Response to the report of the International Quality Assurance Review Committee: Evaluation of the Medical School at the Azrieli Faculty of Medicine at Bar Ilan University

Committee Recommendation	Steps towards implementation (including timetable)
Essential	
1) **Complete the strategic plan.** Strategic planning is still underway, after a pause during the pandemic. While the DCI self- study targets completion by summer of 2021, it is unclear at the time of the present review if this deadline will be met. This represents the first strategic plan for the medical school, and it is surprising that one was not developed at the time of founding. From the dean's slide deck at the time of the site visit, the strategic plan will have 5 elements: *1) mission vision update; 2) strengthening medical centers and community health connections: 3) research faculty and development recruitment; 4) strategic planning of educational tracks and outcomes; and 5) Galilee student and staff experience*.	The strategic planning initiative is indeed progressing, and a large faculty retreat is planned before the end of the year to make significant progress in finalizing the overall plan. An additional element and corresponding working group has been added, namely: achieving gender equity.
2) **Formal mission, vision, and value statements should be formulated.** A vision statement was offered in the DCI, but of note, it was approved only at the end of December 2020, just in time for the review. This 'vision statement' is not really a vision, but rather a cataloguing of goals (*Research faculty recruitment and development; Strengthening the connection with the medical centers and community health; Strategic planning of educational tracks and outcomes; Faculty's contribution to the strengthening of the Galilee*), which overlap with the aforementioned strategic plan elements. There is no mission statement *per se*. Hence, mission, vision, and goals are being conflated, and there is no formal statement around values. All of this should be addressed. A *mission* statement should concisely set forth the medical school's primary purpose. A *vision* statement should convey what the medical school aspires to be and what it intends to look like several years down road. A *values* statement should crisply	We thank the IQARC for this important clarification, which will assist greatly as the 'mission vision update' element of the strategic plan process progresses to its advanced stages. Importantly, the working group tasked with this component of the strategic plan had been enjoined to propose only a Mission and Vision, and conflated 'core values' into the vision. The IQARC clarification will now be transmitted to the working group, and we anticipate that this will deconvolute the 'core values' from the 'vision'. We hope to have this ready for presentation to the University leadership by January 2022".

express the core principles that frame all that medical school does. In turn, specific goals and action plans follow from, and give life to, the mission/vision/values statements.	
3) **Develop a unique identity for the medical school that distinguishes it in the Israel medical school landscape.** The dean is appropriately thinking in terms of focused areas of AFOM-BIU strength and distinction. With respect to research, areas of emphasis include genetics of isolated populations; diabetes; population health sciences; infection, immunity, and microbiome; data sciences; and AI medicine. The diabetes-focused *SPHERE (Social Precision Medicine Health Equity Research Endeavor)* exemplifies the types of initiatives that tie into such areas of focus. To reinforce the medial school's unique identification with these areas, they should be translated into educational offerings and experiences for the students in a deliberate fashion.	We thank the committee for this recommendation. The Medical Educational Directorate will review the issue and explore opportunities for further exposure of the students to these specific domains in various educational venues. The first and most straightforward to implement will be in the repertoire of topics of the mandatory MD thesis projects. Indeed, the SPHERE has a well-budgeted education arm that cuts across "Prevent, Control, Care, Cure" pillars – wherein Diabetes will be used as a platform for education in chronic disease patient engaged education relevant to the Galilee that aligns with a major integrated community research domain. Also, the possibility of either expansion of existing courses or development of new mini- or full courses will be considered.
4) **Translate the university bylaws into a medical school handbook that codifies policies and procedures.** AFOM-BIU operates under the university bylaws, but this has not been translated into a medical school handbook that codifies its school-specific policies, guidelines, and procedures relating to faculty, student, alumni, and administrative affairs.	The Faculty will construct a medical school handbook that will be a highly accessible "go-to" reference for all relevant stakeholders.
5) **Clarify governance within the medical school.** The DCI self-study states that the governing body is *Faculty Leadership*, which must be approved by the university. Specifics around it are entirely lacking (e.g., membership; operational details; relationship to the dean and other administrative entities). There is also reference to a *Faculty Council*, and it is unclear if this is the same one. How are junior and mid-career faculty represented and engaged? The medical school's governance structure must be crisply developed and then made clear to all stakeholders.	The statutory Faculty Leadership is proposed by the Dean for approval by the Rector of the University following extensive broad consultation and discussions. The leadership meets at least weekly, and this is supplemented by ad hoc meetings as required. The members of the leadership are the Dean, the Associate Deans for Medical Education, Academic Promotions, Research and Post-graduate programs, the Vice-Deans for Pre-Clinical, Clinical and Community studies and Hospital based Clinical Research, the Senior Assistant to the Associate Dean for Medical Education, the Head of the Graduate

	studies committee, and Faculty Administrative Director. The Faculty Council is a consultative body comprising all Faculty members with the academic rank of Senior Lecturer and above. This body meets four times per year, is presided by a "Chair of the Faculty Council" and receives reports from the Faculty leadership and provides input from the consultants. The Faculty Council elects of a new Dean following each term. Junior and mid-career Faculty members are well represented in leadership roles such as membership of important committees, such as the Teaching/Curriculum, Examinations, Student and Student Evaluation and Assessment Committees. The governance and organizational structure is clearly delineated in a slide deck but has not been previously made public. We accept the IQARC recommendation to publish it and will incorporate into the handbook (item 4).
6) **Establish a formal *Department of Medical Education*.** The DCI self-study mentions several entities that touch on medical education at AFOM-BIU. These include directorates (a *Directorate for Medical Education*, paired with a Directorate for Research); units (the *Medical Education Research and Development Unit* and the *Education and Evaluation Unit*) and committees (*Teaching/Curriculum Committee*). While an organizational chart containing these entities was offered, their respective domains of authority and responsibility were vague, as was their membership, governing principles, and operational specifics (e.g., how often they meet; how they relate to each other). Further complicating the picture are the pre-clinical and clinical components under the *Directorate for Medical Education*. The relationship of these various entities to the Vice Dean for Medical Education is also not clearly defined. The IQARC recommends the establishment of a formal *Department of Medical Education*, powered by	Establishment of a formal Department of Medical Education is a high priority objective of the Faculty. However, it must be recognized that "trained professionals with *bona fide* educational science expertise" are in limited supply in Israel. In order to meet this challenge, and in light of the recommendation of the IQARC report, AFOM-BIU is initiating three simultaneous new processes: 1) BIU leadership at the level of the Rector has given AFOM permission to include three positions for full-time BIU tenure-track or tenured academic medical education scholars/researchers in its first tier recruitment beginning with the 2021-2022 academic recruitment cycle. 2) AFOM-BIU will actively identify/encourage among our students and postgraduate trainees, those talented individuals who seek to and will be supported to pursue doctoral and postdoctoral training in medical education. 3) we have established a collaborative interaction with the newly appointed Dean (Professor Kobi Yablon) of the newly constituted BIU Faculty of Education (formerly a department

trained professionals with *bona fide* educational science expertise, and simplification of the matrix of directorates, units, and committees under the umbrella of this department. University leadership expressed an intention to create a *Faculty of Education*, and a *Department of Medical Education* within the medical school would provide a home for its professional educators.	within Social Sciences) to develop joint programs in Medical Education training. The Medical Education Directorate (Associate Dean for Medical Education and three Vice-Deans (pre-clinical, clinical, ambulatory) is the Executive academic level decision and implementative body, it receives input from the Teaching/Curriculum Committee which meets monthly to review current developments within all courses and clerkships. In addition, the Committee plays a major role in Curricular Planning. The current Medical Education Research and Development consists of a Senior Clinician with advanced training in Medical Education Science and administrative support. This unit undertakes specific directed projects and reviews reporting both to the Dean and the Associate Dean for Medical Education, and these will be rolled into the Medical Education Department as above. The Education and Evaluation Unit is led by an Education Specialist (PhD) and supported by a statistician and administrative staff. The Unit conducts the administration, analysis and reporting of the student evaluation process. In addition, the Unit is involved in Educational initiatives such as the Near Peer tutoring course and support for Active Education techniques such as Team-Based Learning. This Unit also reports to the Associate Dean for Medical Education, and will also be rolled into the "Medical Education Department" to be urgently developed as described above.
7) **Invest in faculty development.** Many of the volunteer faculty in the community hospitals have little specific expertise in evidence-based medical education. Faculty development training is not mandatory and appears to be episodic. Require all clinical faculty to engage in a longitudinal, rigorous faculty development process that leads to certification (e.g., as a promotion criterion). Over time, this will build clinical education capacity for the whole system. Single 'workshops' are not effective. More structured *teaching-the-teachers*	We fully recognize that current Faculty Development initiatives are valuable but insufficient. Development and expansion of a wide-ranging compulsory Faculty Development program is a central aim of the Faculty and has been hampered by a combination of insufficient well-trained trained resources, and interpersonal issues. Both of these impediments are under resolution. Moreover, we anticipate that the Medical Education Department will interface with Faculty Development. Faculty Development engagement and outcomes are also now being

will foster equivalency of training across the various clinical affiliate sites. Mandatory faculty development of clinical instructors should focus on the clerkship educational goals, bedside teaching, active learning, observation skills, work-based assessment, feedback, communication skills, and aligning clinical instructors with what students were taught in the pre-clinical years.	incorporated into academic promotion criteria. .
8) Invest in, test, and rapidly expand a community-based model for clinical medical education. The community sites are not yet adequate to the current or future need for community-based clinical training. Many clerkships do seem to have ambulatory/community experiences, but the percentage is low. This will require a well-developed plan. The barriers within the purview of the medical school should be addressed (e.g., curriculum and faculty development) while advocating with the relevant ministries for resources needed. This represents a national challenge, and AFOM-BIU should take the lead, thinking in terms of a community-based campus. With only three major hospitals, it should be considered as a way forward.	Indeed, expansion of Community-based education has been a priority of the Medical School over recent years and has included significant exposure to Family Practice, Community Pediatrics, Community Obstetrics and Gynecology, Psychiatry and several Internal Medicine Sub-specialties (e.g. chronic Congestive Heart Failure ambulatory clinics. However, the Committee has correctly identified the national imperative to improve and expand community education resources and AFOM-BIU intends to take a leading role in this process, especially geographic, demographic, and professional distribution patterns of the Galilee. To this end, AFOM-BIU has received substantial funding for two undergraduate and postgraduate training programs in community medicine and educational innovation.
9) **Build *home-grown* capacity for medical education scholarship and innovation.** For starters, invest in 3-5 junior faculty with interest and focus on medical education, including giving them the opportunity to obtain a master's or PhD in *Health Professions Education* from one of the premier international centers. This investment would enable AFOM-BIU to position itself as a leader in medical education. *{Standard 2}*	Significant expansion of the Medical Education Faculty is planned for coming years, both by recruitment and in-house development, as described in greater detail in the response to recommendation (6).
10) **Strengthen the pathway toward academic promotion for medical educators.** Support and maintain an educator's portfolio for all faculty. Advocacy for medical educators during central university deliberations on tracks, promotion, resourcing, and compensation will be essential.	Recently, the Faculty has reviewed and reformed the academic promotions criteria that recognizes all forms of Creative Professional Activities, including educational performance, innovation, and initiatives. as factors in the promotions process. This change has been published and promulgated widely and is already beginning to

	influence advancement of Education-focused faculty. Moreover, for promotion under "Educator Performance" a portfolio for scoring of such performance is required.
11) **Address faculty diversity in the pre-clinical years and ensure gender equity in appointments, promotions, and compensation.** The dean has taken steps to address such diversity and equity issues, and these must be carried forward. Aggressively recruit faculty and students from underrepresented ethnic, racial, religious, and nation-of-origin groups in the region. Diversity is critical to achieving the school's mission. A particular concern relates to possible inequities at the university level vis-à-vis faculty title and rank for women faculty. AFOM-BIU should implement a requirement that all faculty be discussed on an annual basis by the school's appointments and promotions committee, with regular assessment and consideration of appropriateness of track and rank, readiness for promotion, and status of regular mentoring by assigned senior faculty mentors.	Diversity and gender equity are important considerations in future faculty recruitment. However, Israeli law demands absolute equal opportunity for all applicants to Higher Education institutions such as Medical Schools. Accordingly, despite the logical rationale behind the Committee's suggestion to selectively recruit students based upon geographic location of the applicants is not open to the Medical School, after multiple attempts of changing. The main strategy is therefore the six-year track (as outlined in response to comment 13). All faculty appointments are reviewed annually by a committee consisting of the Dean and the associate Deans for Medical Education and Research. Issues of diversity and gender equity are frequent relevant considerations. The Associate Dean for Promotions meets regularly with faculty at all teaching institutions, offering both group and individual meetings to guide the progress of individuals. As noted above "Advancement of Gender Equity" has been added to the strategic planning working groups, and a Special Advisor to the Dean in Gender Equity has been funded and empowered at multiple levels.
12) **Introduce a formal rating system of faculty by students.** There is apparently a *flagging system* to identify faculty with low rating scores, purportedly in real-time. AFOM-BIU might consider an expanded rating system that would also identify high-performers.	Indeed, the flagging system picks up problematic performance after the end of specific courses and clerkships. High performers are identified on an annual basis and the top 10% are rewarded with Outstanding teaching awards. In recent years, ceremonies have been conducted in each of the main teaching hospitals in addition to the event at the Faculty itself. This investment in time and energy of Faculty Leadership has been extremely well received by teachers at all levels in the Faculty.
13) **Build the 6-year program to both expand the number of physicians and enhance the attractiveness of a career in medicine for regional students.**	The 6-year program has been developed and submitted to the Council for Higher Education for approval. This is a detailed process, and it is hoped that approval will be forthcoming allowing

A plan is being developed for a new 6-year track which it is thought might attract more students from local communities and potentially increase the number who choose to stay and practice in the north.	the program to start in 2023. This program should hopefully attract students from the Galilee, who currently choose six-year programs at other Faculties in Israel and abroad.
14) **Commit to and implement a fully competency/outcomes-based curriculum.** Such a curriculum would build on and integrate the many solid components AFOM-BIU already has in place. The DCI self-study does identify the need to move toward a genuine competency-based medical education (CBME) curriculum, but much needs to be done towards this end. By example, efforts need to be invested in assessing outcomes and providing feedback in the clinical years. *Task-pad* or *skills* notes, though clear, only include the medical procedures a student should observe, but do not encompass professionalism or communication issues (e.g., whether a clinical faculty observed them in different professional tasks; the quality of their patient interviews). Further, they are mainly checking if the student observed or participated in specific procedures/situations, but not how they have done it nor feedback on how to improve in the future (e.g., how to organize KABALA better). When moving to more CBME, assessment should entail a system of work-based assessment in the clinical phase assessing broad outcomes, while providing documented feedback and to more and diverse assessment approaches in the preclinical. With representation on the national committee to set CBME outcomes, this has the potential to transform medical education in the country. Consider contributing towards an Israeli Competency Framework (e.g., see CanMeds, Scottish Doctor, ACGME Outcomes).	The general concept of CBME at both undergraduate and postgraduate levels has been a topic of much discussion in Israel in general in recent years. Some baby steps have been taken at a national level. A CBME program for either residency or fellowship training has been promoted by the Scientific Council of the Israel Medical Association (the postgraduate specialty educational and certification authority) and has been undertaken in certain leading specialties such as Neonatology. The forum of the Deans of the Medical Schools established committees to re-write national curricula for the five main specialties – Internal medicine, Surgery, Pediatrics, Obstetrics and Gynecology and Psychiatry. These are the subjects assessed in the National Final Exams. The new curricula include elements of CBME, although these are not fully implemented. Experience to date with the move towards CBME suggests that major investment of resources will be required in order to implement a full CBME system nationally. Independently of the above-described national reality, AFOM-BIU, is implementing CBME assessments in the major clinical clerkships. This will be increased and monitored in the coming years. Several of the medical educators are well trained in CBME and will be asked to act as key pivots.
15) Clarify the overarching curricular framework and justification for the pre-clerkship "block" structure. It seems to be a combination of discipline-based (e.g., anatomy, bioenergetics) and disease/pathology-based (oncology) curricula.	The pre-clinical curriculum was originally designed to consist of 5 basic courses (population health, anatomy, pathology, pharmacology and bioinformatics), and 8 integrative fields (genetics, reproduction, growth & development; bioenergetics; infection & inflammation;

	immunity & transplantation; neoplasia, structural change & aging; trauma and brain & mind). The teaching of population health as the first course in the curriculum stresses the commitment of the faculty to the community and the importance attached to social accountability. The innovative educational principle was to integrate pre-clinical courses (integrative fields) around biological processes, and not body systems as is customary. The feeling was, and still is, that this better represents the day-to-day practice of medicine. This integrated block approach distinguishes our faculty from others and is highly regarded by our alumni. It should be recalled that the blocks are accompanied by 2+ spiral educational programs. Nevertheless, during the past decade, the pre-clinical curriculum has evolved such that 4 of the basic 5 block courses remain in the first phase of the curriculum - population health, anatomy, pathology, and bioinformatics. Basic and systemic pharmacology has been moved to a later stage of the curriculum when the students have a stronger background in clinical medicine. Similarly, organ systems pathology has been moved to a later stage for the same reason. 6 of the original 8 integrative fields remain in the second phase of the pre-clinical curriculum - genetics, reproduction, growth & development; infection & inflammation; immunity & transplantation; neoplasia, structural change & aging, and brain & mind. The trauma course was integrated into the general surgery clinical rotation, and bioenergetics evolved from an integrative field teaching the flow of energy in the human body to a basic and systemic physiology course and was therefore moved to the first phase of the pre-clinical curriculum. The clinical skills course and the medical humanities + bio-ethics course are the longitudinal courses running the whole length of the pre-clinical curriculum with content that is coordinated with that of the block courses being taught at the same time.

	Hopefully, this explanation clarifies a central tenet of the teaching philosophy of the Faculty.
16) **Reduce contact hours and implement a more comprehensive approach to active learning.** It is evident that students are exposed to a dense weekly program of direct contact/exposure. A significant part of this time should be freed up to promote self-directed, active learning. There have been some steps in this direction in both the pre-clinical and clinical years, as well as in integrating team-based learning. However, it remains unclear precisely what has been done, how many hours are invested in it, its success thus far, and the barriers.	Implementation of Active Learning during the preclinical years in the 4-year curriculum was successfully piloted in the Bioenergetics, Bioinformatics and Introduction to Clinical Medicine courses. The student body has provided mixed feedback on these initiatives and there remains a large proportion of Israeli students who favor intensive frontal passive teaching by faculty with more limited self-learning. The AFOM-BIU is committed to changing this by demonstrated success of the pilots.
17) **Coordinate education across the various clinical affiliate sites to ensure equivalency of training.** The distributed nature of the clinical campus has many inherent challenges. There should be a clearly designated and empowered educational coordinator at each of the clinical affiliate sites, and these coordinators should meet regularly under the auspices of the central administrative educational leaders. There should be a more systematic approach to site visits in clerkships, rather than their being done in *"intervals as seem fit"*. It is unclear how academic issues at the various clinical sites are handled, with the general statement that *"fi ndings are reported in the relevant forums and acted upon as required"*. While it is encouraging that there seems to be substantial department (specialty)-specific crosstalk among the various affiliates, the interplay of academic department and central medical school administrative entities in these matters must be clearly defined. All of this must come together to ensure equivalency of training across the affiliate network.	There are coordinators in each of the hospitals and for the community by area. These coordinators have direct contact with the Medical Secretariat and the Medical Education Directorate and deal with a multitude of problems. At least once a year, all of the coordinators meet with the whole Medical Education Directorate to discuss both local and general issues. Before the Covid 19 pandemic, a decision was taken to organize site visits in a structured, system-wide manner. This was not possible during the pandemic. However, as we are all learning how to live alongside Covid 19, we are currently working on a detailed plan. The teaching in each clinical specialty and sub-specialty is coordinated and reviewed by a senior Faculty member from one of the relevant departments. This appointment is renewed or changed every 2-3 years. Ensuring equivalency of content at the different teaching sites is central to the coordinator's role. We are aware that there are disciplines in which this process requires corrective support and development and this will be targeted in the coming year.
18) **Add more structure to educational assessment, including an integrated database.** Various ways of assessment have been	Observation of student competencies during clinical clerkships is not currently practiced as a routine. This recommendation will be reviewed

implemented, including *"a combination of written examinations, OSCE-style clinical examinations, written and practice assignments and clerkship performance assessments"*. However, students are not observed in a systematic way, and it is unclear when and how they receive feedback. A more integrative and inclusive database should be developed that tracks each student's progress and challenges. The current assessment system follows the block design. Therefore, the assessment volume is high in the preclinical curriculum, but not present in the clinical years. By moving to vertical and horizontal integration, the assessment frequency could be more easily distributed.	by the Medical Education Directorate. A more integrative student database has recently been proposed within the Faculty and a proposal for discussion and implementation will be presented at the Strategic Planning retreat.
19) **Amplify structured student assessment forms.** Students do fill out assessment forms after each clerkship, but questions should be added relating to ongoing feedback and their opportunity to learn from it; whether they were observed during different interactions with patients; whether they were treated with respect; and how much of the teaching was team-based learning. Observation of performance, including interaction with the patient, and feedback on this in the clinical years is critical to students' development. Furthermore, the feedback should be guided to focus on specific items, not, as one faculty member mentioned, based on *"personal impression"*.	Observation of performance and provision of frequent feedback are important targets for Faculty development in the coming years as described in the response to recommendations (6) and (7).
20) **Explore new models for the clinical clerkships.** Given that the homing model has students spending most of their required clerkships at single clinical affiliates, such continuity of experience and associated mentoring lends itself to *Longitudinal Integrated Clerkship* models. This could be developed more formally. Other options such as advanced clerkship and *incremental increases in authority* models can be grafted onto the clinical training schema to better prepare students for their transition to residency and beyond.	The idea of introducing an LIC has been considered internally and indeed has been included in the proposal for the new 6-year program. It is possible that a pilot will be tried in next 1-2 years. Advanced clerkships have been explored in both internal medicine and pediatrics. However, the feedback was not universally positive and changes in structure are being considered.

21) **Implement an inter-professional education (IPE) curricular thread.** While students claimed to be learning how to work on inter-professional teams, they could not cite specific examples of having ever trained alongside another health professions student. A single such experience (with nursing students) is described in the DCI self-study. It would be reasonably straightforward to incorporate IPE competencies into a curriculum structured such as that of AFOM-BIU, and assessment of IPE could be added to *OSCE's* and *Direct Workplace Observation*.	IPE is indeed important and currently insufficiently taught. We will leverage the proximity of the nursing and allied health professions programs of the Zefat Academic College and Ziv Medical Center to this end.
22) **Further develop the curriculum around cultural competence and healthcare disparities.** The content for these elements is spread throughout the HILA course, clerkships, and active learning experiences exploring personal biases. An explicit conceptual framework for this material would be valuable in tying the material together for both educators and students. For instance, while there is reference to a *Social Determinants of Health* curriculum and communication skills practice, cultural humility is only hinted at in the description of students exploring their own biases.	Both cultural competence and healthcare disparities are among the highest-level priorities at both the education and research levels. More specifically, the aim is to inculcate cultural humility, insight, and tolerance. Certain specific study days are highly emotionally charged, and humility may be overly played. Examples include the Medicine in the Holocaust day, the LGBT+ study day and a day devoted to specific sub-populations such as the Ethiopian immigrants. As noted, SDOH as part of the opening Population Health course, as well as special programs such as ETGAR, provide AFOM-BIU students with opportunities to improve these competencies.
23) **Develop a well-structured process for continuous quality improvement.** A detailed process for orchestrating quality improvement activities should be developed. Two examples of quality improvement actions are offered in the DCI self-study by example (in Surgery and OB/GYN), but it is unclear if they were simply handled at the departmental level and how this tied to school-wide quality improvement processes.	Both of the Quality Improvement initiatives described were conducted as joint projects between the Medical Education Directorate and the individual departments. In response to this recommendation, we are in the midst of appointing a particular candidate to build and lead new Educational QA program teams for AFOM-BIU.
24) **Create a database for longitudinal tracking of graduates.** As a new school, AFOM-BIU has a unique opportunity to track long-term outcomes of its graduates right from its founding. This could be part of comprehensive, prospective program	Prior to the accreditation process, a committee was established to set up a formal Alumni Organization that would also include establishment of a graduate database. This has begun and numerous graduates have already enrolled as "Alumni". We elected to the name

evaluation that provides guidance for continuous quality improvement and mission monitoring. Correlations with career choice, location of practice, communication skills, cultural competence, inter-professional teamwork, teaching evaluations, and academic success would become possible.	Alumni Association in tribute to the memory of the Founding Associate Dean for Medical Education, a "larger than life" medical education leader and innovator, Professor Michael Weingarten. We hope that this will provide a basis for outcomes research in the future.
25) **Create continuity of student mentoring across the pre-clerkship and clerkship curriculum.** A longitudinal mentoring program is briefly described in the DCI self-study. It is not clear if all students are mentored in a consistent way.	All students receive the same mentoring support during both the pre-clinical and clinical years. The primary mentorship is via group meetings with physician mentors and psychologists separately. Individual mentoring is provided to identified students with specific issues.
26) **Address processes for academic remediation.** While there is an early intervention attitude towards academic remediation and a professional educator who works with students, there is a need for a dean of students who coordinates disciplinary and ethics issues in conjunction with the rest of the university.	There is indeed a BIU Dean of Students who works closely with the Associate Dean for Medical Education, and with the AFOM Chair of Student Affairs and the elected Medical Association representative.
27) **Grow scholarship support, especially for students with families to support.**	Over the past few years, a number of additional philanthropic contributions have allowed the Faculty to expand scholarship support to students in need. We are continuing to work on further expansion.
Important	
28) **Develop a formal multi-year faculty recruitment plan.** As noted by the dean, at its founding, faculty recruitment was per force largely opportunistic. A more deliberate approach is now envisioned under the strategic plan. Given the competing interests of recruiting health science v. basic science v. education science faculty, faculty recruitment objectives should be developed framed by a multi-year horizon, so that faculty build does not devolve into opportunistic recruiting. Of note, faculty search committees are headed by the Associate Dean for Research; input of educators is obviously essential.	The AFOM-BIU currently comprises 26 BIU tenure track or tenured full time Faculty members at multiple academic ranks, recruited during the ten years since the founding of the Faculty. In addition, there are 280 Faculty members with clinical appointments, whose primary employer is a formal affiliated medical center, or health maintenance organization. The AFOM-BIU has the backing for and plans to expand faculty in both categories. BIU employed academic faculty – the current 26 Faculty members will be expanded to 50 during the coming five years (approximately 4-5 new Faculty recruitments *per annum*). This has been the pace of recruitment during the past 2-3 years under the current AFOM-BIU academic leadership. As mentioned by the careful IQARC reported recommendations, the initial Faculty

	recruitment was opportunistic. The vision, mission, and core values for the AFOM-BIU, the opportunities for establishing a unique identity and academic competitive advantage at the national and international levels, favor a programmatic approach with an emphasis on medical education, health services research, population health, and medical humanities in a set of disciplines from among those listed below. Consideration in prioritizing these disciplines relate to health inequalities and disparities that challenge the communities of the Galilee, as well as the diversity and population isolate substructure, which characterizes the Galilee. As for the recruitment process, it can be envisioned as a matrix that will prioritize recruitment of promising and leading researchers with background training in the conceptual and technical skill sets mentioned, with a focus on the following disciplines: diabetes, infection immunity and microbiome, genetics of population isolates, population health sciences, data sciences, and artificial intelligence in medicine. The Chair of the recruitment committee is himself also the Associate Dean for Research, and an active medical research scientist and clinician. This is an advantage in ensuring the highest possible scientific and research levels of the recruited candidates, and indeed this has proven itself with broad input from both the full time BIU and clinical faculty. As noted in the response to recommendations by IQARC, additional academic positions have been committed as full time BIU Faculty members in medical education research, and in addition AFOM-BIU has initiated a collaborative interaction with the newly established Faculty of Education at BIU, through its Dean, Professor Yaacov Yablon, with one of the ideas being joint education research, training, Faculty development and recruitment. Clinical Faculty – with the growth of the student body, and the move to increased medical education in the community, AFOM-BIU has been given a financial basis for being able to markedly

	increase the number of clinicians in the HMO ambulatory clinics throughout the Galilee, to be eligible for clinical academic appointments and promotions. Our aim is to increase clinical faculty appointments from 270 to 400 in the coming five years. At least 60% of this increase will be in the ambulatory setting and will align itself with the other Faculty priorities of enhancing gender equity, and cultural diversity at the Faculty level.
29) **Supplement pre-clinical didactics with online teaching.** Online teaching by best teachers (potentially from other faculties of medicine as well) could solve some of the issues related to lack of faculty in some pre-clinical courses.	Supplements to pre-clinical teaching that have grown out of our learning from the Covid 19 pandemic are beginning to be implemented. More advanced audio-visual equipment is being installed in order to allow full audio + video recording of lectures in order to allow for asynchronous student review. In addition, the faculty has already invested in temporary provision of access to internationally recognized software educational packages such as Osmosis, Amboss, Lecturio, and others and is engaged in BIU with Coursera. Ongoing availability will undoubtedly be a major budgetary issue to be considered. This is all over and above recruitment of Faculty trained and themselves actively engaged in techno-pedagogical innovation.
30) **Address the need for simulation training.** There is an intention to access a simulation center to be opened at a college in Tzfat. This plan must be executed, as access to simulation is now viewed as foundational for any contemporary medical education system.	Simulation is already a fundamental part of training specifically in the HILA course. While we await progress on the construction of a simulation center with advanced capabilities at Safed Academic College (500 meter distance), we are intending to include simulation facilities in the new Medical Education Building under construction.
31) **Augment reflections and communication skills development, longitudinally.** The DCI self-study mentions the use of reflections and feedback, but it remains unclear how reflective practice is actually taught, as well as the assessment used to guide feedback on it. A guiding assessment tool would be useful. It is essential to have longitudinal follow-up of the student in a more organized way throughout the years (perhaps more integration between the important HILA course and mentoring). This longitudinal follow-up should help	Indeed, we recognize that reflection and communication skills assessment need to be augmented in the clinical years and will work towards this goal. This will be accomplished principally with the intention of expanding the Mentorship Program already active in the clinical years to a higher level of exposure.

students maintain and develop their reflective abilities and communication skills. Currently, the competency skills of reflections and communication are formally taught and assessed only in the pre-clinical years and are missing in the clinical years. More direct observation, feedback, and work-based assessments or OSCE's are needed.	
32) **Make routine psychometric testing of exams available.** Improve the pre- and post-test quality control around item and test development, including a psychometric analysis.	The Faculty is in the process of recruiting a new education faculty member with specific skills in psychometric evaluations of examinations.
33) **Establish a dedicated committee to deal with conflict-of-interest.** There is not a dedicated individual or committee dealing with conflict of interest. Instead, the dean steers each conflict-of-interest matter, as it arises, to whomever he believes should handle it (medical education committee; student affairs; and so on). This is inappropriate.	This is relegated to BIU by university bylaws. Attempts to form overlapping statutory committees (e.g., disciplinary at the Faculty level have met with resistance and were dismantled).
34) **Develop a conflict-of-commitment policy.**	BIU policies are in place.
35) **Ensure clinical affiliation agreements are updated.** Clinical affiliation agreements have been signed. However, given that most date back to 2010 and 2011, end-dates of these agreements should be monitored, and they should be updated as appropriate.	All of the updates of the clinical affiliation agreements are currently actively underway and near completion.
36) **Explore collaborative opportunities with the Technion Faculty of Medicine in addressing the healthcare needs of the underserved in the north.** Given that AFOM-BIU and the Technion Faculty of Medicine are both situated in the north, the two institutions should find ways to collaborate on defined projects, both clinical and research—particularly projects geared to the health needs of the underserved of that region. Such inter-institutional collaboration could attract government and philanthropic support, and it would model the type of collaborative spirit that would benefit many of the academic institutions within the country. The notion of *coopetition* has become mainstream elsewhere.	The IQARC correctly points to the opportunity for cooperation between AFOM-BIU and the Rappaport Faculty of Medicine of the Technion in serving the medical education and service needs in northern Israel. Such cooperation already exists, but again more in an opportunistic rather than programmatic manner. For example, AFOM-BIU "purchases" the clinical teaching services of clinical departments of Technion affiliated medical centers on a "need" basis. Since the anatomy course at the AFOM-BIU has certain robust capabilities, it had been made available to the Technion, also on an "as needed basis" pending the Technion's imminent upgrade of Anatomy teaching facilities. These are opportunistic proofs-of-principle, that can be

	turned into a strategic plan between the two Faculties of Medicine, with the cooperation of the respective University institutional leaderships. Prior to COVID-19 pandemic, initial discussions in this regard began between the current Dean of AFOM-BIU and the previous Dean of the Rappaport Faculty of Medicine, who is now a member of the Technion's senior academic leadership. This was put on hold, as each of the Faculties moved into urgent response mode to the COVID-19 pandemic medical education challenges. It is now the time to resume this process, comparing and complementing the vision, mission, and core values, statements and goals of the respective faculties, comparing the emerging strategic plans and trying to derive a rational cooperative set of arrangements that can best serve the needs of the population in northern Israel, and also enhance the opportunities for advancement of both Faculties of Medicine to unique identities and highest potential.
37) **Formalize assessment in key educational threads.** Assessment should be better developed as it relates to *Ethics and Human Values*, the HILA program, professionalism, humanistic values, and leadership, among others.	Assessment in these fields is currently under review within the Faculty and the Medical Education Directorate specifically.
38) **Implement a *Resident-as-Teacher* training program and recognize/award residents for their contributions to the teaching of medical students.**	Residents in each of the hospitals are actively involved in teaching and some have even won outstanding teacher awards. As the number of AFOM-BIU graduates in our own teaching hospitals increases gradually, we expect to be able to significantly expand resident teaching.
39) **Sustain the curricular innovations introduced during the COVID-19 pandemic.**	The Faculty contracted with a Education specialist with expertise in digital teaching planning to assist in developing a Faculty wide plan for integration of frontal and online teaching in the long term. This report has been submitted and is currently under review.
40) **Address student life issues.** The current facilities are acknowledged as limited, but adequate for the current size of the faculty and student body. Student feedback	We recognize the limitations of the current facilities and are actively working on possible solutions. We appreciate the committees valuable suggestions for monitoring the process in concert

suggested basic satisfaction with almost everything except the quality and cost of food on campus. Survey students on these issues regularly (consider a random sample of students quarterly) to monitor their experience as administration makes changes. Delegate student surveys to student council and include them in the interpretation of survey results and the development of solutions. Whenever reporting any survey data, share the response rates, means/modes, and standard deviations in a table that makes it easier to interpret the meaning of the results. Also, when monitoring these issues, share change over time.	with the students on a regular basis. This remains a substantial challenge wherein BIU leadership support is sought in developing relevant infrastructure for such programs.
41) **Proceed with implementation of the *North Star* program.** This program is designed to sway more students to stay and practice in the north.	The program is indeed moving ahead with new sources of support. This is a significant contribution to the health care in the North and is now being picked up by support from the Ministry of Health.
Desirable	
42) **Assess the impact of admission procedures on student diversity.** There are rigorous and comprehensive admission procedures, covering both cognitive and non-cognitive domains, common to both programs. The result is a highly selective outcome with very bright students entering the program. However, a risk might be that the student population is not representative for the population in the country.	The committee correctly recognizes that the student body is not representative of the ethnic and cultural make-up of either the North or the country as a whole. This results from Israeli law which demands that all admission procedures be totally transparent and equitable. Thus, selection based on geographic and ethnic diversity is precluded. However, as noted in the response to recommendations 11 and 13 we are confident that the six-year program, if approved by CHE will go a long way to resolving this disparity.
43) **Revise the Multiple-Mini-Interview (MMI).** A genuine MMI would have many more oral stations and examiners.	The Faculty chose knowingly to move away from the MMI structure previously employed. To date, selection outcomes appear satisfactory.
44) **Strengthen career counseling.** Adding career counselling to the mentorship program in the clinical years would help students decide on electives.	Career counselling has just recently been made available via the Mifne program of the Israel Medical Association. AFOM-BIU played a central role in establishment of this program. We are now planning to launch in-house counselling within the next year.
45) **Develop an ethics code for the faculty.** AFOM-BIU developed an important and clear ethics code for students. However, it is worth adding a similar code for faculty.	This suggestion will be proposed to the Faculty administration for consideration in either the 2021-2022 or 2022-2023 academic year, and will have to be coordinated with BIU leadership.

46) **Remedy the mold issue in the library.**	This is a long-standing problem that stems from the original construction of a new building on old foundations. A number of solutions have been undertaken. Special double walls were added to the room in question. An external specialist contractor examined air quality in the room and found there to be no danger, but only an unpleasant aroma. There is some improvement over time. The solution will be when we move to library to the new Education building that is currently under construction.
Recommendations Related to the International QA Review Process	
47) **Make assessment of performance vis-à-vis CHE standards part of the medical school's operational rhythm.** Preparation for re-accreditation should be viewed as a continuous process, as opposed to a last-minute sprint as the site visit approaches. AFOM-BIU should identify a lead coordinator for overseeing this process—perhaps the Vice Dean for Academics, or else another empowered individual—who can visit exemplary medical schools in other countries and observe first-hand how the re-accreditation journey is handled. They might also consider inviting an external review team in mid-way through the re-accreditation cycle to assess status and propose mid-course corrections.	We agree and thank the committee for these valuable practical suggestions.
48) **Prepare future DCI self-studies with more attention to detail.** There should be a better process for writing the DCI self-study, with a view towards clarity, unity, and accuracy. The dean's slide presentation to the review committee was impressive and conveyed a comprehensive perspective that was lacking in the DCI self-study.	Future DCI documents will be more carefully detailed and include a major introductory overview before delving into the DCI items.
49) **Provide English translations for key supporting documents in the DCI self-study.** Organizational charts were in Hebrew, as was much of the documentation. At the very least, there should be descriptors/titles in English for key	We will consult with CHE to determine the sets of support documents to be provided in English translation, in a manner that will be as uniform as possible among faculties, and as helpful as possible to the assessing committees.

documentary evidence.	
50) **Provide a table of contents in the DCI self-study.**	See attached.