EVALUATION OF THE MEDICAL SCHOOL AT THE SACKLER FACULTY OF MEDICINE AT TEL AVIV UNIVERSITY

INTERNATIONAL QUALITY ASSURANCE REVIEW COMMITTEE ON HIGHER EDUCATION

NOVEMBER 2021

Background and Procedures

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

1.2 The Higher Education Institutions (HEIs) participating in the evaluation process were:

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

1.3 To undertake the evaluation, the Vice Chair of the CHE appointed an International Quality Assurance Review Committee (IQARC; 'the evaluation committee'), under the auspices of the CHE's Committee for the Evaluation of Medical Education (CEME) 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 Coordinator of the IQARC evaluation committee on behalf of the CHE.

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

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

- examine the self-evaluation reports submitted by the medical schools in Israel
- conduct on-site visits (physical and/or virtual) at those institutions participating in the evaluation process
- draw conclusions vis-à-vis each of the 11 standards
- submit to the CHE an individual report on each of the medical schools participating in the evaluation
- set forth the committee's findings and recommendations for each school

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

- submit to the CHE a general report regarding the evaluated field of study within the Israeli system of higher education, including recommendations for changes to the standards for Medical Education

1.6 The IQARC evaluation committee examined only the evidence provided by each participating institution — considering this alongside the distinctive mission set out by each institution in terms of its own aims and objectives. This material was further elaborated and explained in discussions with senior management, lecturers, students, and alumni in the course of the visits to each of the institutions.

1.7 This report deals with the Sackler Faculty of Medicine at Tel Aviv University. Notwithstanding travel challenges associated with the coronavirus pandemic, the evaluation committee's site visits and deliberations were conducted in-person. Three of the committee members (Prof. Tykocinski, Prof. Haim Bitterman, and Prof. Cees van der Vleuten) visited the medical school on November 2. Prof. Adina Kalet was unable to participate in the site visit due to pandemic-associated travel delays, although she did gain entry into Israel in time for her to participate in-person in the committee's deliberations. The schedule of the visit is attached as **Appendix 2**. The committee also visited Sheba Medical Center on November 4, which included a tour of the MSR simulation center there. One of the evaluation committee members (Prof. Orit Karnieli-Miller) recused herself from this medical school evaluation.

1.8 The IQARC evaluation committee would like to thank the management of the Sackler Faculty of Medicine at Tel Aviv University for their self-evaluation report, supportive interactions with the evaluation committee in the course of the evaluation process, and hospitality towards the committee members who visited the institution.

Key findings

Executive Summary

Sackler Faculty of Medicine at Tel Aviv University (SFOM-TAU), established in 1964, is distinguished by its central location in Israel and the impressive set of academic medical centers located in that region which serve as its clinical affiliates. This expansive clinical resource, along with a solid foundation of basic biomedical science and clinical innovation in its hub university and clinical affiliates, creates significant opportunities for the medical school's educational and research agendas. The medical school is also distinguished by its pioneering programming in the medical simulation space, showcased by the internationally-recognized Israel Center for Medical Simulation (MSR) at its Sheba Medical Center clinical affiliate.

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

The IQARC framed its deliberations around several core elements:

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

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

3) **Operating and budgetary constraints for Israel's medical schools |**
   Evaluation of medical school performance must *per force* factor in the operational environment. TFOM 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) close university oversight of medical school educational curricula and programming, faculty appointments and promotions, and operating and capital allocations; and c) complex interplay with its substantive network of clinical affiliates, notable for their reputational prominence and independent spirit. Navigating this matrix of constraints is demanding on leadership, limits degrees of freedom, and in turn, must factor into recommendations.

4) **First evaluation against a new set of CHE standards |**
   Subsequent to the 2014 medical school review cycle, the CHE, in its journey to WFME status,

set forth for the first time a structured set of standards for medical school quality assurance assessment in Israel. Further, there was a revision of these CHE standards within months of the June 2021 review cycle. Medical schools were given the option of revising their self-studies at this late stage, which was challenging as they faced the coronavirus pandemic.

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

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

The IQARC's overarching findings are:

1) SFOM-TAU features an array of foundational strengths, with a strong university-wide culture of research and discovery; an exceptional network of clinical affiliates; an impressive commitment to solid clinical education; and preeminent medical simulation capabilities. Yet, there is substantial room for elevating the medical school to a next tier, especially with respect to curricular design and implementation.

2) There is a pressing need to broaden conceptions at the institution of what curricular reform actually means, across a spectrum of curricular structures and didactic approaches—small-group learning; self-learning; competency-driven; technology-leveraged with

multidimensional simulation; high-flex in-person plus online modalities; cross-cutting knowledge domains, e.g. digital medicine. While some of these may be simply considered desirable features, most must be viewed as essential for a medical school that is heading into the mid-21st century aspiring for educational relevance and even excellence. This report sets forth high-level recommendations for how this can be best achieved, but for this to happen, a mindset open to educational reform will need to be embraced. A nucleus of faculty with education science expertise will be essential to champion and catalyze the necessary transformation, starting with a comprehensive master plan for curricular change and a compelling competency framework. Further, medical school leaders would be well-advised to look to student-centered medical education programs abroad for inspiration, and from best practice learning, crystallize a deliberate and achievable path forward for SFOM-TAU.

3) The medical school will not be able to do it alone. University leadership will have to open itself to the latest trends in medical education, and give credence to the discipline of education science. While the expertise and role-modeling of elite researchers and clinicians are without doubt a key component, truly first-rate medical education demands a cadre of faculty steeped in education science and empowered to effect forward-looking, transformative change. All faculty must have their educational contributions valued, as reflected in dedicated academic time and faculty tracks that duly recognize educational contributions, and they must be empowered and financed for the task at hand. From site visit interviews, it became clear that altering the current narrative will be no small challenge for this institution.

4) One question at hand is whether incrementalism should give way to a quantum leap forward, that is, revolution versus the current incrementalism or evolution. To the extent that there is a perception among various stakeholders, inside and outside of the medical school, that curricular reform would demand financial resources that are unattainable in the current environment, this perspective should be challenged. For example, increased costs associated with running multiple small groups can be offset by decreasing other costs driven by the current unusually high load of contact hours (reportedly 30+ hours per week). Various other curricular changes could be accomplished within the current financial envelope by simply shuffling resources and prioritizing programming. However, this is not to say that a small group-intensive curriculum will not have a somewhat higher baseline cost.

5) There is an imperative for a far more structured approach to strategic planning and articulation of mission, vision, values, strategic goals, and derivative action plans, with clear milestones, metrics, and handbook-codified policies. Documents offered under the guise of ‘strategic plans’ do not fit the bill. The medical school accreditation process can itself be constructive in this regard, not only compelling a clear framing of the aforementioned elements, but ensuring that there is continuous monitoring and periodic updating of them. Rather than being a last-minute sprint, preparations for accreditation should span years, and be powered by knowledgeable individuals tasked specifically with this process.

6) SFOM-TAU can take pride in a variety of initiatives undertaken to strengthen its educational mission. Among them are the *Division of Quality Teaching, Research and Evaluation* and the

Sheba-based Israel Center for Medical Simulation (MSR). There are also an array of distinguishing activities, such as participation of clinicians in preclinical education, integration of radiology into anatomy teaching, an introduction to clinical medicine clerkship, coordination across the clinical clerkships, an exemplary primary care clerkship, a solid longitudinal communication and professionalism curriculum, advances in assessment, training of residents for medical education, and informal senior-to-junior medical student peer mentorship.

7) Notwithstanding these laudable initiatives, there is an opportunity to bring a higher level of coordination to these activities and create a high-functioning administrative platform to add missing pieces and elevate the overall educational product. This can be accomplished by restructuring the organization and associated leader roles. SFOM-TAU might consider bringing the educational pieces under the umbrella of a Department of Medical Education, with a single leader who coordinates all of academic affairs. To engender a more systematic approach to student affairs and student life, a Vice Dean of Student Affairs position could be helpful.

8) There are other opportunities for elevating SFOM-TAU's educational programming. Some relate to the general concept of embracing a longitudinal perspective, whether it be in the areas of assessment and tracking (e,.g., learning dossiers for longitudinal development of student growth; development of non-cognitive skills) and mentoring (i.e., a longitudinal mentoring program). Others relate to driving new areas, such as expanding community-based clinical training for all students; growing interprofessional education; and visioning the global physician of the mid-21st century.

9) One of SFOM-TAU's core strengths is also an area of great opportunity—its network of clinical affiliates. In principle, the clinical affiliates could be leveraged to a much greater extent, creating a whole for the medical school that is much bigger than its parts. A higher-level of cross-institutional cross-talk would allow for new kinds of programs and learning experiences, some of which could be pioneering. Admittedly, attaining this objective will not be trivial, given the need to integrate across independent entities with varied missions and strategic priorities. Yet, the medical school could propel this process by clearly delineating value propositions for all involved.

10) SFOM-TAU is known for its longstanding American program. Of note, this program has in many ways led the ways for educational innovations at the medical school. However, the medical school would be well advised to undertake a critical reassessment at this time of this program's purpose and function. There must be more rationale than simply its serving as a source of revenue, and students in this program should be more meaningfully integrated with the others, programmatically and culturally. American program students should be viewed as future ambassadors for Israel.

11) Given its attractive central location in Israel, along with its high-profile clinical affiliates, SFOM-TAU is a key institution within Israel's medical education ecosystem. Its leaders should seize the opportunity to lead the way as a thought leader in mapping the future of Israel's

healthcare delivery system and shaping national health manpower policy. Towards this end, SFOM-TAU should key in on areas such as longitudinal outcomes measurement, steering specialty choices, augmentation of workforce diversity, and addressing health inequities.

The IQARC's more specific findings related to the CHE standards are embodied within the series of commendations/good practices and 52 recommendations set forth in detail in the following section. This includes recent major changes and key challenges faced by SFOM-TAU, 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 SFOM-TAU meets all 11 standards set forth by the Committee on Higher Education. That said, 8 of the 11 standards are categorized as *Needs Major Improvement* (2 'Score 3'; 6 'Score 4), and 3 of the 11 standards as *Needs Minor Improvement* (3 'Score 5').

There are substantial areas of commendation/good practice, and yet there is significant opportunity for elevating SFOM-TAU's administrative structures and educational programming, which are captured in the 52 recommendations set forth in the section below.

Conclusions about the Sackler Faculty of Medicine at Tel Aviv University

The IQARC evaluation committee reached the following conclusions about the higher education provision at the medical school at the Sackler Faculty of Medicine at Tel Aviv University.

Israeli Standards for Medical Education

The Sackler Faculty of Medicine at Tel Aviv 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 evaluation committee identified the following areas for commendation and features of good practice at the Sackler Faculty of Medicine at Tel Aviv University:

1) SFOM-TAU is advantaged by its central geographic location in Israel, affording it a robust set of affiliated hospitals and medical centers, some with international stature and their own research institutes, that make the medical school attractive to medical school applicants and affords excellent clinical exposure for medical students. This extensive learning environment includes some of the largest hospitals in the country, as well as many other clinical facilities.

2) The medical school and its array of clinical affiliates feature a number of outstanding figures in medical education. One of SFOM-TAU's clinical affiliates, Sheba Medical Center, is home to the Israel Center for Medical Simulation (MSR), a world-class simulation center, that is recognized internationally for its pioneering activities at the frontier of this field.

3) There is a strong cadre of research-intensive faculty in the medical school, along with an extensive milieu of other university research faculties and departments. University leadership is clear in its prioritization of research as a prime strategic differentiator. Research staff seem well-resourced.

4) The medical school is led by a well-established, accomplished Dean.

5) SFOM-TAU demonstrates a commitment to medical education in a number of ways. The *Division of Quality Teaching, Research and Evaluation* is an important resource, and is well-positioned to be further developed. It provides high-quality support for monitoring and fine tuning the curriculum and making incremental changes. There is a rather meticulous system of coordination among the departments and tutors of the large clinical clerkships. There is structured training of residents for the teaching of medical students.

6) SFOM-TAU's wealth of clinicians and strong research faculty contributes substantially to a strong learning environment, and their commitment to training activities is manifest across a number of dimensions. The active participation of clinicians in pre-clinical courses is commended. There is a research requirement for medical students—enabled by the faculty's research depth—with stipends available, albeit no protected time. The medical school is also

complemented by a strong set of other health professions.

7) There is a large and satisfied family medicine faculty, who also serve as resources for faculty development on a nationwide basis.

8) Educational facilities and support services feature a number of strengths. Library resources are significantly more robust than those at other Israeli medical schools, with strong staffing (25 FTE) and high levels of student satisfaction. There is an impressive anatomy suite facilitating the integration of clinical imaging tools, hence enabling strong coordination of anatomy teaching with radiology. Two simulation centers at key clinical affiliates provide a full array of world-class training and assessment programs. Clinical training facilities more broadly are extensive and provide a wide range of learning opportunities for students.

9) The curriculum provides comprehensive coverage and grounding in fundamental biological sciences.

10) A structure for mid-course evaluation in preclinical years is in place, providing infrastructure for a future competency-based program of assessment. There is mid-term feedback in clinical rotations.

11) SFOM-TAU sets high standards for student progression from preclinical to clinical. Introduction to clinical medicine clerkship, eight weeks of internal medicine, provides students with a hardy preparation for the transition from preclinical to clinical curriculum.

12) There is a strong longitudinal communication and professionalism curriculum taught in small groups providing vertical integration of communications ethics and humanism. Of note, assessment of communication skills and reflective ability is an exemplar of performance assessment because it has the potential to engage the student in continuous improvement of their performance through actionable feedback against clear standards. The course on professionalism and communication skills is a good example of an effective longitudinal teaching modality.

13) The primary care clerkship can serve as blueprint for other clerkships. It is a highly mentored experience that reflects state-of-the-art clinical education. Assessment is robust and the faculty are excellently prepared, enthusiastic and satisfied in their work, making them excellent role models and mentors who work in a highly competitive and fully subscribed residency in family medicine.

14) Overall, students perceive and appreciate that they are receiving excellent clinical training.

15) The medical school has been implementing educational changes over the years, albeit incremental. Notably, it demonstrated an ability to pivot and innovate educational delivery modalities in the face of the pandemic. Pandemic-driven online migration gave students more “space” for their own self-learning.

16) There are significant strengths vis-à-vis assessment and evalution, at several levels. The assessment program is comprehensive and constructively aligned with the current curriculum. Every course/rotation is extensively and summatively assessed. There is a fair amount of feedback for faculty's teaching performance. There is continuous evaluation, on an annual basis, to maintain comparability in teaching across clinical sites. Exams are quality-assured through pretest item-review and post-test psychometric analysis.

17) There is a comprehensive system of admission to medical school in place consisting of cognitive and non-cognitive elements. This is true for both medical programs at SFOM-TAU. High standards are set. This results in highly qualified and motivated students entering SFOM-TAU that are ready to complete their medical studies and who will become high-performing physicians after training. An admission process is in place for lateral transfers, albeit in very limited numbers.

18) There are opportunities for further study (e.g., MD-PhD, MPH). This flexibility in training paths allows maximum capacity building for interested students.

19) A good system for monitoring grades with strict timelines is in place. Review sessions are held for students. Except for the clerkship grades, appeals by students are possible.

20) There are sufficient personnel to assist students, including in the financial domain. An academic counselor is available for students with personal problems. A personal mentor for career path guidance is available.

21) Informal peer mentorship occurs wherein more senior students help the more junior students. This adds to a sense of cohesion and caring amongst the student body.

Recommendations

The IQARC evaluation committee makes the following recommendations to the Sackler Faculty of Medicine at Tel Aviv University.

<u>Essential</u>:

1) Develop a strategic plan that sets forth a clear articulation of mission, vision, and values, along with defined action plans and goals that are directed towards instantiating them. Of note, the 2021 document referred to as a 'strategic plan' in the DCI self-study materials is not actually a plan *per se*. Deliverables should be tracked systematically over time, with reaffirmation of goals and plans with dean transitions. The medical school's strategies and tactics must be demonstrably aligned with those of the broader university.

2) Bring the medical school's educational mission and needs into greater focus for top university leaders. There is concern over a mind-set, conveyed at the time of the site visit, that only scientists should teach, as well as an attitude that reflects a lack of appreciation for

current concepts in education science and that it is a discipline in-its-own-right. This deficiency is further reflected in the exclusion of educational tracks from university promotion and tenure. Even if research is seen by senior leaders as the overarching university priority, the commitment to medical education must be reinforced alongside it, with an appreciation that approaches to medical education must be allowed to evolve over time.

3) Align the medical school and the rest of the university around operational and financial drivers tied to the educational mission. The dean at SFOM-TAU, as is the case for all Israeli medical school deans, is constrained in his authority around faculty appointment/promotion and budgetary latitude. This raises the core question of whether certain resource-demanding recommendations of an IQARC review panel can even be implemented. This will be especially important as the medical school looks to embrace core recommendations of the IQARC review panel related to the educational mission.

4) More systematically leverage SFOM-TAU's clinical partners, perhaps with a coordinated approach that starts with a comprehensive clinical asset map, for both clinical faculty and clinical programs. A more intentional approach would yield dividends in terms of maximizing student learning opportunities and fostering higher order collaborative interactions among faculty and staff across the array of clinical affiliates, contributing towards a more vibrant, cross-institutional community of scholars and a more deeply matrixed academic clinical ecosystem. Finding ways to better integrate across the multiple clinical affiliate sites will allow for more effective leveraging of this distinguishing asset of the medical school and in particular, better drawing on the academic prowess of the distributed clinical faculty into the preclinical years.

5) Develop a comprehensive master plan for curricular change which transitions from the current traditional curriculum to a competency-based, learner-centered program with extensive vertical and horizontal integration of foundational and clinical science across all years of training. Begin with a robust planning process which targets a launch date and phase-in-period beginning with Year 1 curriculum building and implementing subsequent curricular years as the current curriculum is phased out over a full 6-year cycle.

6) Adopt a competency framework which guides and aligns choices about the curriculum, starting from learning objectives, to curricular elements (longitudinal strands, blocks, mini-courses, longitudinal integrated clerkships), to instructional strategies (case/problem/team-based, self-study, small group learning, lecture, simulation, laboratory), to assessment approaches (formative/summative) and data sources (e.g. directly observed performance, narrative/reflective, multiple choice questions, log books) and provides focus for comprehensive faculty development. This competency framework will enable mapping of all course elements and longitudinal student assessment.

7) Ensure there is a unified model for coordinating all educational activities across the medical school and its clinical affiliates, and consider combining all subunits and personnel now dealing with issues related to medical education into one strong department of medical

education. This would include integrating it with the *Division of Quality Teaching, Research and Evaluation.* Such a plan would be part-and-parcel of a more general effort to expand and restructure medical education expertise within the medical school, building on available resources and recruiting additional staff. By restructuring SFOM-TAU's education enterprise in this way and better leveraging the *Division for Advancing Quality Teaching, Research and Evaluation*, the capacity of clinical educators to engage in rigorous, inter-institutional medical education scholarship will be enhanced.

8) Recruit a cadre of faculty with an education focus, trained in the latest advances in education science and who can nucleate these concepts for the rest of the teaching faculty. Create incentives and academic career paths for these dedicated education faculty, as well as for education-focused faculty more generally, including clinician educators. Expanding pathways toward academic promotion for clinical educators, both in hospital and community settings, could draw on learnings from others, as models for rigorous criteria for promotion of medical educators are well-established in world class institutions throughout North America and Europe. Address issues related to protected academic time and educational leadership time. Building up and valuing the medical school's education-focused faculty should be approached as an imperative.

9) Transform the institutional approach to reaccreditation, viewing it as a continuous process, as opposed to a last-minute sprint as accreditation site visits loom. SFOM-TAU should identify a lead coordinator for overseeing this process—preferably an empowered medical school leader—who can visit exemplary medical schools in the U.S. and other countries and observe first-hand how the reaccreditation journey is handled. SFOM-TAU might also consider inviting an external review team midway through the reaccreditation cycle to assess status and propose mid-course corrections.

10) Collaborate with other medical schools in the country and internationally to enhance medical education literacy and capacity for curriculum innovation, designing a locally appropriate competency framework, and conducting faculty development programs.

11) Leverage the Israel Center for Medical Simulation (MSR) at Sheba Medical Center more directly with preclinical students, into the early preclinical curriculum, and strengthen its capabilities with respect to virtual medical education (VME). Overall, simulation activity should be increased to involve students at all stages of training.

12) Reduce the number of scheduled contact hours dramatically and shift most of this faculty:student and student:student contact to small scale learning activities. Currently, the curriculum is ~6% small group (174 small group /2683 total hours). This transition should protect significant time for self-directed learning.

13) Change the semester system to an integrated block system, avoiding multiple independent courses running concurrently.

14) The number of summative examination moments is extremely high. This is due to the nature of the current curriculum which is essentially discipline-based. Try to significantly reduce the number of summative moments by having interdisciplinary exams.

15) Consider assessing more performance dimensions once a competency-based curriculum is adopted, to replace the many traditional assessments summative examinations. Try and seek consensus across medical schools to adopt a single competency framework for all undergraduate (and postgraduate) training in Israel.

16) Increase meaningful feedback to students for better learning from the assessments (grades are a poor form of feedback). Provide sub-score performance information on blueprints of individual tests, where the individual performance is related to the performance of the cohort. Use documented narrative data from feedback dialogues to inform complex skills such as professionalism, communication, teamwork, leadership, and so on.

17) Create learning dossiers for longitudinal development of student growth. There are many vendors of electronic portfolios. Explore possible collaboration with other medical schools in the country in this area.

18) Create a longitudinal mentoring program for all students. Mentoring is essential for promoting reflective and self-directed learning skills, and it is also beneficial for safeguarding the well-being of students. Require students to self-analyze their academic progress periodically as a basis for a dialogue with their mentors.

19) Aggregate information of individual assessment data to inform summative decisions on student progression in relation to the competencies.

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

21) Introduce authentic work-based assessment to replace oral examinations and OSCEs and ensure consistency of implementation across all clinical sites. Examples of work-based assessment instruments include Mini-CEX, field notes, case-based discussions, peer observation, video assessment and multisource feedback. Maximize the feedback and learning value of these assessments and avoid summative signals (i.e., grades). Train the assessors on how to give feedback. Find ways to introduce these work-based assessments as part of the ongoing clinical routine.

22) Design and implement a comprehensive, longitudinal mentoring program—extended into the clinical training years—which addresses the noted lack of individualized coaching, early identification of academic struggle and career counseling.

23) Develop a core required faculty development program for all medical educators, preclinical and clinical, resident and faculty, to ensure communication of competency framework and

instructional objectives, as well as enhancing educator/assessor skills. Developing a structured approach to faculty development and mentorship, a path to promotion for eductors, along with mandating faculty development activities, would also lead to more robust attendance at faculty development programs.

24) Assure cross-site equivalency of training by implementing a clear process to ensure that clinical training objectives are understood and assessments implemented across the large array of clinical sites. Ensure strong central curriculum leadership to coordinate content learning, assessment and longitudinal monitoring of student performance and address the variability in quality of clinical tutoring across the clinical clerkships.

25) Ensure that health care disparities and cultural competence curricular content comprehensively addresses the most common local and regional societal needs in an epidemiologically state-of-the-art fashion.

26) Ensure that the architectural plans for the new medical education building include a well-structured plan to support transition to small group learning. The goal is to move away from the current predominance of large and medium size (25-60) medical education spaces towards smaller, flexible room configurations.

27) Significantly expand community-based clinical training for all students, in primary and specialty clinics out of the hospital setting. Consider an ambitious target of 20-30% of all clinical training to take place out of hospital, to be accompanied by extensive faculty development to ensure high-quality clinical learning.

28) Expand interprofessional education to include all medical students.

29) Incorporate alternative ways of assessing non-cognitive skills in the admission process that go beyond personality assessments *per se*, e.g., written Situational Judgment Tests (SJT) and Multiple Mini Interview (MMI).

30) Implement innovative admission policies to actively address lack of diversity of the student body, to better reflect the population served. Work with CHE to develop paths for diversifying admitted student demographics, including minority groups and those from underprivileged backgrounds.

31) Rethink the goals of the medical school's American program, recognizing the bad optics associated with using foreign students to subsidize Israeli students. Better integrate students from the American Program into the mainstream student body so they can later be effective ambassadors for Israeli medical education.

Important:

32) Develop a more regular cadence of meetings between the medical school dean and the rector of the university.

33) Develop a formal medical school handbook that translates the university bylaws into well-defined medical school policies that govern faculty, student and staff affairs, and the senior management structure and operations.

34) Establish a *Vice Dean for Student Affairs* position in the medical school to better structure student support services. Such a dedicated vice dean for student affairs would facilitate the creation of a more robust organizational infrastructure for administrating student affairs and student life.

35) Conduct a well-written, annual required student satisfaction survey, to monitor adequacy of support services and educational programs and provide consistent outcome data to assess impact of changes and innovations.

36) Start to address the time and financial pressures on SFOM-TAU students by directing meaningful philanthropic dollars towards student support. Work with university-level development officers to create a meaningful number of endowed scholarships, to lighten the financial and time commitment burdens on students. This, in-and-of-itself, would message a fundamental commitment to the education mission, and would further indicate that philanthropy need not be solely directed towards the research mission.

37) Provide more structured student guidance procdss for choice of specialty and residency/fellowship path.

38) Align the multiple committees within the administrative oversight structure, with the goal of streamlining operations. Remedy aspects of the hierarchical structure that impede constructive and transformative change.

39) Bring the portfolio of clinical affiliation contracts and memoranda of understanding up to date and ensure completeness.

40) Implement a *Conflict of Commitment* policy. Constitute formal *Conflict of Interest* and *Conflict of Commitment* committees that develop, and are then guided by, well-structured policies, and oversee disclosures through a systematic, annual process.

41) Start to leverage other health professions for interprofessional education, perhaps building on the Yachad program that is not well known.

42) Plan for participation of pre-clinical teachers in clinical courses.

43) Provide more detailed information related to student retention and student progression, that is track- and years-in-place-dependent. This will reveal length of study and dropout/attrition within the program.

44) Develop a system for longitudinal tracking of educational outcomes, as a pressing need and opportunity. This is not just for SFOM-TAU itself, but also towards the medical school's larger obligation to help build Israel's physician workforce. Medical school-specific data as to numbers of graduates practicing in Israel, types of medicine practiced, and kinds of clinical venues are crucial for proper assessment and planning. A longitudinal database to track medical school graduate career paths over time would allow for more systematic assessment of medical education outcomes over time and correlation with respective medical school performance parameters. Explore collaboration opportunities to aggregate this kind of data across medical schools in the country.

45) Enhance the "Yachad" (interprofessional education) program to prepare medical students to work effectively in the highly interdependent health care teams of the future.

46) Tap into Israel's start-up ecosystem for co-curricular student experiences and or research thesis opportunities.

47) Expose students to the highly satisfied, exceptionally prepared primary care practitioners in the medical school's orbit, to promote attractiveness of primary care as a career choice and thus help address the national need for Israel-trained physicians to fill these critical roles.

48) Leverage the American/NYS Program, which is more advanced in implementing integrated curriculum. This program can serve as a laboratory to pilot and study curricular and instructional innovation, with the downstream goal of infusing the Israeli programs with new approaches.

49) Strengthen program evaluation by students. Given the limited variance in responses of students, the data (as reported in the DCI self-study) is generally not meaningful or actionable.

50) Ensure rigorous assessment of curricular content that is migrated online, at the course and individual faculty level.

Desirable:

51) Free up time for students to engage meaningfully in research and for off-campus experiences (e.g., community service work, embedding in high-tech environments).

52) Provide English translations of all key documents in future DCI self-studies.

Explanation of the findings about the Sackler Faculty of Medicine at Tel Aviv University, according to individual standards

This section sets forth key review findings, for each of the 11 standards, with commendations and recommendations.

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

- SFOM-TAU is advantaged by its central geographic location in Israel, affording it a robust set of clinical sites, some with international stature, that make the medical school attractive to medical school applicants and affords excellent clinical exposure for medical students.

- SFOM-TAU is enriched by a strong research faculty, both within the medical school and across the rest of the university.

- The staff are well-resourced.

Provide summary of the recommendations relevant to this standard

- Develop a strategic plan that sets forth a clear articulation of mission, vision, and values, along with defined action plans and goals that are directed towards instantiating them. Of note, the 2021 document referred to as a 'strategic plan' in the DCI self-study materials is not actually a plan *per se*. Deliverables should be tracked systematically over time, with reaffirmation of goals and plans with dean transitions. The medical school's strategies and tactics must be demonstrably aligned with those of the broader university.

- Bring the medical school's educational mission and needs into greater focus for top university leaders. There is concern over a mind-set, conveyed at the time of the site visit, that only scientists should teach, as well as an attitude that reflects a lack of understanding of current concepts in education science and a discipline in-its-own-right. This deficiency is further reflected in the exclusion of educational tracks from university promotion and tenure. Even if research is seen by senior leaders as the overarching university priority, the commitment to medical education must be reinforced alongside it, with an appreciation that approaches to medical education must evolve over time.

- More systematically leverage SFOM-TAU's clinical partners, perhaps with a coordinate approach that starts with a comprehensive clinical asset map.

- Develop a formal university handbook that translates the university bylaws into well-defined medical school policies, governing faculty, student and staff affairs, and the senior management structure and operations.

- Bring the portfolio of clinical affiliation contracts and memoranda of understanding up to date and ensure completeness.

- Implement a *Conflict of Commitment* policy.

- Constitute formal *Conflict of Interest* and *Conflict of Commitment* committees that develop, and are then guided by, well-structured policies, and oversee disclosures through a systematic, annual process.

- Rethink the goals of the medical school's American program, recognizing the bad optics associated with using foreign students to subsidize Israeli students.

- Start to address the time and financial pressures on SFOM-TAU students by directing meaningful philanthropic dollars towards student support. This, in-and-of-itself, would message a fundamental commitment to the education mission.

- Provide English translations of all key documents in future DCI self-studies.

- Transform the institutional approach to reaccreditation, viewing it as a continuous process, as opposed to a last-minute sprint as site visits approach. SFOM-TAU should identify a lead coordinator for overseeing this process—preferably an empowered medical school leader—who can visit exemplary medical schools in the U.S. and other countries and observe first-hand how the reaccreditation journey is handled. SFOM-TAU might also consider inviting an external review team midway through the reaccreditation cycle to assess status and propose mid-course corrections.

- Develop a system for longitudinal tracking of educational outcomes, as a pressing need and opportunity. This is not just for SFOM-TAU itself, but also towards the medical school's larger obligation to help build Israel's physician workforce. Medical school-specific data as to numbers of graduates practicing in Israel, types of medicine practiced, and kinds of clinical venues are crucial for proper assessment and planning.

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

Standard 1 is met, albeit *needs major improvement* (Score 3). There is particular concern over the approach to medical education at the university level. A structured strategic plan, with well-articulated mission/vision/values/goals is needed, and there is a need for a more structured approach to policies and procedures, as well as the accreditation process itself.

- 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

- SFOM-TAU is led by a well-established, accomplished Dean.
- The *Division of Quality Teaching, Research and Evaluation* is an important resource, albeit in some ways it is underdeveloped.

Provide summary of the recommendations relevant to this standard

- Align the medical school and the rest of the university around operational and financial drivers tied to the educational mission. The dean at SFOM-TAU, as is the case for all Israeli medical school deans, is constrained in his authority around faculty appointment/promotion and budgetary latitude. This raises the core question of whether certain resource-demanding recommendations of an IQARC review panel can even be implemented. This will be especially important as the medical school looks to embrace core recommendations of the IQARC review panel related to the educational mission.
- Develop a more regular cadence of meetings between the medical school dean and the rector of the university.
- Establish a *Vice Dean for Student Affairs* position in the medical school to better structure student support services.
- Align the multiple committees within the administrative oversight structure, with the goal of streamlining operations. Remedy aspects of the hierarchical structure that impede constructive and transformative change.
- Find ways to better integrate across the multiple clinical affiliate sites and more effectively leverage this distinguishing asset of the medical school. The academic prowess of the distributed clinical faculty should be leveraged into the preclinical years.
- Ensure there is a unified model for coordinating all educational activities across the medical school and its clinical affiliates and consider expanding the mission of the Department of Medical Education by integrating it with the *Division of Quality Teaching, Research and Evaluation.*

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

Standard 2 is met, albeit *needs major improvement* (Score 4). The medical school is embedded within an outstanding university, and it is further advantaged by a network of exceptional clinical affiliates. The challenge for the organization is how to more fully leverage these core assets for the benefit of its students. Streamlining organizational structures within and outside of the medical school will be key to this goal.

- 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

- There is a strong cadre of research-intensive faculty in the medical school and an extensive milieu of other university research faculties and departments.
- The university's strengths are complemented by a collection of affiliated hospitals, many of them with research institutes. This extremely large learning environment includes the three largest hospitals in the country, as well as many other clinical facilities.
- One of SFOM-TAU's clinical affiliates, Sheba Medical Center, is home to MSR, a world-class simulation center, that is recognized internationally for its pioneering activities at the frontier of this field.
- The medical school and its array of clinical affiliates feature a number of outstanding figures in medical education.
- There is structured training of residents for education.
- There is a rather meticulous system of coordination among the departments and tutors of the large clinical clerkships.
- There is a research requirement for medical students, with stipends available, albeit no protected time.

Provide summary of the recommendations relevant to this standard

- Expand and restructure medical education expertise within the medical school, building on available resources and recruiting additional staff.
- Consider combining all subunits and personnel now dealing with issues related to medical education into one strong department of medical education.
- Leverage MSR more directly with preclinical students and strengthen its capabilities with respect to virtual medical education (VME). Overall, simulation activity should be increased to involve students at all stages of training.

- Create a human asset map encompassing the large collection of clinical affiliates in order to foster a vibrant community of scholars and academic clinical ecosystem.

- Develop a structured approach to faculty development and mentorship.

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

Standard 3 is met, albeit *needs minor improvement* (Score 5).

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

Standard 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

- SFOM-TAU features a large faculty base which includes a wealth of clinicians and a strong research faculty.
- There is a large and satisfied family medicine faculty, who also do faculty development on a nationwide basis.
- The medical school is complemented by a strong set of other health professions.
- The active participation of clinicians in pre-clinical courses is commended.
- There is a fair amount of feedback for faculty's teaching performance.

Provide summary of the recommendations relevant to this standard

- Recruit more faculty with an education focus, recognizing advances in education science.
- Create incentives and academic career paths for education-focused faculty, including clinician educators, and approach this as an imperative.
- Address issues related to protected academic time and educational leadership time.
- Start to leverage other health professions for interprofessional education, perhaps building on the Yachad program that is not well known.
- Plan for participation of pre-clinical teachers in clinical courses.
- Mandate faculty development activities so that there is more robust attendance.

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

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

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

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

Unsatisfactory Satisfactory

1 2 3 **4** 5 6

Standard 5: Educational Resources and Infrastructure

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

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

- Library resources are significantly more robust than those at other Israeli medical schools, with strong staffing (25 FTE) and high levels of student satisfaction.
- There is an impressive anatomy suite facilitating the integration of imagining tools in the teaching.
- Two simulation centers provide a full array of world-class training and assessment programs.
- Clinical training facilities are extensive and provide a wide range of learning opportunities for students.

Provide summary of the recommendations relevant to this standard

- Conduct a well-written, annual student satisfaction survey that is required, to monitor adequacy of support services and educational programs and provide consistent outcome data to assess impact of changes and innovations.
- Ensure that the architectural plans for the new medical education building include a well-structured plan to support transition to small group learning. The goal is to move away from the current predominance of large and medium size (25-60) medical education spaces towards smaller, flexible room configurations.
- Significantly expand community-based clinical training for all students. Consider an ambitious target of 20-30% of all clinical training to take place out of hospital, to be accompanied by extensive faculty development to ensure high-quality clinical learning.
- Expand pathways toward academic promotion for clinical educators, both in hospital and community settings. Models for rigorous criteria for promotion of medical educators are well-established in world class institutions throughout North America and Europe.

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

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

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

Standard 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

- There is a strong longitudinal communication and professionalism curriculum taught in small groups providing vertical integration of communications ethics and humanism. Of note, assessment of communication skills and reflective ability is an exemplar of performance assessment because it has the potential to engage the student in continuous improvement of their performance through actionable feedback against clear standards.

- Introduction to clinical medicine clerkship, 8 weeks of internal medicine, provides students with a hardy preparation for the transition from preclinical to clinical curriculum.

- A structure for mid-course evaluation in preclinical years is in place, providing infrastructure for a future competency-based program of assessment.

- The *Division for Advancing Quality Teaching, Research and Evaluation* provides high-quality support for monitoring and fine tuning the curriculum and making incremental changes.

Provide summary of the recommendations relevant to this standard

- Develop a comprehensive master plan for curricular change which transitions the current traditional curriculum to a competency-based, learner-centered program with extensive vertical and horizontal integration of foundational and clinical science across all years of training. Begin with a robust planning process which targets a launch date and phase-in-period beginning with Year 1 curriculum building and implementing subsequent curricular years as the current curriculum is phased out over a full 6-year cycle.

- Adopt a competency framework which guides and aligns choices about the curriculum, starting from learning objectives, to curricular elements (longitudinal strands, blocks, mini-courses, longitudinal integrated clerkships), to instructional strategies (case/problem/team-based, self-study, small group learning, lecture, simulation, laboratory), to assessment approaches (formative/summative) and data sources (e.g. directly observed performance, narrative/reflective, multiple choice questions, log books) and provides focus for comprehensive faculty development. This competency framework will enable mapping of all course elements and longitudinal student assessment.

- Collaborate with other medical schools in the country and internationally to enhance medical education literacy and capacity for curriculum innovation, designing a locally appropriate competency framework, and conducting faculty development programs.

- Expand the use of considerable simulation capacity into the early preclinical curriculum.

- Reduce the number of scheduled contact hours dramatically and shift most of this faculty:student and student:student contact to small scale learning activities. Currently, the curriculum is ~6% small group (174 small group /2683 total hours). This transition should protect significant time for self-directed learning.

- Change the semester system to an integrated block system, avoiding multiple independent courses running concurrently.

- Develop a core required faculty development program for all medical educators, preclinical and clinical, resident and faculty, to ensure communication of competency framework and instructional objectives, as well as enhancing educator/assessor skills.

- Design and implement a comprehensive, longitudinal mentoring program—extended into the clinical training years—which addresses the noted lack of individualized coaching, early identification of academic struggle and career counseling.

- Leverage the *Division for Advancing Quality Teaching, Research and Evaluation* to enhance the capacity of clinical educators to engage in rigorous, inter-institutional medical education scholarship.

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

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

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

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

Unsatisfactory Satisfactory

1 2 **3** 4 5 6

Standard 7: Curricular Content

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

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

- There is strong coordination of anatomy teaching with radiology.
- The curriculum provides comprehensive coverage and grounding in fundamental biological sciences.
- The primary care clerkship can serve as blueprint for other clerkships. It is a highly mentored experience that reflects state-of-the-art clinical education. Assessment is robust and the faculty is excellently prepared, enthusiastic and satisfied in their work, making them excellent role models and mentors who work in a highly competitive and fully subscribed residency in family medicine.
- Students perceive and appreciate that they are receiving excellent clinical training.

Provide summary of the recommendations relevant to this standard

- Implement a clear process to ensure that clinical training objectives are understood and assessments implemented across the large array of clinical sites to assure equivalency of training. Ensure strong central curriculum leadership to coordinate content learning, assessment and longitudinal monitoring of student performance and address the variability in quality of clinical tutoring across the clinical clerkships.
- Ensure that health care disparities and cultural competence curricular content comprehensively addresses the most common local and regional societal needs in a state-of-the-art fashion.
- Enhance the “Yachad” (interprofessional education) program to prepare medical students to work effectively in the highly interdependent health care teams of the future.
- Tap into Israel’s start-up ecosystem for co-curricular student experiences and or research thesis opportunities.
- Expose students to the highly satisfied, exceptionally prepared primary care practitioners in the medical school’s orbit, to promote attractiveness of primary care as a career choice and thus help address the national need for Israel-trained physicians to fill these critical roles.

- Leverage the American/NYS Program, which is actually more advanced in implementing integrated curriculum. This program can serve as a laboratory to pilot and study curricular and instructional innovation, with the downstream goal of infusing the Israeli programs with new approaches.

- Better integrate students from the American Program into the mainstream student body so they can later be effective ambassadors for Israeli medical education.

- Strengthen program evaluation by students. Given the limited variance in responses of students, the data (as reported in the DCI self-study) is generally not meaningful or actionable.

- Implement innovative admission strategies to actively address lack of diversity of the student body, to better reflect the population served.

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 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

- There is continuous evaluation, on an annual basis, to maintain comparability in teaching across clinical sites.
- The medical school has been implementing educational changes over the years, albeit incremental. Notable, it demonstrated an ability to pivot and innovate educational delivery modalities in the face of the pandemic.
- Pandemic-driven online migration gave students more “space” for their own self-learning.
- The course on professionalism and communication skills is a good example of an effective longitudinal teaching modality.

Provide summary of the recommendations relevant to this standard

- Ensure rigorous assessment of curricular content that is migrated online, at the course and individual faculty level.
- Broaden conceptions at the institution of what curricular reform actually means (small-group learning, self-learning, competency-driven, technology-leveraged with multidimensional simulation, high-flex in-person plus online modalities, cross-cutting knowledge domains, e.g. digital medicine, humanities, design-thinking).
- Expand clinical teaching in primary and specialty clinics in the community.
- Expand interprofessional education to include all medical students.
- Look at student-centered medical education programs abroad for inspiration.
- Provide more structured guidance for choice of specialty and residency/fellowship path.
- Free up time for students to engage meaningfully in research and for off-campus experiences (e.g., community service work, embedding in high-tech environments).

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

Standard 8 is met, albeit *needs minor improvement* (Score 5).

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

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

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

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

- The assessment program is comprehensive and constructively aligned with the current curriculum. Every course/rotation is extensively and summatively assessed.
- SFOM-TAU sets high standards for student progression from preclinical to clinical.
- There is mid-term feedback in clinical rotations.
- Exams are quality-assured through pretest item-review and post-test psychometric analysis.

Provide summary of the recommendations relevant to this standard

- The number of summative examination moments is extremely high. This is due to the nature of the current curriculum which is essentially discipline-based. Try to significantly reduce the number of summative moments by having interdisciplinary exams.
- Consider assessing more performance dimensions once a competency-based curriculum is adopted, to replace the many traditional assessments summative examinations. Try and seek consensus across medical schools to adopt a single competency framework for all undergraduate (and postgraduate) training in Israel.
- Increase meaningful feedback to students for better learning from the assessments (grades are a poor form of feedback). Provide sub-score performance information on blueprints of individual tests, where the individual performance is related to the performance of the cohort. Use documented narrative data from feedback dialogues to inform complex skills such as professionalism, communication, teamwork, leadership, and so on.
- Create learning dossiers for longitudinal development of student growth. There are many vendors of electronic portfolios. Explore possible collaboration with other medical schools in the country in this area.
- Create a longitudinal mentoring program for all students. Mentoring is essential for promoting reflective and self-directed learning skills, and it is also beneficial for safeguarding the well-being of students. Require students to self-analyze their academic progress

periodically as a basis for a dialogue with their mentors.

- Aggregate information of individual assessment data to inform summative decisions on student progression in relation to the competencies.

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

- Introduce authentic work-based assessment to replace oral examination OSCEs and ensure consistency of implementation across all clinical sites. Examples of work-based assessment instruments include Mini-CEX, field notes, case-based discussions, peer observation, video assessment and multisource feedback. Maximize the feedback and learning value of these assessments and avoid summative signals (i.e., grades). Train the assessors on how to give feedback. Find ways to introduce these work-based assessments as part of the ongoing clinical routine.

- Start a longitudinal database to track medical school graduate career paths over time, to assess medical education outcomes and correlate with respective medical school performance parameters. Explore collaboration opportunities to aggregate data across medical schools in the country.

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

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

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

Unsatisfactory Satisfactory

1 2 3 **4** 5 6

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

Unsatisfactory Satisfactory

1 2 **3** 4 5 6

Standard 10: Medical Student Selection, Assignment, and Progress

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

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

- There is a comprehensive system of admission to medical school in place consisting of cognitive and non-cognitive elements. This is true for both medical programs at TAU-SOM. Standards are set highly. This results in highly qualified and motivated students entering SFOM-TAU that are ready to complete the medical study and who will become high-quality physicians after training.

- There are opportunities for further study (e.g., MD-PhD, MPH). This flexibility in training paths allows maximum capacity building for interested students.

- An admission process is in place for lateral transfers, albeit in very limited numbers.

Provide summary of the recommendations relevant to this standard

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

- Work with university-level development officers to create a meaningful number of endowed scholarships, to lighten the financial and time commitment burdens of students.

- Incorporate of alternative ways of assessing non-cognitive skills in the admission process that go beyond personality assessments *per se*, e.g., written Situational Judgment Tests (SJT) and Multiple Mini Interview (MMI).

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

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

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

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

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

Unsatisfactory Satisfactory

1 2 3 4 **5** 6

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

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

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

- A good system for monitoring grades with strict timelines is in place. Review sessions are held for students. Except for the clerkship grades, appeals by students are possible.
- There are sufficient personnel to assist students, including in the financial domain.
- An academic counselor is available for students with personal problems.
- Informal peer mentorship occurs wherein more senior students help the more junior students.
- A personal mentor for career path guidance is available.

Provide summary of the recommendations relevant to this standard

- Provide more detailed information related to student retention and student progression, that is track- and years-in-place-dependent. This will reveal length of study and dropout/attrition within the program.
- Create an organizational infrastructure for administrating student affairs and student life under a dedicated vice dean for student affairs.

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

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

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

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

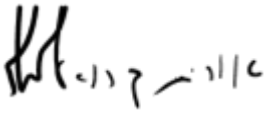
- The score that the committee gives the institution in this standard:

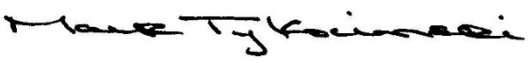
Unsatisfactory				Satisfactory	
1	2	3	4	**5**	6

Signed by:

Prof. Haim Bitterman: 

Prof. Adina Kalet: 

Prof. Orit Karnieli-Miller: 

Prof. Mark Tykocinski: 

Prof. Cees Van der Vleuten: 

Appendix 1 – the Committee's Letter of Appointment

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

Dear Professor,

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

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

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

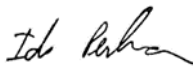
It is with great pleasure that I hereby appoint you to serve as chair of the Council for Higher Education's Committee for the Evaluation of **Faculties of Medicine and Medical Schools in Israel**. In addition to yourself, the composition of the Committee will be as follows: Prof. Haim Bitterman, Prof.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

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

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

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

Sincerely,



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

Appendix 2 – Visit Schedule

TAU Schedule of site visit Tuesday, November 2nd		
09:00-09:30	Opening session with the head of the institution	Rector: Prof. Mark Shtaif Vice Rector/ Head of the Office of Academic Assessment & Evaluation: Prof. Eyal Zisser
09:30-10:45	Meeting with the Dean of the Faculty of Medicine	Dean: Prof Ehud Grossman Head of the School of Medicine: Prof. Iris Barshack
10:45-11:00	**Break – at the meeting room**	**Closed-door meeting of the committee**
11:00-11:45	Meeting with the QA Report Commissioner*	Accreditation Task Force: Prof. Meir Lahav MD, Dr. Galit Sacajiu MD MPH, Mira Nir M.A., Melody Kasher MPH, MB PhD candidate
11:45-12:30	Meeting with senior academic staff *	Prof. Karen Avraham Prof. Amiram Fishman Prof. Amitai Ziv Prof. Neta Erez Prof. Ariel Mani Dr. Efrat Wertheimer Prof. Nir Giladi Prof Gil Zalsman Dr. Hadas Keidar Dr. Sharon Weise
12:30-13:15	Meeting with Adjunct academic staff*	Dr. Raz Gross Dr. Robert D. Hoffman Dr. Sharon Peles Dr. Yifat Wiener Dr. Dorit Ravid Dr. Roni Sharon Dr. Hagit Yonat Dr. Lior Rozental Dr. Galia Barkai
13:15-13:45	**Lunch**	**Closed-door meeting of the committee**
13:45-15:30	Meeting with Clinical instructors*	Dr. Hofit Cohen Prof. Alon Grossman Dr. Shai Shemesh Dr. Ian White Dr. Liran Shachtman

		Dr. Oz Hillel Gvish Dr. Assaf Vionta Dr. Shirley Freidman Dr. Vatad Abdallah Dr. Ilana Helman Dr. Noa Elikim-Raz
15:30-16:00	Tour of the School	
16:00-16:45	Meeting with pre-clinical students**	Jasmine Li-Brubacher Sabrina Fried Gal Binshtok Yael Erez Asaf Bloch Tomer Kagan Itay Shavit Lior Zuckerman Noga Lempel Shachar Eliahu Tamira Tishler
16:45-17:30	Meeting clinical students**	Raviv Markovitz Shir Welber Yael Shtilerman Ori Hadad Shahar Dekel Tal Rabin Dana Englender Roni Kochlender Yair Vilian Sari Asaf Adi Kidron
17:30-18:15	Meeting with Alumni**	(Graduates last 3-7 years) Micki Goldenfeld Giland Feinberg Assaf Shemer Naama Rapaport
18:15-18:30	**Break– at the meeting room**	**Closed-door meeting of the committee**
18:30-19:00	Closing meeting with the Dean	Dean: Prof. Ehud Grossman Head of the School of Medicine: Prof. Iris Barshack
