We thank the CHE and the IQARC for the thorough review of our medical school. We appreciate the recognition of our strengths, as well as the identification of several issues we need to improve. We have conducted various meetings to study these recommendations and develop a plan to address them.

Please note: Some of the elements of the plan for change mentioned below cannot be applied without additional resources and financial support from the VATAT. A detailed letter specifying the financial needs will be submitted in the very near future.

Furthermore, some changes require the support of CHE and MOH (mentioned briefly in specific comments).

Below is our initial plan for improvement based on the committee's comments.

Committee Recommendations 1-31 Essential 23-50 Important 51-52 Desirable	**Steps toward implementation** **(Below are the responses and general timeline)**
1) Develop a strategic plan that sets forth a clear articulation of mission, vision, and values, along with defined action plans and goals that are directed towards instantiating them. Of note, the 2021 document referred to as a 'strategic plan' in the DCI self-study materials is not actually a plan per se. Deliverables should be tracked systematically over time, with reaffirmation of goals and plans with dean transitions. The medical school's strategies and tactics must be demonstrably aligned with those of the broader university.	A team was assigned to write an approved mission, vision, and values, with a defined action plan. The team will include individuals from the Faculty of Medicine and the University leadership, as well as an external expert consultant. We realize that to adequately accomplish this essential comment, we need to create an inclusive process, and intend to realize this by beginning of 2023.

2) Bring the medical school's educational mission and needs into greater focus for top university leaders. There is concern over a mind-set, conveyed at the time of the site visit, that only scientists should teach, as well as an attitude that reflects a lack of appreciation for current concepts in education science and that it is a discipline in-its-own-right. This deficiency is further reflected in the exclusion of educational tracks from university promotion and tenure. Even if research is seen by senior leaders as the overarching university priority, the commitment to medical education must be reinforced alongside it, with an appreciation that approaches to medical education must be allowed to evolve over time.	The medical school team has reached out to the University leadership and recruited them to take an active role in the planned upcoming changes. At present, the medical school is actively working on developing the medical educational track and identifying potential faculty members for these positions. We strive to accomplish this recommendation and we believe that it fits with the University mission of excellence in teaching; however, we will need permissions/capabilities and increased independence to accomplish this. In our discussions with the University leadership, we identified several channels to address the financial and resource needs that are being pursued. To do this, the CHE may aid in developing educational tracks and identifying further resources needed.

3) Align the medical school and the rest of the university around operational and financial drivers tied to the educational mission. The dean at SFOM-TAU, as is the case for all Israeli medical school deans, is constrained in his authority around faculty appointment/promotion and budgetary latitude. This raises the core question of whether certain resource-demanding recommendations of an IQARC review panel can even be implemented. This will be especially important as the medical school looks to embrace core recommendations of the IQARC review panel related to the educational mission.	As stated in response to comment #2, we are creating an inclusive medical education team that will lead the restructuring of the medical school curriculum and the changes that such restructuring entails. The extent of the authority on promotion for the medical educational track is critical and requires collaboration between the CHE and University and faculty leadership to achieve it.

4) More systematically leverage SFOM-TAU's clinical partners, perhaps with a coordinated approach that starts with a comprehensive clinical asset map, for both clinical faculty and clinical programs. A more intentional approach would yield dividends in terms of maximizing student learning opportunities and fostering higher order collaborative interactions among faculty and staff across the array of clinical affiliates, contributing towards a more vibrant, cross-institutional community of scholars and a more deeply matrixed academic clinical ecosystem. Finding ways to better integrate across the multiple clinical affiliate sites will allow for more effective leveraging of this distinguishing asset of the medical school and in particular, better drawing on the academic prowess of the distributed clinical faculty into the preclinical years.	TAU-SFOM will continue to further explore ways to connect and leverage the various high-quality clinical settings and specialties. Please note that a lot of the clinical faculty comes from the preclinical faculty. We aim to create a more cohesive connected ecosystem to ensure homogeneity across the different institutions. As well as fulfill the request for creating harmony between clinical and preclinical years

5) Develop a comprehensive master plan for curricular change which transitions from the current traditional curriculum to a competency-based, learner-centered program with extensive vertical and horizontal integration of foundational and clinical science across all years of training. Begin with a robust planning process which targets a launch date and phase-in-period beginning with Year 1 curriculum building and implementing subsequent curricular years as the current curriculum is phased out over a full 6-year cycle.	A medical education team is being established to accomplish this recommendation. We are working on a comprehensive master plan. Subsequently, we are planning on implementing the changes in another 2.5 years- Fall 2024 school year (October 2024).

6) Adopt a competency framework which guides and aligns choices about the curriculum, starting from learning objectives, to curricular elements (longitudinal strands, blocks, minicourses, longitudinal integrated clerkships), to instructional strategies (case/problem/teambased, self-study, small group learning, lecture, simulation, laboratory), to assessment approaches (formative/summative) and data sources (e.g. directly observed performance, narrative/reflective, multiple choice questions, log books) and provides focus for comprehensive faculty development. This competency framework will enable mapping of all course elements and longitudinal student assessment.	A medical education team is being established to accomplish this recommendation. We are working on a comprehensive master plan. Subsequently, we are planning on implementing the changes in another 2.5 years- Fall 2024 school year (October 2024).

7) Ensure there is a unified model for coordinating all educational activities across the medical school and its clinical affiliates, and consider combining all subunits and personnel now dealing with issues related to medical education into one strong department of medical education. This would include integrating it with the Division of Quality Teaching, Research and Evaluation. Such a plan would be part-and-parcel of a more general effort to expand and restructure medical education expertise within the medical school, building on available resources and recruiting additional staff. By restructuring SFOM-TAU's education enterprise in this way and better leveraging the Division for Advancing Quality Teaching, Research and Evaluation, the capacity of clinical educators to engage in rigorous, inter-institutional medical education scholarship will be enhanced.	A Medical Education Center, where the medical education team is housed, is being established to accomplish this recommendation. We are working on a comprehensive master plan. This will include the integration of the Division of Quality Teaching. Subsequently, we are planning on implementing the changes in another 2.5 years- Fall 2024 school year (October 2024). We need the appropriate resources to announce (Kol Koreh) and recruit the needed faculty and staff. Of course, this requires "Tkanim" (positions) and additional funding to the budget to make this happen. CHE's support and financing are needed.

8) Recruit a cadre of faculty with an education focus, trained in the latest advances in education science and who can nucleate these concepts for the rest of the teaching faculty. Create incentives and academic career paths for these dedicated education faculty, as well as for education-focused faculty more generally, including clinician educators. Expanding pathways toward academic promotion for clinical educators, both in hospital and community settings, could draw on learnings from others, as models for rigorous criteria for promotion of medical educators are well-established in world class institutions throughout North America and Europe. Address issues related to protected academic time and educational leadership time. Building up and valuing the medical school's education-focused faculty should be approached as an imperative.	We acknowledge that in order to form the Medical Education Center, we require additional human resources with the additional appropriate expertise (see comments above and cover letter). As part of starting the developmental process, we are attending the Maastricht SHE summer school, as well as learning from the top universities around the world.

9) Transform the institutional approach to reaccreditation, viewing it as a continuous process, as opposed to a last-minute sprint as accreditation site visits loom. SFOM-TAU should identify a lead coordinator for overseeing this process—preferably an empowered medical school leader—who can visit exemplary medical schools in the U.S. and other countries and observe first-hand how the reaccreditation journey is handled. SFOM-TAU might also consider inviting an external review team midway through the reaccreditation cycle to assess status and propose mid-course corrections.	As part of the new Medical Education Center that we hope to establish, a division that is responsible for evaluation and accreditation will also be formed. We will create a protocol to follow. We will consider the methods implemented in other universities. We will perform a periodic mini-accreditation that will result in a report to enhance the medical school. To do this well, we need to add tools that will create databases so that we can collect the data and create a picture of all processes (e.g.: admissions statistics, committee decisions and changes, and residency statistics etc.) Some challenges exist as we have constraints from the University regarding: 1) software use that is different from what is provided by the university, and 2) assuring the maintenance of confidentiality and data protection. We will build an action plan around these, and intend to start implementing these processes before Fall 2024.

10) Collaborate with other medical schools in the country and internationally to enhance medical education literacy and capacity for curriculum innovation, designing a locally appropriate competency framework, and conducting faculty development programs.	As mentioned above, this summer we have already registered to attend a global medical education conference where a group of medical education leaders will go to Maastricht University. Furthermore, we have begun a process of enhancing education literacy through a forum on Innovative Teaching and through providing lectures about medical education in committees. We will work on enhancing coordinated education literacy also in other meetings (such as faculty counsel, clerkship directors' meetings, etc.) and beyond.

11) Leverage the Israel Center for Medical Simulation (MSR) at Sheba Medical Center more directly with preclinical students, into the early preclinical curriculum, and strengthen its capabilities with respect to virtual medical education (VME). Overall, simulation activity should be increased to involve students at all stages of training.	Following initial discussions with the University leadership, there is a general consensus to invest in the simulation needs, which includes an increase in the length of time and the extent of topics hours that students learn at MSR, and/or build a simulation center to use as needed in teaching and assessment as will be required by the updated curriculum. This will require increased budget. .

12) Reduce the number of scheduled contact hours dramatically and shift most of this faculty:student and student:student contact to small scale learning activities. Currently, the curriculum is ~6% small group (174 small group /2683 total hours). This transition should protect significant time for self-directed learning.	We are currently reviewing our program to advance self-directed learning, decrease contact hours, and increase small group learning. This is part of the revolution of SFOM that will be implemented by Fall 2024.

13) Change the semester system to an integrated block system, avoiding multiple independent courses running concurrently.	As part of restructuring the curriculum, the Medical Education Center will coordinate the implementation process of the aforementioned block system by Fall 2024.

14) The number of summative examination moments is extremely high. This is due to the nature of the current curriculum which is essentially discipline-based. Try to significantly reduce the number of summative moments by having interdisciplinary exams.	As part of introducing the new teaching modalities, new evaluation and testing methods are being considered and assessed and will be implemented by Fall 2024.

15) Consider assessing more performance dimensions once a competency-based curriculum is adopted, to replace the many traditional assessments summative examinations. Try and seek consensus across medical schools to adopt a single competency framework for all undergraduate (and postgraduate) training in Israel.	As part of introducing CBME, modified evaluation and testing methods will also be implemented accordingly. We look forward to taking an active role with CHE and the MOH to generate a consensus along with other universities around the issue of performance dimensions.

16) Increase meaningful feedback to students for better learning from the assessments (grades are a poor form of feedback). Provide sub-score performance information on blueprints of individual tests, where the individual performance is related to the performance of the cohort. Use documented narrative data from feedback dialogues to inform complex skills such as professionalism, communication, teamwork, leadership, and so on.	Similar to the above comment, we will modify the evaluations, and with them, we will modify the feedback process. We acknowledge that class-ranking and statistical descriptions will benefit the evaluation process and will most likely implement it. We want to clarify that we have a number of these processes already in place. Students receive narrative feedback in addition to scores (in clinical rotations and in professionalism and communication skills learning). Furthermore, in the University, as a whole, when a student receives a grade, they also receive an automated analysis of their performance in comparison to peers in each particular class.

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

Part of learning from other institutions will include assessing available electronic portfolios that will match our needs. We plan to introduce and pilot the electronic portfolios before Fall 2024.

This is very much dependent on the CHE to supporting a body or organization that will connect across the medical schools and establish the needed equilibrium.

18) Create a longitudinal mentoring program for all students. Mentoring is essential for promoting reflective and self-directed learning skills, and it is also beneficial for safeguarding the well-being of students. Require students to self-analyze their academic progress periodically as a basis for a dialogue with their mentors.	The current small group facilitator in the Professionals and Communication Skills courses do provide longitudinal mentoring to the students. We do focus on reflective practice (mentioned as an example in the report) over time and do focus on student well-being, having a support group, and an individual physician who knows and accompanies them throughout the years. To improve this process, we will explore adding more 1:1 time with the facilitator as well as "caring over"/feedforwarding of the feedback from grades and clinical assessments to the group facilitators so the process of mentorship will not be part of the grading process. This will require an additional budget and human resources. We are planning on implementing this by Fall 2024.

19) Aggregate information of individual assessment data to inform summative decisions on student progression in relation to the competencies.	Similar to previous comments, we will modify evaluation processes to assess achievement of different competencies. We would like to create an electronic student portfolio, and as mentioned we would like to pilot it before 2024.

20) Implement a system for tracking and sharing academic performance across clinical rotations. Monitoring growth on competencies in clinical years requires carrying over information from one rotation to the other to improve continued learning.	We discussed this approach for a system that tracks and shares academic performance across clinical rotations, however we were deterred by the concern that it may lead to biases in evaluation of students across clinical clerkships in our culture. Instead, we have been tracking student performance and discussing them at the level of the medical school leadership. Having said that, we are taking the committee comments seriously and will re-evaluate our approach based on the literature as it relates to our medical school culture.

21) Introduce authentic work-based assessment to replace oral examinations and OSCEs and ensure consistency of implementation across all clinical sites. Examples of work-based assessment instruments include Mini-CEX, field notes, case-based discussions, peer observation, video assessment and multisource feedback. Maximize the feedback and learning value of these assessments and avoid summative signals (i.e., grades). Train the assessors on how to give feedback. Find ways to introduce these work-based assessments as part of the ongoing clinical routine.	Similar to previous comments (17-18, 19, and 20), we are in the process of making considerable modifications to the evaluations and create new evaluation form, which entails considerable investment in the planning, training supervision and execution. This will require funding.

22) Design and implement a comprehensive, longitudinal mentoring program—extended into the clinical training years—which addresses the noted lack of individualized coaching, early identification of academic struggle and career counseling.	The notion of systematic mentorship seems to be foreign in Israel, as such, we are planning on learning from other institutions. One of the limiting factors is the availability of the appropriate faculty members to drive this intervention and the funding for it. We plan to introduce and incorporate a fruitful mentorship program by Fall 2024.

23) Develop a core required faculty development program for all medical educators, preclinical and clinical, resident and faculty, to ensure communication of competency framework and instructional objectives, as well as enhancing educator/assessor skills. Developing a structured approach to faculty development and mentorship, a path to promotion for educators, along with mandating faculty development activities, would also lead to more robust attendance at faculty development programs.	The new Medical Education Center will include a division responsible for faculty development to ensure that these aforementioned needs are met. It is clear that the current faculty members cannot deliver the curricular changes without meaningful training in CBME, which includes new educational and evaluation tools. Promotion of educators is based on the University leadership and CHE assertion of its importance..

24) Assure cross-site equivalency of training by implementing a clear process to ensure that clinical training objectives are understood and assessments implemented across the large array of clinical sites. Ensure strong central curriculum leadership to coordinate content learning, assessment and longitudinal monitoring of student performance and address the variability in quality of clinical tutoring across the clinical clerkships.	Cross-site equivalency of training is important and challenging. We plan to improve it through mandatory faculty development and by developing qualified educational leadership in the hospitals. Under the leadership of the planned Medical Education Center, a division responsible for faculty development will be created to ensure that these new needs are met. This will require, as mentioned above, an investment in human resources. The planning stage has already begun, and we intend to implement this by Fall 2024.

25) Ensure that health care disparities and cultural competence curricular content comprehensively addresses the most common local and regional societal needs in an epidemiologically state-of-the-art fashion.	We need to expand our viewpoint on training in cultural competencies and consider the different minorities in Israel. We will seriously plan how we can appropriately include these elements in our curriculum. As of now, there are some learning opportunities offered in certain courses and electives that already address these issues, however, we will further expand on it. A curriculum enhancing the concepts of health care disparities and cultural competence will be incorporated by Fall 2024.

26) Ensure that the architectural plans for the new medical education building include a well-structured plan to support transition to small group learning. The goal is to move away from the current predominance of large and medium size (25-60) medical education spaces towards smaller, flexible room configurations.	We understand all the new curricular activities that will be implemented will require changes in the current facilities and additional appropriate physical entities. An existing structure was identified by the University leadership, which will require interior renovations to suit our needs.

27) Significantly expand community-based clinical training for all students, in primary and specialty clinics out of the hospital setting. Consider an ambitious target of 20-30% of all clinical training to take place out of hospital, to be accompanied by extensive faculty development to ensure high-quality clinical learning.	We share the notion for a need of more community-based clinical training and plan to increase it. This will require additional financial investment due to a number of factors. With the support of the University leadership and the active involvement of the MOH and CHE, we will be able to move this forward. Assuming these factors occur, we plan to implement these changes by Spring 2025.

28) Expand interprofessional education to include all medical students.	The course, “Yachad”, will be continued and enhanced to meet this recommendation. Furthermore, inter-professional education will be reinforced and solidified as a goal during clinical rotations.

29) Incorporate alternative ways of assessing non-cognitive skills in the admission process that go beyond personality assessments per se, e.g., written Situational Judgment Tests (SJT) and Multiple Mini Interview (MMI).	We use the multiple mini-interviews, along with other components in the admissions process. However, we are in the process of re-evaluating the admissions process to further improve admission. New changes are planned for the next application cycle (incoming 2024 class).

30) Implement innovative admission policies to actively address lack of diversity of the student body, to better reflect the population served. Work with CHE to develop paths for diversifying admitted student demographics, including minority groups and those from underprivileged backgrounds.	We agree with the need for diversity and are investing efforts in this. The University and medical school leadership created special programs to attract and support a diverse study body. We are tuned to changes in the Israeli society and in the representation of physicians in Israel. In recent years, we succeeded in increasing the number of graduating physicians from the Arab community, including providing them with support in integrating in the University. Currently, we are targeting other underrepresented communities including the Ultra-Orthodox, individuals from Ethiopian descent, and students from low-income neighborhoods. Clearly, we recognize that students from underrepresented backgrounds need scholarships and support.

31) Rethink the goals of the medical school's American program, recognizing the bad optics associated with using foreign students to subsidize Israeli students. Better integrate students from the American Program into the mainstream student body so they can later be effective ambassadors for Israeli medical education.	We appreciate this comment and take it seriously. Many debates have been raised in recent years about the American vs. the Israeli programs. We will follow with a better integration of the programs, encouraging more exposure between the two by creating curricular and extra-curricular activities that will create more exposure between the two programs.

32) Develop a more regular cadence of meetings between the medical school dean and the rector of the university.	Following initial conversations held with the University leadership, the University leadership has aspired to take an ongoing and active role in the planned upcoming changes starting immediately.

33) Develop a formal medical school handbook that translates the university bylaws into well-defined medical school policies that govern faculty, student and staff affairs, and the senior management structure and operations.	We do have a medical school handbook for students, as well as bylaws for the faculty. We may have misrepresented it in the report, and we therefore apologize.

34) Establish a Vice Dean for Student Affairs position in the medical school to better structure student support services. Such a dedicated vice dean for student affairs would facilitate the creation of a more robust organizational infrastructure for administrating student affairs and student life.	As part of the new Medical Education Center, the position of Vice Dean for Student Affairs will be included and implemented by Fall 2024 contingent on budgetary approval.

35) Conduct a well-written, annual required student satisfaction survey, to monitor adequacy of support services and educational programs and provide consistent outcome data to assess impact of changes and innovations.	Evaluation methods will be augmented and implemented to improve student engagement in the feedback process, and in turn, will improve data acquisition to impact quality of teaching and satisfaction. We will try to collaborate with other institutions and MOH on a general satisfaction survey.

36) Start to address the time and financial pressures on SFOM-TAU students by directing meaningful philanthropic dollars towards student support. Work with university-level development officers to create a meaningful number of endowed scholarships, to lighten the financial and time commitment burdens on students. This, in-and-of-itself, would message a fundamental commitment to the education mission, and would further indicate that philanthropy need not be solely directed towards the research mission.	Part of the ongoing work with the University leadership will include addressing financial support for the medical school. Indeed, scholarships account for a large contribution for the medical school's costs.

37) Provide more structured student guidance process for choice of specialty and residency/fellowship path.	This will be achieved as part of restructuring our mentorship program, considering the creation of Vice Dean of Student Affairs, and will serve as an additional component to the mentorship provided in the current Medical Professionalism course. During Years 3 and 4, the mentorship support will be steered towards residency and fellowship guidance for students.

38) Align the multiple committees within the administrative oversight structure, with the goal of streamlining operations. Remedy aspects of the hierarchical structure that impede constructive and transformative change.	This goal will be addressed in the development of the new Medical Education Center.

39) Bring the portfolio of clinical affiliation contracts and memoranda of understanding up to date and ensure completeness.	We recognize the deficiencies and would like to address them. However, we will need support from the University leadership, CHE, and MOH to effectively advance this issue. If this becomes a requirement from MOH, then it will happen.

40) Implement a Conflict of Commitment policy. Constitute formal Conflict of Interest and Conflict of Commitment committees that develop, and are then guided by, well-structured policies, and oversee disclosures through a systematic, annual process.	We recognize the deficiencies and will consult with the legal authorities of the University on this matter.

41) Start to leverage other health professions for interprofessional education, perhaps building on the “Yachad” program that is not well known.	The course, “Yachad”, will be continued and enhanced to meet this recommendation. Furthermore, we will be considering scholarly activities for the faculty who run this course. In addition, we will be planning interdisciplinary experiences in other timepoints of medical school, including during the clinical years.

42) Plan for participation of pre-clinical teachers in clinical courses.	We acknowledge that as part of the changes in the curriculum, especially the CBME approach, preclinical teachers' participation in the clinical courses is vital. Within the current academic structure, we cannot commit to this. However, together with the aforementioned changes, this may be possible in the next few years.

43) Provide more detailed information related to student retention and student progression, that is track- and years-in-place-dependent. This will reveal length of study and dropout/attrition within the program.	Although we have this information in our possession, we recognize that we need to enhance the reporting of student retention and student progression to gain a clearer picture. We aim to create an electronic student portfolio, and to hope to use similar software like other institutions around the country.

44) Develop a system for longitudinal tracking of educational outcomes, as a pressing need and opportunity. This is not just for SFOM-TAU itself, but also towards the medical school's larger obligation to help build Israel's physician workforce. Medical school-specific data as to numbers of graduates practicing in Israel, types of medicine practiced, and kinds of clinical venues are crucial for proper assessment and planning. A longitudinal database to track medical school graduate career paths over time would allow for more systematic assessment of medical education outcomes over time and correlation with respective medical school performance parameters. Explore collaboration opportunities to aggregate this kind of data across medical schools in the country.	Indeed, the outcome of the students' career paths reflect on the medical school, and Israel as a whole, and we will therefore implement follow-up data collection procedures. We believe this should be a countrywide commitment, and therefore will need MOH assistance. Furthermore, we need to strengthen the alumni organization.

45) Enhance the “Yachad” (interprofessional education) program to prepare medical students to work effectively in the highly interdependent health care teams of the future.	The course, “Yachad”, will be continued and enhanced to meet this recommendation, specifically we will work on adding appropriate evaluation formats. And as was mentioned in #28, the educational goals of “Yachad” will be reinforced during the clinical years.

46) Tap into Israel's start-up ecosystem for co-curricular student experiences and or research thesis opportunities.	As a first step, we will create a required longitudinal research methodology course, which among others, we will consider pursuing collaborations with start-ups. At present, we already offer an elective that is called "Yazamut", and the content of the course includes innovation. In addition, we intend to provide an option for biomedical engineers to transition into medical school.

47) Expose students to the highly satisfied, exceptionally prepared primary care practitioners in the medical school's orbit, to promote attractiveness of primary care as a career choice and thus help address the national need for Israel-trained physicians to fill these critical roles.	We agree with the need for more primary care exposure. In addition to the current experiential elements, we will consider implementing new approaches by examining our capacities while trying to learn from other institutions around the world. Achieving this goal will require support and resources from the CHE and MOH. Thus, we will try to pursue this recommendation pending that the available budgetary concerns will be met.

48) Leverage the American/NYS Program, which is more advanced in implementing integrated curriculum. This program can serve as a laboratory to pilot and study curricular and instructional innovation, with the downstream goal of infusing the Israeli programs with new approaches.	As part of the collaborative process, we have been and we will further tap into the American/NYS Program.

49) Strengthen program evaluation by students. Given the limited variance in responses of students, the data (as reported in the DCI self-study) is generally not meaningful or actionable.	We will enhance and modify evaluation methods implementation and structure to improve student engagement in the feedback process, and in turn, will improve data acquisition. We will focus on learning how to improve our evaluation processes and increase student engagement, a challenge we experience. Ultimately, additional resources are needed.

50) Ensure rigorous assessment of curricular content that is migrated online, at the course and individual faculty level.	Evaluation methods will be modified and implemented to ensure CBME success.

51) Free up time for students to engage meaningfully in research and for off-campus experiences (e.g., community service work, embedding in high-tech environments).	We currently provide summer research projects and other projects at Sheba and other institutions as well as on campus to students. We apologize that we didn't previously clarify this. In addition, we are planning to create a research methodology training course and hope to set aside time for scholarly activity.

52) Provide English translations of all key documents in future DCI self-studies.	We acknowledge this is necessary and will be implemented accordingly.