Faculty of Health Sciences
Dean's Office
Ben-Gurion University of the Negev

הפקולטה למדעי הבריאות
לשכת הדיקן
אוניברסיטת בן-גוריון בנגב

Prof. Angel Porgador Ph.D ,פרופ' אנג'ל פורגדור

30 June, 2022

Ms. Pe'er Bryce-Barnea,
Dept. of Quality Assurance,
Council for Higher Education,
Jerusalem

Dear Ms. Bryce-Barnea,

Thank you for your letter of 14 March, 2022 along with the evaluation report of the visiting committee (Nov., 2021) and for your invitation to respond. As requested, we recently (mid-April) sent you a response to any errors of fact and/or possible misunderstandings by the committee.

The present document responds in detail to all of the 57 recommendations according to the table which you have asked us to fill in. In certain cases, where relevant, our present response will include some of the material from the April letter.

Again, we thank the visiting committee and the CHE for all of their efforts in accrediting the two medical programs at BGU. We are certain that this process will lead to an ongoing improvement in the quality of our teaching within the FOHS.

Yours sincerely,

Prof Angel Porgador

Dean FOHS,

Ben-Gurion University of the Negev

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

International Evaluation Committee recommendations of November 2021

BGU academic unit response 2022

Committee Recommendations	**Steps toward implementation (including time table)**
Essential:	
1) Reinvigorate BGU-FOHS' original commitment and energy to educational innovation, recognizing that the school's past status as a pioneer in medical education, dating to the early years after its founding, has faded over time. The medical school's prime aspiration has de facto morphed from	i) As pointed out in the self-study document (DCI), we are acutely aware that our leading edge in medical education which we had enjoyed in the first decades of the Faculty's existence has slipped. As such, we had

educational innovation to research excellence, and there is a sense that the medical school has lost its way when it comes to excelling in, let alone pioneering, medical education. Over the years, there were apparently opportunities to recruit expert medical educators, but university and affiliate hospital funding was not forthcoming. BGUFOHS leadership stated that the plan is to use the Moshe Prywes Center for Medical Education as a framework to drive medical education reform, with initiatives such as sending educators to forefront medical education hubs like Maastricht to learn best practices. However, the funding necessary for such initiatives is yet to be secured. In the meantime, an evolutionary approach is envisioned ('if we can do 10 courses to the new method of teaching, perhaps in 5-6 years'). The IQARC review team views this step-	already begun efforts to improve our situation in this domain even before the MALAG visit. ii) We agree with the importance of sending physicians to centers of excellence in medical education such as Maastricht University. In fact, in 2019-2020, we sent four physician-interns to Maastricht University in the Netherlands and two physicians to their New York campus to learn best educational practices and bring them back to the schools. Unfortunately, subsequently it was difficult to ensure enough protected time to complete their program or bring their knowledge back in any meaningful way but we will make every effort to move this along.

wise approach as unlikely to succeed and questions whether medical school leaders are overestimating the financial investment that will be required for significant curricular reform and are too locked into a view of budget as the primary barrier.	iii) Furthermore, we have recruited an educational consultant, Prof Daphna Meitar to help further the schools' efforts to improve our educational practices.
2) Develop a well-structured strategic plan that clearly articulates mission/vision/values/ strategic objectives and sets forth milestones/action plans/timelines. These various elements tend to be conflated in the DCI self-study. During the site visit, in response to questioning about strategic planning, the dean distributed to the review team members copies of a booklet entitled "Shaping the Future Together—The Faculty of Health Sciences, Ben-Gurion University of the Negev, Strategic Plan 2016-2030". The document reflects output of a strategic planning process launched in November 2015 in	i) With respect to the Strategic Plan developed by Prof Amos Katz, the previous dean, much of the mission/vision/values/strategic objectives appear in the 2018 document titled "*Image of a graduate: vision and list of skills*". We concur that a plan that sets forth milestones/action plans/timelines is largely lacking. This document "*Shaping the Future Together—The Faculty of Health Sciences, Ben-Gurion University of the Negev, Strategic Plan 2016-2030*" was meant as an overview of the organization of FOHS and not just of the medical schools.

conjunction with a strategic consulting firm called TACK Growth Strategies. Of note, this document was not highlighted in the DCI self-study per se, nor were its findings set forth systematically in detailed fashion. The document itself is high level and superficial; lacks detailed milestones and metrics that would ground a concrete plan of action; is not medical school-specific, as it relates to all the college's professional training programs; and is dated by five years. Within a formal strategic plan, BGU-FOHS should also bring more rigor in addressing the recommendations of the Goldman Committee (IARC), by more systematically cataloguing those recommendations and developing discrete action plans around them, assuming they are still relevant.	ii) Unfortunately, due to a technical slip up, the Committee members did not receive an English hard copy of this document and this lacuna was only discovered early on the morning of the first day of the Committee's visit. Immediately the Committee was supplied with this document. iii) This strategic process was not meant to focus primarily on medical education *per se* but on other aspects within the purview of the FOHS. iv) However, in order to work strategically we do plan to use the good offices of the IARC (Goldman Committee) to help us with this process. As already pointed out elsewhere in the DCI, we have benefitted over the years from their wise counsel, and they have been sent a copy of all accreditation materials so as

	to be better placed to aid us in our ongoing efforts at strategic planning. We have scheduled a meeting with the IARC within the next few months in order to begin this process. The medical school leadership, joined by our educational consultant Dr Dafna Meitar and Dr. Arie Koifman the head of the Prywes Center of Medical Education defined the new vision/mission/values statement for the school and all the discussions from this point will be in line with this approach as soon as it will be approved by the faculty's committees
3) Articulate BGU-FOHS's mission priorities with clarity, as they relate to advancing medical education; serving the underserved of the Negev; pioneering biomedicine; nurturing global perspectives; and so on. At the site visit, the dean stated that the original primary overarching	i) Over the years, many of the faculty's efforts and those of the university have been meant to improve the social and health status of the population in southern Israel. Our renewed focus on the educational side of the education/research ledger is

mission—to improve healthcare in southern communities and train excellent physicians who will stay in the south and serve those communities—continues to this day. This is reassuring. However, there is concern about other mission elements. Of most concern, the substantial commitment of financial and other resources for growing the research enterprise, while under-investing into the education side of the house, suggests a de facto evolution in focus away from the education mission. A shift in mission prioritization is apparent in the dean's stated priorities, e.g., launching programming that would connect medicine and engineering faculties, and a 4-year track with an obligatory PhD. The primacy of the research agenda is also reflected in the "Shaping the Future Together" booklet, wherein the 'Focus 1' is 'Groundbreaking Research'.	detailed in many of our specific responses to the recommendations in this document. ii) Financing these efforts is an ongoing challenge and we are making every effort to find the requisite resources to support this refocus, including turning to our parent BGU administration. Finding and establishing a synergistic relationship with the developing Negev will be one of focus points of the FOHS. That being said, because of ongoing political instability in Israel (new elections) we are not sure when VATAT-MALAG will be able to respond to the financial needs. Regarding the curriculum : we have already begun a comprehensive update of our curriculum. The update

The primary mission has clearly evolved over time, and it is now multifaceted; 'Focus 2' is 'Leadership in Education and Training of Tomorrow's Health Professionals' and 'Focus 3' is 'Strategic Partnerships to Impact the Health of Individuals and Communities'. This begs the question: have these various missions been appropriately supported financially and have curriculum and co-curriculum been adapted to fulfill them? To what mid-21st century physician(s) does BGU-FOHS aspire and gear its educational programming?	is school wide meaning pre med , systems year and clinical rotation are all being revised.
4) Convey a more grounded view of the medical school's strengths and weaknesses, as a predicate for a meaningful call to action and a clear path forward. The DCI self-study is replete with a series of bold claims that simply lack substantiating evidence and are wanting in perspective and self-awareness,	i) With respect, we think that the DCI had actually been very clear and frank in pointing out where our strengths and especially our weaknesses lie. Although the accreditation process has definitely helped to clarify our priorities, it is not a lack of insight which is impeding progress.

by example, 'the most student friendly campus in the country' and 'only medical school in the world (whose) main focus is Global Health'.	In the curricular changes, we definitely will address those issues/comments as pointed out by the committee. ii) With respect to our 4-year program (MSIH), indeed it is to the best of our knowledge the only medical school, the primary focus of which is Global Health (GH). Many other schools do offer tracks in this domain but GH does not suffuse the whole curriculum as it does at MSIH, nor are all students in any other school with which are familiar exposed to GH in the comprehensive way the 4 year program does at our FOHS. For documentation of this claim, please see: doi: 10.3389/fpubh.2020.00283 and doi.org/10.1186/s12992-019-0526-2
5) Embrace the CHE/IQARC medical school accreditation process in a deeper way, recognizing	As alluded to elsewhere we will be using the IARC (Goldman Committee) to help us in this process.

that DCI self-studies are not last-minute sprints. Instead, accreditation should be viewed as a never-ending process of continuous self-improvement, wherein internal and external quality assurance are aligned, and strategic plans are crafted and executed systematically, monitored continuously, allow for critical self-analysis, and importantly, survive dean transitions. Oversight of performance to accreditation standards should be overseen by active, empowered senior faculty and administrative staff, with due accountability. BGUFOHS should identify a lead coordinator for overseeing this process who can visit exemplary medical schools in the world and observe first-hand how the re-accreditation journey is handled. BGU-FOHS might also consider inviting an external review team to the campus midway through the re-accreditation cycle to	The accreditation officer will be Dr. Arie Koifman, chairperson of the Prywes Center for Medical Education. With respect to the 2014 recommendations, many of these indeed overlap with the present accreditation cycle and these recommendations. That being said we will reexamine the report to see if there are any unchecked issues and deal with them accordingly.

assess status and propose mid-course corrections. This recommendation is particularly pressing given that there was no diligent follow-up to the findings of the 2014 accreditation review under the CHE's auspices. The present DCI self study fails to account for those previous recommendations, which remain as relevant today as they were back then.	
6) Align financial decision-making between the university and the medical school to address critical educational imperatives in an effective way. Finances and funds flows are clearly stressors for BGU-FOHS, as the dean's cover letter within the DCI self-study lists as one of the 'major limitations': 'Lack of transparency from the BGU administration with respective to annual funding decisions hinders the FOHS ability to plan long term'. This raises the core question of whether certain resource-demanding	We are in continuous contact with the BGU administration to this end. Furthermore, many of the mechanisms for BGU (and thus FOHS) funding are decided at the VATAT level and are national issues, common to all of Israel's medical schools. We hope that via this report and those on the other medical schools and the MALAG's communication with the VATAT, where relevant, additional resources (including philanthropic) can be found to help us fulfill these missions.

recommendations of an IQARC review panel can be implemented, and whether the dean will have the necessary budgetary latitude. Further, beyond finances per se, the dean at BGU-FOHS, as is the case for other Israeli medical school deans, is constrained in his authority around faculty appointments/promotion. This could hamper some of the faculty recruitment that will be required to drive curricular reform.	
7) Address lack of continuity in dean leadership staff during dean transitions, as well as the pressing need to sustain commitment to longer-term strategic goals. This is particularly important given that dean terms at BGU-FOHS are three years. Of note, the current dean assumed his role in the summer of 2020 and was thus in a most challenging position, as it was on the threshold of the present IQARC medical school	This is a university-wide issue that the FOHS will bring up with the university administration. That being said, with respect to the FOHS, when the next dean is elected, Prof. Porgador will make every effort to arrange a sufficient period of overlap.

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<tr><td>review and amidst a pandemic. The dean is a recognized scientist with international stature, but as a PhD, he will obviously require input on guiding the medical education continuum, particularly as it relates to the clinical education component. The DCI self-study notes that the Vice Dean represents the dean's clinical complement, although Table 2.5-2 indicates that his administrative effort is only 30%.</td><td>With respect to the 30%, the vice dean actually spends more of his time at the FOHS than this number reflects.
As pointed out above, teh dean will continue to work with the Prywes Center in this domain.</td></tr>
<tr><td>8) Consider organizational restructuring steps to streamline curricular transformation, for example, within a restructured Department of Medical Education, that would additionally provide a home for faculty recruits who are experts in education science. This will entail reorganizing the various committees dealing with education into a more coordinated unit, that serves to integrate all aspects of curricular governance and streamlines the path towards</td><td>i) Please see response to para 1 above. We re-emphasize that we are planning to re-structure the two curricula in the spirit of the accreditation committee's comments.

ii) In addition, the FOHS is actively considering the idea of making the Prywes Center into a national resource which would serve all five schools of medicine across the country. As well, Prof. Porgador</td></tr>
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<td>significant curricular reform and co-curricular enrichment. This reorganization will require unwavering support from the dean and his senior administrative team, and it will call for an embrace of a broad transformation agenda and meticulous long-range planning, as opposed to the current approach of small incremental changes. In other words, a revolution mindset is required now, as opposed to one of evolution. On the positive side, both junior and senior faculty members express their openness to such transformation and recognize the need to rebuild the school's medical education expertise, and in the process, reignite a passion for medical education innovation. Assembling a cadre of faculty with education science expertise will be key. A solid departmental structure will serve to catalyze the</td>
<td>has proposed to the National Committee of Deans that where relevant, lecture materials be shared so that something like 75% of lectures would be common to all 5 curricula. The remaining 25 % would meet the specific needs of our two respective programs, both the 4 and 6 year schools.

In this arrangement, these lectures-in-common could be viewed by the students in the flipped classroom model allowing our faculty to engage the students is smaller discussion groups.

iii) As pointed out in our letter to you in mid April, the FOHS Curriculum Committee oversees medical studies at BGU and includes 6 members, with representatives from both basic and clinical sciences. There are 2 related subordinate committees, one for</td>
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meticulous preparation and implementation that is now required for profound curricular transformation.	pre-clinical studies (years 1-3; 8 members), and one for clinical studies (years 4-6; 10 members). They form the basis for overseeing and guiding curriculum transformation.
9) Commit to and implement a fully competency-based medical curriculum (CBME), which at this stage must viewed as a pressing imperative. While the DCI self-study does identify competencies, this is set forth in an isolated table (Table 6.1.1, p. 57), which neither specifies how competencies are taught nor how they are assessed. When moving to a CBME, there should be a comprehensive system of work-based assessment, with documented feedback.	We are re-shaping our curriculum according to CBME principles. This will be dependent upon our efforts towards further relevant faculty development. We are already revising our evaluation forms for clinical rotations to recognize competencies and will be instructing faculty on this shift of focus. In this way we hope to work towards a comprehensive system of work-based assessment, utilizing documented feedback.

10) Map curricular content against competencies in a systematic and comprehensive fashion across the pre-clinical and clinical continuum	ii) We do understand the importance of this action. In order to accomplish this goal we will be seeking the requisite resources from the university. As well, given the fact that all medical schools in the country need to do this we hope to receive more resources as per para 6 above. iii) We intend to consult with the BGU Faculty of Education to receive their help and advice with this domain. iv) To move this process ahead we are also considering finding (and funding) a PhD or post-doc candidate in the relevant educational field.
11) Reduce contact hours and implement a more comprehensive approach to active learning. A significant portion of students' time should be freed	i) Please see response to paras 1 and 8 above. ii) As pointed out in the April response,

up to promote self-directed, active learning. Currently, small group learning represents a small proportion of the learning experience, and self-directed learning is rarely used. Time devoted to self-directed learning should be systematically monitored	over the past five years, we have added self-study time for the preclinical courses where appropriate, including endocrinology, the various anatomy courses (e.g., neuroanatomy is nearly 50 % self-study), genetics (self-study plus discussions only) and physics (hackathons in which students working in small groups to discover physical laws using apparatus in the science museum and then present them to the entire class). Self-study is also part of the 11-week pediatrics course in the 4th year in which students spend one day a week at home engaging in self-study. iii) Furthermore, as described in our self-study document, the FOHS has recently opened an advanced simulation program in a new special building for active small group learning, with extensive

	use of simulations and group discussions. The building is already being used widely in teaching POCUS (ultrasound) during years 4, 5, and 6, in basic courses such as nephrology, first aid, ATLS, clerkships including those in internal medicine, ENT, among others. Small group learning including case-based learning is also used in basic sciences, ophthalmology, pediatric clerkships, internal medicine clerkships, nephrology, family practice, and others.
12) Consider transitioning from a semester-based to a block-based system as early as possible in the curriculum.	As pointed out in our April response, all of BGU uses a semester system and this structure guides the organization and teaching of basic and introductory science courses and basic and introductory biology courses in the first two preclinical years. All courses in clinical years 3-6 are taught in blocks.

13) Introduce more horizontal and vertical integration in the pre-clinical years to balance the department-centric culture.	As pointed out in our April response, early Clinical Experience (longitudinal primary clinical exposure clerkships) and Clinical Confrontation in the first two years initiates the vertical and horizontal curricular integration with a clinical context whenever possible. The Case-based Clinical Thinking offering in the second year continues this learning process. Even though these instructions take place during the basic science years, in our on-going efforts to integrate basic science with clinical thinking these offerings are led by clinicians.
14) Revise the compendium of evaluation parameters for clinical rotations by adding key indicators that are missing, such as ones related to whether students receive feedback, are observed	We are in the midst of revising the relevant forms accordingly. In addition, we will be fostering a cultural change in longitudinally evaluating students. For this faculty

during different interactions with patients, engage in team-based learning, and are treated with respect	development is needed as well as increasing the scope of the evaluation unit in FOHS.
15) Develop a portfolio for continuous and longitudinal dialogue between learners and teachers.	We are working on this for all students and the 6 year school will consult with the 4 year program for guidance on how they accomplish this. For problematic students we do "connect the dots". This whole procedure will require additional resources and we are working on acquiring them.
16) Add educational programming to address, develop and assess reflective abilities. Reflective practice, which is essential for contemporary medical education, is not mentioned in the DCI self-study.	i) For the 4 year program there are already multiple opportunities to accomplish this goal (eg Humanities in the GH module, GH 4th year Capstone Clerkship). ii) With respect to the 6 year program, we regret that the DCI did not point out that reflective practice is indeed offered in quite a few domains: for example, within the Ethics offering (year 1), Holocaust and Medicine course (year 2), the Balint groups (year 4)

	and Internal medicine clinical rotations (both years 4 and 6) . In addition, we plan to add additional reflective elements in relevant parts of the curricula.
17) Develop communication skills longitudinally, with attention to how communication skills, along with clinical skills and clinical reasoning, are observed (how many, by whom), developed (who provides feedback, when), and assessed. Longitudinal follow-up of students should be well-organized and span years to help students continuously grow their abilities. To this end, BGU-FOHS can leverage its early exposure to practice-with-intention, with focus on communication skills and professionalism in the pre-clinical years. Overarching objectives of communication skills training and the approach to	i) Unfortunately, the DCI did not make clear how well developed our offerings in communications skill actually are. ii) As pointed out in our previous letter, the basis for such instruction is already set in the preclinical years, especially in the Pre-clinical Education course. In fact, this offering spans 4 semesters beginning with 24 days during which students in small groups cover communication at various life-history stages (children, adult, women, aged, rehabilitation, and community) in which students are introduced to the different wards in the hospital and clinics in the community.

longitudinal threading of this competency should be clearly articulated. Though the DCI self-study states that BGU-FOHS has spent many years developing programming on communication skills within medicine, it does not offer clear design, goals, and processes. Principals and the behaviors taught should be set forth, as how they will be subject to longitudinal formative and summative assessment.	iii)This experience is followed up with an additional 4 weeks in the first year and 4 more weeks in the second year in which students apply and improve their communication skills in the wards and the clinics. iv) All of these offerings will need to be better connected and coordinated, and we are working on this presently. v)The students learn direct and indirect communication skills by supervised interviewing of patients on the wards and in clinics. This instruction includes extensive bereavement training, communication with psychiatric patients, communication with autistic children, and so forth. Students receive criticism and feedback from their instructors and participate in reflective learning by viewing video recordings of their interview efforts.

	vi) We can indeed improve in the domains of offering clearer design, goals, and processes.
18) Invest in formal faculty development and require all clinical faculty to engage in a longitudinal, rigorous faculty development process that leads to certification and becomes a promotion criterion. Over time, this will build clinical education capacity for the whole system. Of note, currently available activities are poorly attended. Single 'workshops' and episodic programming are ineffective. More structured teach-the-teachers will foster equivalency of training across the various clinical affiliate sites. Mandatory faculty development of clinical instructors should focus on the clerkship educational goals, bedside teaching,	i) Indeed, as pointed out in the DCI, while faculty development had long been a strength at BGU, this lead has waned over the years. In an effort to renew our efforts in this domain, several years ago already we had re-initiated explorations via a visit by Dr Yvonne Steinert of McGill University (Director of the McGill Faculty Centre for Medical Education and past-president of the Canadian Association for Medical Education).

active learning, observation skills, work-based assessment, feedback, communication skills, and aligning clinical instructors with what students were taught in the pre-clinical years. Faculty recognize that this is lacking. Structured faculty development will cultivate over time a sense that their educational contributions are appreciated by the medical school and that their teaching is more than ‘volunteering’, as they juggle this role with their substantial clinical obligations.	ii) More recently there have been quite a number of activities organized by the Prywes Centre. A two headed approach was adopted: a)Thematic. The Center established a small group of Faculty Development instructors focusing in different aspects of teaching and educating students (the platform was named “Table for Ten “). These meetings addressed building syllabi, writing MCQs, feedback and evaluation, assessment in the clinical rotation, small group learning. These meeting were 3-3.5 hours long and were open to basic science and clinical faculty. b) Field based.

	These meetings were focused on clinical faculty members from Pediatrics, Internal Medicine and OB/GYN. b.1 A combined meeting was held involving the heads of clinical rotations and the teaching tutors from those fields. Topics included were: identity formation as educators, how to construct a meaningful clinical rotation and introduction to competency based medical education. This meeting was 8 hours long involving 33 participants. b.2 Profession-based Faculty Development was completed with both Internal medicine and Ob/GYN clinical instructors. Each meeting was focused on specific fields relevant to each group (rotation construction,

	bed-side evaluation of students, standardizing exams, personal well-being, resilience and more). Three such meetings (each more than 3 hours) were held and the overall participation was usually around 35 physicians. b.3 In addition, some in person mentoring for potential leaders in medical education was done. These offerings will be continued, modified, and expanded according to the resources available (both time and personnel).
19) Establish a promotion track for clinical educators and ensure that it meets the needs of a range of faculty stakeholders.	There are already ongoing negotiations about this option between the FOHS and the BGU administrations.

20) Recruit more faculty with a medical education focus, as well as some with an understanding of contemporary education science. A core group of such faculty will convey medical education literacy across the faculty and serve as catalysts for educational innovation. Without such faculty, who can additionally solicit insights from institutions abroad who have successfully implemented competency-based curricula, it is hard to see how BGU-FOHS can effectively orchestrate a comprehensive curricular transformation agenda in all its dimensions.	We will make this effort pending receipt of adequate additional resources from the BGU and VATAT etc (see para 6).
21) Increase the ambulatory/community component of clinical training, given that outpatient medicine is under-represented in the curriculum. While some clerkships do have ambulatory/community experiences, the percentage is low. This will require	Unfortunately, due to the structure of the Israeli health care system (health care provision by not-for-profit HMOs - the mission of which is primarily service provision, not teaching), this is a national problem. As such, in order to make significant progress in this

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<td>a well developed plan. The DCI self-study alludes to this issue, referring to it as a ‘lacuna’ and alluding to a role for the curriculum committee, class representatives and clerkship instructors in monitoring time students spend in both ambulatory and inpatient settings, but a meaningful plan to achieve this goal is not set forth</td>
<td>domain, in addition to efforts at the level of the FOHS and BGU, national investments will be required as well.
That being said, as pointed out in our previous letter, while we recognize that there is not yet enough community-based teaching, we do intend to expand it.
We also pointed out that students do have ambulatory/community experience in pediatrics, psychology, gynecology, geriatrics, and family practice, including a week of ambulatory experience in the fourth year, a week in the community, and an additional week of ambulatory experience in pediatrics in the sixth year, community experience in gynecology in the 5th year, and 4 weeks in the community in family practice in the 5th year. There is also a two-week clerkship in ambulatory medicine in the 5th year.</td>
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22) Align best practices between the 6- and 4-year tracks, and where there are differences, account for them. For example, the 4-year track, but not the 6-year one, offers two days of simulations related to cross-cultural issues and psychosocial matters. Interprofessional education experiences are there for the 6-year, but apparently not for the 4-year track. There are major differences between the two tracks on the way societal matters are addressed. For example, while disparities in healthcare is taught in the 6-year track's Ethics and Physician and Society courses, the 4-year track addresses the subject in the On Being a Doctor course and in various global health offerings. This difference is of particular interest since 4-year program students apparently want more exposure and understanding of regional	i) The two programs have long shared knowledge and experience. For future efforts, the 6 year program can help the 4 year develop its ethics and Holocaust instruction modules and the 6 year program can clearly benefit from the 4 year school's expertise and experience in Global Health. To remind, it is the same faculty which teaches in both schools and there is a natural and organic sharing of knowledge and instructional approaches which this hybrid model encourages. ii) As well, as pointed out in our previous letter, Geriatrics is a required course in the 6-year program, not an elective. The 6-year program also covers 'On Being a Doctor' during the orientation course, a three-week experience that all incoming students have.

population needs, while 6-year program students would like more global learning. Yet another example are the subjects of nutrition and treating the elderly which are apparently addressed only in the 4-year track as core curricular elements (albeit treating the elderly is there as an elective for the 6-year program). Key subjects should be addressed in both tracks, with translation of best practices between the two	Students meet a minimum of 10 different physicians in various specialties to discuss relevant topics. All students in the 6-year program take a 2-day course in nutrition.
23) Expand training in research methods that goes beyond biostatistics. Students feel there is limited guidance for their research endeavors. Revise the research thesis requirement to better articulate and elevate expectations of scholarly inquiry and provide protected time for the students' research activity. There is a general sense among the 6-year students of little encouragement for their research activities.	i) We recently offered a "speed date" experience to expose students to potential research supervisors and we intend to repeat this process at reasonable intervals. ii) As well, a list of potential supervisors is posted on the FOHS website to facilitate students matching up with faculty supervisors.

Rigor should be added to the MD thesis so that it is not perceived as small and insignificant. A structured approach for instilling a research component in the 4-year program should also be developed.	iii) As pointed out in our previous letter, students take a week-long course in Research Experience at the start of the 4th year. In the middle of the 4th year and again in the 5th year, students meet with course instructors to present their planned research topic. Students receive 2 days of instruction during the 5th year regarding statistical issues. This course is currently being revised. Starting in 2024, 4th year students will receive more protected time for research.
24) Rethink the approach to inter-professional education (IPE), including timing within the curriculum, the number of encounters, and their relevance for working inter-professionally. Only two experiences are mentioned in the DCI self-study, and while some initiatives are contemplated for enhancing IPE, there is no clear plan set forth for overcoming problems todate in implementing them	We do recognize that IPE is an important domain and recently tried to institute such a program. We did not succeed for various reasons. We shall try again and are considering how to use the simulation center to this end

and addressing students complaints. A comprehensive IPE plan should be developed and consider adding social workers and occupational therapists to IPE processes.	
25) Coordinate education across all clinical affiliate sites to ensure equivalency of training. While some effort has been made to foster such equivalency (e.g., faculty site visits, collection of student feedback), BGU-FOHS should be more active in identifying deficiencies at specific sites/settings and taking appropriate corrective action in a timely fashion. Differences are noted in the DCI self-study—for instance, only one department has an exceptional journal club, and another is mentioned for its thorough syllabi—yet no clear plan is offered to share best practices across sites, instead vaguely stating that there is a plan to 'assist in sharpening	We recognize that this issue has not been successfully dealt with by the previous model of leading it up to the Divisional directors. We are planning to nominate "Academic Course Coordinators" to take on the task. However, we have made other efforts to facilitate these requirements. For example, the "Moodle Platform" helps keep us all on the same page - both faculty and students. As well we have initiated a session with relevant faculty groupings wherein we share our educational expectations in each clinical domain.

this matter. There should be a designated and empowered educational coordinator overseeing all the clinical affiliates, along with a more systematic approach to site visiting clinical clerkships. Clarity should be brought to how academic issues and unevenness in offerings (e.g., quality of grand rounds) at the various clinical sites are handled.	In addition, coordination efforts have been strengthened in Internal medicine, pediatrics and OB/GYN rotations in order to alleviate this problem.
26) Establish clear and systematic processes for monitoring students with difficulties and develop clear approaches for remediation. Best practice for remediation identifies underlying causes of the difficulty and configures individualized remediation with timelines and accountability plans.	As pointed out in our previous letter, while monitoring could certainly improve, we wish to point out that BGU-FOHS does have long-standing and well developed programs for students with psychological issues and the University overall has well equally robust programs for students with learning disabilities. When we do pick up problems, students are helped at various levels:

	i) Each year has a "year committee" (1 faculty member per 15 students). A personal meeting is held with each student at the beginning of the year and if necessary, ongoing consultations with the assigned faculty member can take place throughout the year relating to problems involving academic issues, financial problems or psychological issues. When necessary, these faculty members can then refer the students on to the relevant faculty and/or BGU student services for more focused help. ii) A senior faculty member, Dr Idit Liberty has been named the Vice dean for Student Affairs and when problems are picked up, she is tasked with helping the

	student. As well, a new and more proactive practice involves referring any student who either fail an exam or are in the lowest tenth percentile of grades to Dr. Liberty who meets with them and crafts a personal remediation program. iii) Three psychiatrists are available to any student (or faculty member concerned about a student) who wishes help. The referral takes place without anyone from the FOHS knowing the student has applied for help.

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27) Develop a process to review medical education program objectives, ensure the horizontal and vertical integration of curriculum content, and monitor the overall quality and outcomes of all required learning. This cannot be done through student evaluations alone.	Please see out response to para 13. In addition, we plan to introduce a system of continuous checking of courses specific content to ensure better integration within the new curricula.
28) Ensure that there is a systematic approach for internal quality assurance, with PDSA (Plan, Do, Study, Act) cycles closing the loop of evaluation and addressing the requirements of external quality assurance.	We explore this issue will make an effort to do so.
29) Clarify and verify the different ways medical knowledge is assessed. As part of this, reconsider the assessment of learning program and shift it more	The 6-year program is consulting with 4-year program as to how they manage this issue.

of an assessment for learning program. The assessment program is a traditional summative program with many hurdles. Adopt a competency framework and map all assessment activities to these competencies. Copy some of the diversity of assessment methods from the 4-year MSIH program to the 6-year program (e.g., narratives).	We wish to point out that the much larger number of students in the 6 year program than the 4 year school makes this a more complicated endeavor and thus a structural change in the 6 year program is required.
30) Create more integrated exams and significantly reduce the number of exams. In the preclinical phase of the curriculum, 54 exams are counted.	We will try to do so but this will require more resources.
31) Increase meaningful feedback to students for better learning from assessments (grades are a poor form of feedback). For example, provide sub-score performance information on blueprints of individual tests, where the individual performance is related to the performance of the cohort.	This is a national problem and Prof Porgador will be consulting with the other deans to help move this forward. As pointed out in our previous letter to the MALAG, while this practice can improve, in the first three years, students may indeed sign up for the option of receiving feedback on each exam. Students who do

	opt in receive notice of the questions they missed, what the correct answer is.
32) Use documented narrative data from feedback dialogues in the clinical years to inform complex skills such as professionalism, communication, teamwork, leadership, and so on. Try not to merely capture clinical skills in checklists.	We will make every effort to do so. As well we will ask help from the Prywes Centre to add this subject to their Faculty Development offerings (see para 18 above). As pointed out in our previous letter, we recently introduced clerkship and selectives evaluations which include competency-based narratives that address these issues. There are two types of such clerkship/selective evaluation forms utilizing competency-based rubrics: a short form for selectives of 1-2 weeks and a more comprehensive evaluation form for longer clerkships/selectives of > 2 weeks.

	Once again, this will require investment in faculty development.
33) Implement a system for tracking and sharing academic performance across clinical rotations. Monitoring growth of competencies in clinical years requires carrying over information from one rotation to the other to improve continued learning.	We will make every effort to do so.
34) Consider introducing a mentoring system to monitor student's academic growth and enhance reflective and self-directive learning	Please see para 26 above. In addition to the individual meetings at the beginning of the year we are planning for the tutors to offer group meetings to discuss relevant issues (eg developing professional identity, choice of specialty ,family-career balance, etc) .

35) Replace older methods of assessment (patient-based orals) with more modern ones, such as OSCEs or work-based assessment methods. In particular, the latter would fit best to a CBME approach to assessment.	While we will explore expanding the use of such evaluation methods, OSCEs are indeed already utilized in some rotations including the Internal Medicine and the Ob/gynecology clerkships. In Internal Medicine, evaluation is further based on a series of short clinical examinations. Each student also receives verbal feedback on their functioning in the ward. The final evaluation is based on an evaluation during which students develop cases from beginning to end. Students are similarly tracked and evaluated in Pediatrics.
36) Introduce pretest quality control on item writing and post-test psychometric analysis and review.	We will explore this option.

37) Work with CHE to develop paths for diversifying admitted student demographics, including minority groups and those from underprivileged backgrounds.	In various ways the admission process at the 6th year program does already encourage the acceptance of candidates from the geographical and socio-economic periphery of Israel: i) The "wide funnel" method in which the entry threshold (psychometric [cf MCAT] + high school final exam average) is deliberately set at a relatively low level compared to the other Faculties in Israel. Given that in Israel (as is the case in many other countries) there are significant gaps in matriculation and psychometric data between high and low socioeconomic strata, this approach allows candidates with "reasonable" academic data, including candidates from weaker social / economic strata, to enter the screening process.

	ii) In our personality tests we examine components that do not directly reflect the academic skills of the candidates. This approach allows for an independent and equal evaluation of candidates who come from a broad cultural, social and economic spectrum. iii) In the personal interviews, beyond assessing the basic suitability of the candidates for medical studies, this framework allows the consideration of additional components (such as ambition, resilience and perseverance) that can favor candidates from weaker social / economic strata. iv) Further to section 3, once the candidate passes the earlier screens the final determination does not consider them in the final assessment score, but rather the decision on admission / non-admission to studies depends on the weighted score of the personal interviews. This approach we believe

	significantly reduces the potential advantages of candidates coming from higher socioeconomic strata. Starting this year, the "Ilanot" support program was initiated , the goal of which is to foster medical leadership among medical students, especially those originating in the country's periphery.
38) Incorporate into the admission process alternative ways of assessing non-cognitive skills that go beyond personality assessments per se, e.g., written Situational Judgment Tests (SJT) and replace the current interviewing with Multiple Mini Interviews (MMIs).	The personality test is an integral part of the admission process at our school, which also includes an SJT component. From our experience we have found that in-depth interviews are a better way of examining candidates than conducting a series of short interviews. We have found over the years that having two in-depth interviews with 4 different interviewers (from both medical and non-medical backgrounds) allows for a more all around

	assessment of the candidates, and is more likely to locate specific personality components that question the suitability of the candidates for medical studies. For the next school year, we are considering adding additional non-contingent assessment components such as functioning within group dynamics which will make it possible to assess as much as possible the real world interpersonal functioning of the candidates under stressful conditions.

Committee Recommendations	**Steps toward implementation (including time table)**
Important:	
39) Inventory the extensive academic assets of the parent university and the home city's hi-tech infrastructure and then develop a plan for leveraging these assets for co-curricular enrichment and unique educational programming and training pathways. There is untapped potential for significant, even world-class educational innovation	We are sorry that the DCI did not adequately describe our efforts in this domain but indeed both schools have been active in this domain. For example, the 4 year school has initiated a shared program related to developing health technologies in low income countries involving MSIH and BGU Engineering students as well a "Hackathon". Unfortunately the COVID-19 pandemic put a (we hope temporary) end to these initiatives which we will restart as soon as is practicable.
40) Address the lack of current MOU's and affiliation agreements with some of BGU-FOHS's clinical teaching hospitals.	We have managed to do so with many of our affiliates and will continue towards resolving this issue with those remaining hospitals without a formal MOU. The full formal agreement with Barzilai Medical Center our

	second largest teaching hospital is slated to be signed in July 2022.
41) Establish a structured committee that develops comprehensive conflict-of-interest and conflict-of-commitment policies and then oversees them within BGU-FOHS.	We will work with the BGU administration and legal department to move these forward.
42) Implement a system for longitudinal tracking of BGU-FOHS graduates and educational outcomes. Given that a national goal is to build Israel's physician workforce, medical schoolspecific data as to numbers of graduates practicing in Israel, types of medicine practiced, and kinds of clinical settings and institutions at which they work are crucial for proper assessment and planning.	We are exploring how we can extend what we already do in this domain.
43) Introduce a more structured mechanism to evaluate performance of administrative leaders within BGU-FOHS.	We will work with the BGU administration and Department of Human Resources to move this forward.

44) Add rigor to the research experience of medical students, with protected time.	In this domain, we are sorry the self-study document was not explicit enough about how we currently do address the students' research experience. Currently, 4th year students have a week-long course which goes step by step over scientific writing, with emphasis on the students' own research plan. Following this intervention, they submit a draft manuscript with subject, introduction, and bibliography for feedback from their instructor and teaching assistants. At that point, the manuscripts are submitted to other students for peer review and discussion. The process is repeated in the 5th year, with statistical methods added. The students' proposal is also submitted for review and approval in the 5th year, without which students cannot start their 6th year. During the 6th year, students respond to the critiques, revise their manuscripts, and submit their

	final version. This mandatory project must be completed before students can begin their internship. During their internships, manuscripts receive final review and approval. In this manner, students are guided through the scientific process from conception to completed manuscript. Starting in 2024, expanding this domain, our present 2nd year students will receive several weeks of protected time for research experience.
45) Broaden exposure to primary and specialty clinical teaching in the community and explore ways to increase time spent in primary care and specialty care clinics in the community. This would have the added dividend of lessening the load of teaching carried by a relatively small number of clinical teaching departments.	Please see our response to paragraph 21 above

46) Reintroduce basic scientists in advanced stages of the clinical years, so that it mirrors the participation of clinicians in some of the pre-clinical courses. This will serve to reinforce the basic science-clinical science nexus.	We will explore the need to do this and look for ways of accomplishing this goal.
47) Monitor and deal with Clalit's stated plan to reduce the size of the library	This comprises an ongoing negotiation between Soroka Hospital (on whose ground the medical library sits) and the BGU administration.
48) Increase the number of electives in the 6-year track, including international elective opportunities. There are currently too few electives in that track and no requirement for diversity within them. There are lessons to be learned in this regard from the 4-year MSIH program.	We intend to take these steps insofar as curricular time allows and this issue will be addressed during our curricular reorganization.
49) Address student concerns about curricular overloading, for example, in the 2nd year of the 6-year program.	As pointed out in our previous letter (14 Apr, 2022) to the CHE, a survey of 6-year medical programs in Israel shows that in fact BGU-FOHS offers the least

	amount of hours of basic science teaching of any of the medical programs in Israel. That being said we will of course make every effort to expand the amount clinical material injected into the basic sciences.
50) Commit to teach critical issues related to regional health disparities and cultural competence and develop a well-coordinated approach to this end. The DCI self-study does not describe with sufficient clarity the various offerings dealing with this subject area. Titles of important topics are set forth (e.g., societal problems, caring for the disabled, population-based medicine, wellness, determinants of health), but there is no detailing of how they are taught or assessed. Other important topics, such as professionalism, humanistic values, and leadership are not mentioned at all. Some of these are referred	As pointed out in our previous letter (14 Apr, 2022) to the CHE, we regret that the self-study document did not adequately describe the amount and scope of teaching which actually addresses these important issues. In fact, they are covered extensively throughout all 6 years of instruction. For example, humanistic values are covered in each year. This is taught as stand-alone courses in the 1st, 2nd, 4th, 5th and 6th years and in clinical settings throughout. Eg of relevant offerings:

to in the context of the clinical years, but it is unclear whether they are discrete courses or simply topics that should be touched on in clinical rotations. If the latter, how is it verified that they are indeed being taught? A clear articulation of overarching goals and specific topics is needed upfront	Ethics for Medical Students - 26 hours Physicians in Literature - 26 hours Holocaust and Medicine - 26 hours Medicine and the Law -16 hours Current Issues in Health Systems in Israel and Around the World - 28 hours The Doctor and Society- 35 hours

Committee Recommendations	**Steps toward implementation (including time table)**
Desirable:	
51) Address inadequacies of devoted student spaces at clinical sites.	Together with our affiliated hospitals we will explore this need. As is well known, these hospitals are not “owned” by the FOHS and as such this issue is subject to negotiations. However we do commit to trying to expand this space. For example, the FOHS recently agreed with Barzilai medical Center that they will allocate the area and wewill finance the furniture, etc.
52) Partner with university-level development officers to create a meaningful number of endowed scholarships	We will work with relevant BGU development office to this end.
53) Permit students to review their narrative assessments	As pointed out in our previous letter (14 Apr, 2022) to the CHE, students in the first year are allowed to review their narrative assessments at the completion

	of their first clinical experience. At this time, each student sits with their instructor and goes over their assessment in detail. Students in years 4, 5, and 6 are not allowed to view the evaluations from their clerkships unless the student has a particular problem that needs to be addressed. This policy will be reconsidered in light of the committee's recommendations.
54) Consider motivation to be a key criterion for admission to foreign electives instead of grades.	In fact all students are allowed to seek out foreign electives unrelated to their grades. These rotations are usually approved (pending an examination of their educational validity etc), but are not supported financially. Most of the elective criteria revolve around the students' wishes. However we do think it valuable to

	offer some of these through completive prize to (in a healthy way only) encourage and indeed publicly recognize academic excellence as we do for other prizes.
55) Copy the 4-year MSIH track's career advising for the 6-year track.	As pointed out in our previous letter (14 Apr, 2022) to the CHE, career advising differs between the 4-year program and the 6-year program due in part to differences in the weighting of grades and class standing in placement for residencies abroad (mainly but not exclusively in the US) and Israel respectively. That being said, we are considering ways in which we can better help guide all our students with respect to their career tracks.
56) Provide an explanation for the 10% dropout rate and take actions accordingly.	The dropout rate is actually less than 2%.

<table>
<tr><td>57) Translate from Hebrew to English key documents in DCI self-studies. By example, the bylaws and conflict-of-interest policy documents in the appendix were in Hebrew only</td><td>We are a bit perplexed by this recommendation as our previous accreditation officer Prof. A. Mark Clarfield checked with MALAG on two separate occasions querying this need. He was informed that translation would not be needed as there would be sufficient Hebrew speaking members of the visiting committee to manage all relevant Hebrew documents. Naturally, when English versions were available we preferentially supplied these.</td></tr>
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