assessed, and periodically updated curriculum.

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

Standard 4 is met; however, it warrants major improvement (Score 4). The major suggestion is to found a department of medical education that will lead a mandatory program of faculty development, both for pre-clinical and clinical teachers.

- 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

1. Student feedback suggests basic satisfaction with almost everything except the quality and cost of the food campus which is being addressed.

2. Security policies and procedures are sophisticated.

3. Clinical Affiliates are diverse, high occupancy although the quality of the teaching spaces and available clinical electives are on the lower side of student satisfaction.

4. Satisfaction with library resources is moderate to high.

Provide summary of the recommendations relevant to this standard

1. **Invest in faculty development.** Many of the volunteer faculty in the community hospitals have little specific expertise in evidence-based medical education. Faculty development training is not mandatory and appears to be episodic. Require all clinical faculty to engage in a longitudinal, rigorous faculty development process that leads to certification (promotion criteria). Over time, this will build clinical education capacity for the whole system. Single faculty development 'workshops' are not effective. More structured *teaching-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.

2. **Build a community-based clinical campus.** The community sites are not yet adequate to the current or future need for community based clinical training. The barriers within the purview of the medical school should be addressed (e.g., curriculum and faculty development) while advocating with the relevant ministries for resources needed.

3. **Address student life issues.** The current facilities are acknowledged as limited, but adequate for the current size of the faculty and student body. Student feedback suggested basic satisfaction with almost everything except the quality and cost of food on campus. Survey students on these issues regularly (consider a random sample of students quarterly) to monitor their experience as administration makes changes. Delegate student surveys to student council and include them in the interpretation of survey results and the

development of solutions. Whenever reporting any survey data, share the response rates, means/modes, and standard deviations in a table that makes it easier to interpret the meaning of the results. Also, when monitoring these issues, share change over time.

4. **Address the need for simulation training.** There is an intention to access a simulation center to be opened at a college in Tzfat. This plan must be executed, as access to simulation is now viewed as foundational for any contemporary medical education system.

5. **Ensure clinical affiliation agreements are updated.** Clinical affiliation agreements have been signed. However, given that most date back to 2010 and 2011, end-dates of these agreements should be monitored, and they should be updated as appropriate.

6. **Remedy the mold issue in 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 minor improvement* (Score 5). We agree with the faculty's self-assessment that: *"Although staffing and resources are adequate for current needs, significant growth is required and is intended".* The IQARC feels that the momentum toward resolving major issues in this standard is well-grounded in view of new construction planned for the campus, along with plans to expand the clinical campus to community sites. The strategic plan should address these aims specifically and with an accountability framework that makes clear how progress will be monitored.

- 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

1. The AFOM-BIU did begin to invest in CBME and active learning. For example, the communication skills curriculum engages students actively in a staged, skills-based set of learning activities assessed, both formatively and summatively, in the pre-clinical years.

2. There is monitoring of students with difficulties. For example, the *Student Achievement and Professionalism Committee* monitors the students' academic achievements and development in the field of academic achievement and professionalism during their training towards the practice of medicine. The committee actively works to identify students who are having difficulty meeting academic requirements and/or standards of professional conduct.

3. There is a bi-weekly medical education journal club that initiates changes.

4. Some processes exist that monitor and identify challenges in courses indicating willingness to make changes.

5. The HILA *Professional Foundations for the Future Doctor and the Medical Ethics* courses are longitudinal across the pre-clinical years. These important courses address issues very relevant to the AFOM-BIU's goals.

Provide summary of the recommendations relevant to this standard

1. **Commit to and implement a fully competency/outcomes-based curriculum.** The DCI self-study does identify the need to move toward a genuine competency-based medical education (CBME) curriculum, but much needs to be done towards this end. By example, efforts need to be invested in assessing outcomes and providing feedback in the clinical years. *Task-pad* or *skills* notes, though clear, only include the medical procedures a student should observe, but do not encompass professionalism or communication issues (e.g., whether a clinical faculty observed them in different professional tasks; the quality of their patient interviews). Further, they are mainly checking if the student observed or participated in specific procedures/situations, but not how they have done it nor feedback on how to improve in the future (e.g., how to organize KABALA better). When moving to more CBME, assessment should entail a system of work-based assessment in the clinical phase assessing broad outcomes, while providing documented feedback and to more and diverse

assessment approaches in the preclinical. With representation on the national committee to set CBME outcomes, this has the potential to transform medical education in the country. Consider contributing towards an Israeli Competency Framework (e.g., see CanMeds, Scottish Doctor, ACGME Outcomes).

2. **Formalize assessment in key educational threads.** Assessment should be better developed as it relates to *Ethics and Human Values*, the HILA program, professionalism, humanistic values, and leadership, among others.

3. **Invest in faculty development.** Faculty development training is not mandatory and appears to be episodic. Require all clinical faculty to engage in a longitudinal, rigorous faculty development process that leads to certification (e.g., as a promotion criteria). Over time, this will build clinical education capacity for the whole system. Single 'workshops' are not effective. More structured *teaching-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.

4. **Add more structure to educational assessment, including an integrated database.** Various ways of assessment have been implemented, including *"a combination of written examinations, OSCE-style clinical examinations, written and practice assignments and clerkship performance assessments".* However, students are not observed in a systematic way, and it is unclear when and how they receive feedback. A more integrative and inclusive database should be developed that tracks each student's progress and challenges. Assessment volume is high in the preclinical curriculum but not present in the clinical years. By moving to vertical and horizontal integration, assessment frequency could be more evenly distributed throughout the years.

5. **Augment reflections and communication skills development, longitudinally.** The DCI self-study mentions the use of reflections and feedback, but it remains unclear how reflective practice is actually taught, as well as the assessment used to guide feedback on it. A guiding assessment tool would be useful. It is essential to have longitudinal follow-up of the student in a more organized way throughout the years (perhaps more integration between the important HILA course and mentoring). This longitudinal follow-up should help students maintain and develop their reflective abilities and communication skills. Currently, the competency skills of reflections and communication are formally taught and assessed only in the pre-clinical years and are missing in the clinical years. More direct observation, feedback, and work-based assessments or OSCE's are needed.

6. **Reduce contact hours and implement a more comprehensive approach to active learning.** It is evident that students are exposed to a dense weekly program of direct contact/exposure. A significant part of this time should be freed up to promote self-directed, active learning. There have been some steps in this direction in both the pre-clinical and clinical years, as well as in integrating team-based learning. However, it remains unclear

precisely what has been done, how many hours are invested in it, its success thus far, and the barriers.

7. **Amplify structured student assessment forms.** Students do fill out assessment forms after each clerkship, but questions should be added relating to ongoing feedback and their opportunity to learn from it; whether they were observed during different interactions with patients; whether they were treated with respect; and how much of the teaching was team-based learning. Observation of performance, including interaction with the patient, and feedback on this in the clinical years is critical to students' development. Furthermore, the feedback should be guided to focus on specific items, not, as one faculty member mentioned, based on *"personal impression"*.

8. **Increase the ambulatory/community component of clinical training.** Many clerkships do seem to have ambulatory/community experiences, but the percentage is low. This will require a well-developed plan.

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 4). The needed improvements relate to the need for continuity of the longitudinal courses and their assessments into the clinical years. There is a need for commitment to and implementation of a fully competency/outcomes-based curriculum beyond pre-clinical years. This will include more formalized, structured assessments in key educational threads, both in the pre-clinical and clinical years. Furthermore, there is a need for investment in mandatory, organized, and competency-based faculty development, which is lacking currently. Though efforts are ongoing to enhance active learning and students' self-directed learning, there is a need to enhance these and more clearly assess implementation in students' assessments of courses and clinical rotations. In addition, there is a need to add more opportunities for ambulatory/community training. That said, AFOM-BIU is credited, under Standard 6, for having a block system learning; two longitudinal important courses in the clinical years; and various processes in place to encourage making the suggested improvements.

- 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

1. As reflected in knowledge test scores, AFOM-BIU graduates perform as well as students from other Israeli medical schools. This is suggesting that there is no "harm done" by this evidence- based, modern medical school curriculum. However, it is also clear that they meet the higher standard of preparing the students "for contemporary medical practice. This is a much higher standard.

2. The two current curriculum tracks, 3 or 4 years, are well described, as are the prerequisites and intended student recruits and differences in the preclinical course structure.

3. The HILA Course, *Professional Foundations for the Future Doctor and the Medical Ethics*, is longitudinal across the preclinical years followed by the *Imparting the Basics of Clinical Medicine* (6-week) course, combining CBL and TBL, lectures and case discussions. This course is described as integrated with and timed to reinforce material being taught in the pre-clerkship blocks. A number of detailed examples are given in the text and tables in 7.1.

4. The Societal Problems (7.7) addressed were carefully selected based on the mission of the medical school and challenges specific to the population served. They describe 4 "spiral curricula": The population health course (a small group project), the community placement Course (4 hours/week for 8 weeks) The Preventive medicine Course (embedded in IM Clerkship) and ETGAR "Challenge" (a patient-based transition from hospital to community- experience). This is an exemplar for other medical schools.

5. The "home" model is an excellent structure to provide continuity and longitudinal assessment. Students choose a clinical "home" hospital in which to spend 73-83 weeks doing five core clerkship rotations (Medicine, Pediatrics, Surgery, Obstetrics & Gynecology, and Psychiatry), plus other clinical topics in compulsory, selective or elective periods.

6. The description of *Ethics and Human Values* (7.2) reflects a sophisticated array of issues and concepts addressed and clear alignment with the school's mission to address regional health disparities. The instructional approaches also align with the material.

7. The communication skills curriculum (7.8) engages students actively in a staged, skills-based set of learning activities and is assessed both formatively and summatively. It is appropriately high stakes. The communication skills assessment is 50% of the final grade of the HILA course.

8. The core curriculum is highly integrated. Students described the ability to influence the curriculum and contribute to "co-producing" it (two examples: providing Near Peer Tutoring and

generating a system for selecting a clinical site for clerkships).

Provide summary of the recommendations relevant to this standard

1. **Commit to and implement a fully competency/outcomes-based curriculum.** Such a curriculum would build on and integrate the many solid components AFOM-BIU already has in place. The DCI self-study does identify the need to move toward a genuine competency-based medical education (CBME) curriculum, but much needs to be done towards this end. By example, efforts need to be invested in assessing outcomes and providing feedback in the clinical years. *Task-pad* or *skills* notes, though clear, only include the medical procedures a student should observe, but do not encompass professionalism or communication issues (e.g., whether a clinical faculty observed them in different professional tasks; the quality of their patient interviews). Further, they are mainly checking if the student observed or participated in specific procedures/situations, but not how they have done it nor feedback on how to improve in the future (e.g., how to organize KABALA better). When moving to more CBME, assessment should entail a system of work-based assessment in the clinical phase assessing broad outcomes, while providing documented feedback and to more and diverse assessment approaches in the preclinical phase of the curriculum. With representation on the national committee to set CBME outcomes, this has the potential to transform medical education in the country. Consider contributing towards an Israeli Competency Framework (e.g., see CanMeds, Scottish Doctor, ACGME Outcomes).

2. **In order to accomplish the first recommendation assessment of students on all aspects of the curriculum must be defined in detail.** For instance:
    - **a.** With respect to primary care training (7.4) In the Hila Program students see an individual patient once a month, completes a write up and received feedback on this write up. It is not absolutely clear that the interaction between student and patients is directly observed with feedback given. The table does suggest that they are given verbal feedback during the 4-week Primary care clerkship. However, for that clerkship as well as the 5 weeks of “community clinics” in the preclerkship phase, assessment is described only as “final exam”.
    - **b.** In addition to disease diagnosis, management, prevention and health maintenance the PC (7.5) curriculum incorporates professionalism, humanistic values and leadership Again, it is not entirely clear how students are assessed on this material.
    - **c.** Imaging (including POCUS), Pathology and EM curriculum are integrated longitudinally. Assessment is not clear.
    - **d.** Communication skills are conceptualized in a set of principles rather than a more rigorous behaviourally described set of skills which would make it possible to track progress toward mastery.

3. **Build the 6-year program to both expand the number of physicians and enhance the attractiveness of a career in medicine for regional students.** A plan is being developed for a new 6-year track which it is thought might attract more students from local communities

and potentially increase the number who choose to stay and practice in the north.

4. **Clarify the overarching curricular framework and justification for the pre-clerkship "block" structure.** It seems to be a combination of discipline-based (e.g., anatomy, bioenergetics) and disease/pathology-based (oncology) curricula.

5. **Invest in, test, and rapidly expand a community-based model for clinical medical education.** This represents a national challenge, and AFOM-BIU should take the lead. With only three major hospitals, it should be considered as a way forward.

6. **Explore new models for the clinical clerkships.** Given that the homing model has students spending most of their required clerkships at single clinical affiliates, such continuity of experience and associated mentoring lends itself to *Longitudinal Integrated Clerkship* models. This could be developed more formally. Other options such as advanced clerkship and *incremental increases in authority* models can be grafted onto the clinical training schema to better prepare students for their transition to residency and beyond

7. **Implement an inter-professional education (IPE) curricular thread.** While students claimed to be learning how to work on inter-professional teams, they could not cite specific examples of having ever trained alongside another health professions student. A single such experience (with nursing students) is described in the DCI self-study. It would be reasonably straightforward to incorporate IPE competencies into a curriculum structured such as that of AFOM-BIU, and assessment of IPE could be added to *OSCE's* and *Direct Workplace Observation*.

8. **Further develop the curriculum around cultural competence and healthcare disparities.** The content for these elements is spread throughout the HILA course, clerkships, and active learning experiences exploring personal biases. An explicit conceptual framework for this material would be valuable in tying the material together for both educators and students. For instance, while there is reference to a *Social Determinants of Health* curriculum and communication skills practice, cultural humility is only hinted at in the description of students exploring their own biases.

9. **Strengthen career counseling.** Adding career counselling to the mentorship program in the clinical years would help students decide on electives.

10. **Ensure all students experience having had been mentored**: A longitudinal mentoring program is very briefly described in this section. During our meetings both instructors and learners were able to describe this experience in more detail but were vague about impact.

11. Table 7.8 should be more explicit about which learning objective was addressed in what clinical experience.

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 4). The IQARC agrees with the faculty's self-assessment that while there are many strengths of the curriculum as noted above, there is a lot of work to be done to fully realize a curriculum which is fit for purpose.

- 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

1. AFOM-BIU is active in identifying gaps in specific sites/settings and making adjustments to allow students to learn in other sites.

2. AFOM-BIU mentioned they have good practices for monitoring students with difficulties; for example, the Student Achievement and Professionalism Committee *"actively works to identify students who are having difficulty meeting academic requirements and/or standards of professional conduct"* and find solutions.

3. AFOM-BIU invests effort and focus on continuity of care, e.g., the Etgar course and changes in teaching for Hematology.

4. Block system learning allows better organization of studies, with two longitudinal courses in pre-clinical years.

Provide summary of the recommendations relevant to this standard

1. **Coordinate education across the various clinical affiliate sites to ensure equivalency of training.** The distributed nature of the clinical campus has many inherent challenges. There should be a clearly designated and empowered educational coordinator at each of the clinical affiliate sites, and these coordinators should meet regularly under the auspices of the central administrative educational leaders. There should be a more systematic approach to site visits in clerkships, rather than their being done in *"intervals as seem fit"*. It is unclear how academic issues at the various clinical sites are handled, with the general statement that *"findings are reported in the relevant forums and acted upon as required"*.

2. **Add more structure to educational assessment, including an integrated database.** Various ways of assessment have been implemented, including *"a combination of written examinations, OSCE-style clinical examinations, written and practice assignments and clerkship performance assessments".* However, students are not observed in a systematic way, and it is unclear when and how they receive feedback. A more integrative and inclusive database should be developed that tracks each student's progress and challenges.

3. **Invest in faculty development.** Many of the volunteer faculty in the community hospitals have little specific expertise in evidence-based medical education. Faculty development training is not mandatory and appears to be episodic. Require all clinical faculty to engage in a

longitudinal, rigorous faculty development process that leads to certification (e.g., as a promotion criteria). Over time, this will build clinical education capacity for the whole system. More structured *teaching-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.

4. **Make routine psychometric testing of exams available.** Improve the pre- and post-test quality control around item and test development, including a psychometric analysis.

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 4). The IQARC agrees with the faculty's self-assessment that while there are strengths as noted above, there is a lot of work to be done to fully manage the curriculum well and evaluate and enhance the experience of different students in various sites. This will be enhanced by better coordination of the educational experiences and mandatory, thorough faculty development.

- 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

1. The assessment program is constructively aligned with the training program. Every aspect of the curriculum is being assessed. The assessment itself is of a classic summative type with a prioritization of cognitive skills.

2. High standards are set for students. This leads to very competent graduates.

Provide summary of the recommendations relevant to this standard

1. **Commit to and implement a fully competency/outcomes-based curriculum.**
   Such a curriculum would build on and integrate the many solid components AFOM-BIU already has in place. The DCI self-study does identify the need to move toward a genuine competency-based medical education (CBME) curriculum, but much needs to be done towards this end. By example, efforts need to be invested in assessing outcomes and providing feedback in the clinical years. *Task-pad* or *skills* notes, though clear, only include the medical procedures a student should observe, but do not encompass professionalism or communication issues (e.g., whether a clinical faculty observed them in different professional tasks; the quality of their patient interviews). Further, they are mainly checking if the student observed or participated in specific procedures/situations, but not how they have done it nor feedback on how to improve in the future (e.g., how to organize KABALA better). When moving to more CBME, assessment should entail a system of work-based assessment in the clinical phase assessing broad outcomes, while providing documented feedback and to more and diverse assessment approaches in the preclinical. With representation on the national committee to set CBME outcomes, this has the potential to transform medical education in the country. Consider contributing towards an Israeli Competency Framework (e.g., see CanMeds, Good Medical practice (UK), Scottish Doctor, ACGME Outcomes).

2. **Implement an assessment-*for*-learning approach.**
   In line with an outcome-based curriculum would be using a more assessment-for-learning approach in which learning is supported by rich feedback (quantitative and qualitative) and students are monitored and guided in their development of competencies in a longitudinal fashion. The current assessment system follows the block design. Therefore, the assessment volume is high in the preclinical curriculum. When you would move to vertical and horizontal integration the assessment frequency could be significantly reduced. You may even consider programmatic assessment as an assessment strategy.

3. **Add more structure to educational assessment, including an integrated database.**
   Various ways of assessment have been implemented, including *"a combination of written examinations, OSCE-style clinical examinations, written and practice assignments and clerkship performance assessments".* However, students are not observed in a systematic way, and it is unclear when and how they receive feedback. A more integrative and inclusive database should be developed that tracks each student's progress and challenges. The current assessment system follows the block design. Therefore, the assessment volume is high in the preclinical curriculum, but not present in the clinical years. By moving to vertical and horizontal integration, the assessment frequency could be more easily distributed.

4. **Amplify structured student assessment forms.**
   Students do fill out assessment forms after each clerkship, but questions should be added relating to ongoing feedback and their opportunity to learn from it; whether they were observed during different interactions with patients; whether they were treated with respect; and how much of the teaching was team-based learning. Observation of performance, including interaction with the patient, and feedback on this in the clinical years is critical to students' development. Furthermore, the feedback should be guided to focus on specific items, not, as one faculty member mentioned, based on *"personal impression"*.

5. **Create continuity of student mentoring across the pre-clerkship and clerkship curriculum.**
   A longitudinal mentoring program is briefly described in the DCI self-study. It is not clear if all students are mentored in a consistent way.

6. **Augment reflections and communication skills development, longitudinally.**
   The DCI self-study mentions the use of reflections and feedback, but it remains unclear how reflective practice is actually taught, as well as the assessment used to guide feedback on it. A guiding assessment tool would be useful. It is essential to have longitudinal follow-up of the student in a more organized way throughout the years (perhaps more integration between the important HILA course and mentoring). This longitudinal follow-up should help students maintain and develop their reflective abilities and communication skills. Currently, the competency skills of reflections and communication are formally taught and assessed only in the pre-clinical years and are missing in the clinical years. More direct observation, feedback, and work-based assessments or OSCE's are needed.

7. **Formalize assessment in key educational threads.**
   Assessment should be better developed as it relates to *Ethics and Human Values*, the HILA program, professionalism, humanistic values, and leadership, among others.

8. **Make routine psychometric testing of exams available.**
   Improve the pre- and post-test quality control around item and test development, including a psychometric analysis as part of post-test quality assurance.

9. **Consider using formal standard setting methods.**
   The standards that are set for tests are based on tradition. The literature provides ample strategies for more robust standard setting.

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 4). The assessment is fairly classic, and along with the curriculum, could be further significantly modernized.

- 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

1. There are rigorous and comprehensive admission procedures, covering both cognitive and non-cognitive domains, similar to both programs. The result is a highly selective outcome with very bright students entering the program. A risk might be that the student population is not representative for the population in the country.

Provide summary of the recommendations relevant to this standard

1. **Increase the sampling for assessing non-cognitive skills.**
   The Multiple-Mini-Interview (MMI) is not really an MMI. A true MMI would have many more oral stations with more stations and examiners. More specifically, interviewers in an admission process can never be fully calibrated. The solution lies in sampling many (subjective) judgments, and a true Multiple Mini Interview (MMI) is based on this principle. Many MMIs have 8-10 "stations" each with a different interviewer focusing on a different aspect of the non-cognitive skills.

2. **Reflect your mission in the admission procedures.**
   Interviews at entry could focus on your mission of social accountability. One might select candidates that are more inclined to stay in the region.

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

Standard 9 is met, albeit *needs minor improvement* (Score 4). The admission process is rigorous. The improvement points are relatively minor.

- 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

1. **Confidential storage of data -** A system is in place for confidential storage of student information, such as grades and clerkship performance information. Access is only given on a strict need-to-know basis.

2. **Electives are available -** There is an elective program in the senior years of both medical training programs. Electives are permitted only in facilities affiliated with Bar-Ilan University.

3. **Student support -** There is an extensive system for student support. There is the "Year-Parent" program, a system of mentoring in the clinical years, a Student Achievement and Professionalism Committee, and access is organized for more specialized support such as psychological counseling.

Provide summary of the recommendations relevant to this standard

4. **Streamline the support for finding electives.**
   Students are dissatisfied with the support they can get for finding electives. This needs improvement.

5. **Raise funds for more student scholarships.**
   A system is in place where students can receive scholarships. Continue to find additional sources of funding to extend the financial support of students.

6. **Consider extending the mentoring program to all years of training.**
   Mentoring is a very successful strategy to support self-directed learning and well-being of students. Consider broadening the mentoring program to all years of training. Mentoring could be connected to assessment, for example in a programmatic approach to assessment.

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

Standard 9 is met, albeit *needs minor improvement* (Score 4). Small improvements can make a big difference for students.

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

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

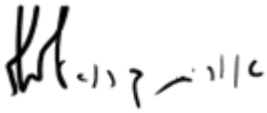
- The score that the committee gives the institution in this standard:

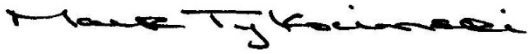
Unsatisfactory				Satisfactory	
1	2	3	4	**5**	6

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

Thursday, June 10th ,2021

Time	Subject	Participants
16:00-16:30	Opening session with the Heads of the University	Prof. Amnon Albeck, Prof. Arie Reich.
16:30-17:00	Presentation by the Dean of Faculty of Medicine*	Prof. Karl Skorecki
17:00-17:15	**Break**	
17:15-17:45	Meeting with the Dean of Faculty of Medicine*	Prof. Karl Skorecki
17:45-18:15	Meeting with the QA Report Commissioner*	Prof. Anthony Luder, Prof. David Karasik, Dr. Rola Perach, Mr. Noam David Reshelbach, Ms. Tal Nahmias
18:15-18:45	Meeting with the Head of Management *	Mr. Noam David Reshelbach
18:45-19:00	**Break**	
19:00-20:00	Meeting with the chair of the ACME	Prof. Rivka Carmi

Sunday, June 13th ,2021

Time	Subject	Participants
16:00-17:00	Meeting with senior academic staff *	Prof. Eric Shinwell, Prof. Jean Soustiel, Prof. Chaim Putterman, Prof. Johnny Younis, Prof. Daniel Glikman, Prof. Omry Koren, Dr. Lilach Malatskey, Dr. Michal Carmiel-Haggai
17:00-17:15	**break**	
17:15-17:45	Meeting with Adjunct academic staff *	Dr. Avi Peretz, Dr. Amiel Dror, Dr. Hillel Frankenthal, Dr. Tali Bertler, Dr. Izabella Mirochnik, Dr. Jonathan Orrelle, Dr. Gordon Littman, Dr. Yair Blumberg
17:15-17:45	Meeting with instructors/Clinical instructors/Clinical center heads (in relevant disciplines) *	Prof. Raymond Farach, Prof. Hassan Kamal, Dr. Sophia Eilat-Tsanani, Dr. Ran Katz, Dr. Doua Bakry, Dr. Einav Yefet, Dr. Sivan Spitzer-Shohat, Dr. Fahed Hakim.
17:45-18:00	**break**	

18:00-18:30	Meeting with pre-clinic students**	Gabriel Abitbol, Hila Hababou, Michele Buchinger, Tova Goldman, Sonia Modilevsky, Hani Makhoul
18:00-18:30	Meeting with Alumni**	Dr. Naama Maimon, Dr. Doron Cohen-Yakubovich, Dr. Ella Khairish, Dr. Nissan Ohana, Dr. Naama Nadevy, Dr. Ariel Ezra Fund, Dr. Noa Abrahami
18:30-19:00	Meeting with Clinical students**	Yaar Landau, Lihi Shalev, Shon Shabat, Lee Azolai, Gai Aviv, Fathi Haj
19:00-19:30	Closing Meeting with the Dean	Prof. Karl Skorecki, Prof. Eric Shinwell, Prof. Anthony Luder.