



SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Medical Doctor (MD) Program

Full Program Proposal

March 15, 2024
SFU Medical School

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1 Executive Summary

a) An overview of the institution's history, mission, and academic goals:

As Canada's engaged university, Simon Fraser University (SFU) is defined by its dynamic integration of innovative education, cutting-edge research and far-reaching community engagement. SFU was founded in 1965 with a mission to bring an interdisciplinary approach to learning, embrace bold initiatives, and engage with communities near and far. Today SFU is consistently ranked amongst Canada's top comprehensive universities and is one of the world's leading teaching and research institutions.

The proposed SFU Medical School (SFUMS) and within that, the Medical Doctor (MD) program, builds upon this proud tradition by embodying SFU's commitment to interdisciplinary approaches, cutting edge research and community engagement. The MD program will equip future physicians with the knowledge and skills necessary to address complex healthcare challenges through innovative educational approaches, authentic community and patient engagement and exposure to interdisciplinary clinical practice.

b) Credential to be awarded:

Doctor of Medicine (MD).

c) Location of program:

SFU Surrey Campus will be the main campus for the MD program, hosting classes, labs, team learning with other disciplines, and research. Clinical experiential learning will occur in various settings primarily (but not exclusively) across the Fraser Health region including Fraser Health Authority (FHA) primary care multi-disciplinary team-care centers, community care centers, urgent care centers, hospitals, and long-term care facilities, as well as privately-owned family medicine practices and other registered health professional and physician specialty clinician practices.

In addition to the partnership with FHA, SFUMS has also partnered with the First Nations Health Authority (FNHA). This partnership will allow for inclusive and immersive clinical experiences within First Nations communities.

d) Faculty offering the proposed new program:

The governance structure is still to be determined and will be finalized through a separate set of Senate motions. The Simon Fraser University Medical School (SFUMS) is the placeholder title until the governance decision has been made.

The final proposed structure of the MD program will need to strictly adhere to the accreditation requirements set by the Committee on Accreditation of Canadian Medical Schools (CACMS). To meet these requirements, the SFUMS must be positioned as a distinct entity with accountability mechanisms that demonstrate adherence to accreditation standards. Furthermore, it must be demonstrated that the Dean, who must be a licensed physician, has direct access to senior university administrators. For this reason, some universities create a “Dean and Vice-Provost” role; others simply indicate the direct reporting relationship between the Dean and the Provost and Vice-President Academic. To that end, the SFUMS will have a Dean responsible for a clearly differentiated medical unit and entity. Ultimately, Board of Governors approval, at the recommendation of Senate, will be required to finalize, adopt, and implement the governance structure for the proposed SFUMS.

e) Anticipated program start date:

Summer 2026.

The Committee on Accreditation of Canadian Medical Schools (CACMS) mandates a minimum of 130 instructional weeks. To ensure the minimum is met, and that students graduate in time to begin residency programs on July 1st in the year of graduation, the MD program will begin partway through the Summer Session Term.

f) Anticipated completion time:

This program will take most students 3 full academic years to complete. However, given its competency-based nature, it is anticipated some students may require or elect to request additional time to achieve the required competencies to complete the program. Flexibility, through policy frameworks and scheduling, will allow the program to proactively plan for this. The MD program will work to support students who require accommodations to the typical program length for a variety of reasons including, but not limited to: learning differences, cultural or family responsibilities, physical needs, and health related concerns. This type of accommodation policy has been in place for many years at other Canadian medical doctor programs and works well. Collaboration with SFU Student Services (e.g., Centre for Accessible Learning, Health and Counseling Services, Indigenous Student Centre, etc.) will be essential to meeting the unique requirements of the program and to supporting student success. The program will be structured to support individual students requiring accommodations and will facilitate their progress and reintegration.

Additionally, it is anticipated that some students may wish to pursue various career-focused enrichment opportunities that will increase the length of time required to complete the program. This has been noted at the two Canadian 3-year MD programs (Cumming School of Medicine at University of Calgary and Michael G DeGroote School of Medicine at McMaster University) and typically involves less than ten percent of the class cohort.

g) Summary of the proposed program:

- **Aims, goals, and objectives:**

There is an urgent need to increase the number of practicing family and primary care physicians in British Columbia (BC). As part of its comprehensive strategy to improve patient care and address a shortage of physicians, the province has prioritized the establishment of a new medical school on Simon Fraser University's Surrey campus. The SFUMS, including the MD program, will be the first new medical school in Western Canada in 55 years. The principal goal of the MD Program is to graduate physicians who have the knowledge, skills, abilities and commitment to provide team-based, community-level health care where it is most needed in BC.

All graduates of MD programs must continue their education within a Post Graduate Medical Education (PGME) residency program following MD program completion. While graduates of the MD program will be well prepared for a PGME program in any specialty, this curriculum will, by design, inspire its students to choose comprehensive, longitudinal, community-based family medicine and other generalist specialties of need (generalist being those “with core abilities characterized by a broad-based practice”¹).

We aim to ensure MD program graduates will become competent physicians who do not just meet the expected Canadian competency standards, but exceed them. Through research-informed curriculum and pedagogy, students will be prepared to meet the preventative and primary care needs of the diverse communities and populations in and across BC, and educated to work in team-based primary care settings that are patient-centred and socially accountable. MD program students will develop the skills and understand the power of relational approaches, to address issues of respect, relevance, reciprocity and responsibility.

Furthermore, the program is committed to genuine and reciprocal partnerships in the development and implementation of the medical school, its academic programs and its research priorities. Community-based learning and research

¹ Generalism in medical education. (n.d.). <https://www.royalcollege.ca/en/educational-initiatives/educational-generalism-medical-education.html>

opportunities will be fully integrated throughout the program and Indigenous knowledge systems in learning, research, and practices, will be embedded.

- **Contribution to the mandate and strategic plan of the institution:**

The MD Program is well-aligned with the recently released Simon Fraser University strategic plan, What's Next: The SFU Strategy (2023), which identifies four key priorities: "Uphold Truth and Reconciliation," "Engage in Global Challenges," "Make a Difference for BC," and "Transform the SFU Experience." The medical school is a cornerstone initiative within the BC government's "Make a Difference for BC" priority, filling a critical gap in the preparation of physicians to deliver care in BC.

Moreover, the program will help SFU advance its "Uphold Truth and Reconciliation" priority by providing an inclusive and culturally safe training environment, developed in collaboration with First Nations communities, Indigenous stakeholders and the First Nations Health Authority (FNHA). This will create opportunities for Indigenous students to become medical providers for their communities and for non-Indigenous students to practice culturally appropriate care. In this way, the MD Program will embed this priority into its curricular foundations, and thereby uphold Recommendation 18 from the In Plain Sight² report and Truth and Reconciliation Commission of Canada (TRC) Calls to Action³ 22, 23 & 24. The program will strive to actively reduce barriers to entry, put dedicated resourcing towards the identification, encouragement, recruitment and retention of potential Indigenous applicants, and regularly review the program to eliminate racist or oppressive practices, content and policies that may prohibit or deter Indigenous applicants or students.

The MD program also aligns with the goals of the SFU Equity Compass. The program is committed to creating a culture and structures which promote respect, inclusion and belonging. We aim to provide an education program that is anti-racist and that reflects our stated values of respect, reciprocity, relevance and responsibility. The program is committed to equity in hiring and collecting data to inform continuous improvement.

- **Linkages between program outcomes and curriculum design:**

The proposed curriculum model facilitates active learning through facilitated case-based small group learning, team-based learning, and immersive clinical and community-based learning. This model will ensure the program is flexible and

² Lafond, Mary & Johnson, Harmony & Charles, Grant. (2020). In Plain Sight Addressing Indigenous-specific Racism and Discrimination in BC Health Care: Summary Report.

³ Truth and Reconciliation Commission of Canada (2015). Truth and Reconciliation Commission of Canada: Calls to Action. http://www.trc.ca/assets/pdf/Calls_to_Action_English2.pdf

responsive to evolving community context and health needs and that students are prepared to meet the present and future public health and health workforce demands of BC.

Importantly, the curriculum will be designed to align with the Canadian consensus standard of the CanMEDS Physician Competency Framework,⁴ whose seven roles (medical expert, professional, leader, collaborator, communicator, health advocate, and scholar) and associated competencies work to ensure that students have the appropriate knowledge and skills to be effective practitioners. Aligning with the CanMEDS Competency Framework will ensure that students will be competitive for, and transition well into, their residency programs of choice.

Furthermore, by embedding Indigenous ways of knowing and being throughout the curriculum the program will illuminate and challenge traditional power structures to promote equity, social justice, and cultural humility. For example, the Indigenous lens known as two-eyed seeing “holds that there are diverse understandings of the world and that by acknowledging and respecting diversity of perspectives (without perpetuating the dominance of one over another) we can build an understanding of health that lends itself to dealing with some of the most pressing health issues facing Indigenous peoples and communities.”⁵ Likewise, Cull et al. suggest this means engaging students with the 4 Rs of of Respect (e.g., “considering in a reflective and non-judgmental way what is being seen and heard”), Relevance (e.g. “involv[ing] Indigenous communities in the [design] of academic curriculum and student services across the institution to ensure Indigenous knowledge is valued and that the curriculum [has] culturally appropriate outcomes and assessments”), Reciprocity (e.g., “[viewing] all participants as students and teachers in the process”), and Responsibility (e.g., “understanding the potential impact of one’s motives and intentions on oneself and the community”),⁶ and this can be seen reflected nationally in the CanMEDS – Family Medicine Indigenous Health Supplement. Locally, Indigenous stakeholders and the First Nations Health Authority have described their health planning and visioning as “Blending the best of two worlds in health – modern medicine and ancestral teachings

⁴ CanMEDS is an educational framework that describes the abilities physicians require to effectively meet the health care needs of the people they serve. It is the basis for the educational and practice standards of the Royal College. Although issued by the Royal College and for residency programs it also has application for the MD program. <https://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e>

⁵ Martin, DH. (2012). Two-eyed seeing: a framework for understanding Indigenous and non-Indigenous approaches to Indigenous health research. *Can J Nurs Res.* 44(2):20-42.

⁶ Cull I., Hancock R.L.A., McKeown S., Pidgeon M., Vedan A. Pulling Together: A Guide for Front-Line Staff, Student Services, and Advisors. BCcampus; Victoria, BC, Canada: 2018. <https://ecampusontario.pressbooks.pub/indigenizationfrontlineworkers/>

and ways”⁷, centering Indigenous values (e.g. respect, trust, fairness), and aligning with previously-identified priorities and work, like improving health outcomes, strengthening relationships and advancing commitments.⁸

Together, these elements will ensure the curriculum meets stringent national accreditation requirements, achieves established program goals, prepares graduates to be leaders and transformative members of the health landscape, and supports the school in meeting its social accountability mandate.

- **Potential areas/sectors of employment for graduates or opportunities for further study:**

It is anticipated that the majority of MD program graduates will work as physicians, mainly in family medicine and primary care areas of medicine, following postgraduate (residency) education. There is an urgent need for family physicians as the province of BC faces a family and primary care physician shortage. Over one million individuals, or one in five people, do not have access to a family doctor in the province of BC. It is well established that existing primary care physicians are stretched thin, leading to inequities of care access and delivery, burnout and work force departure by choice.⁹ This workforce crisis is not unique to BC. Currently, we are facing a global workforce crisis of health human resources, creating an additional challenge in recruiting and retaining physicians across Canada and throughout the world. This has increased competition for medical degrees across Canada, highlighting the need for additional opportunities within our own province and ensuring that graduates will easily find employment within the province and country.

In addition to the completion of the MD program (also commonly referred to broadly as Undergraduate Medical Education, or UGME), a period of residency is required to become licensed to practice medicine in Canada. Most students who graduate from MD programs in Canada choose to enter postgraduate residency training (Post Graduate Medical Education or PGME) by matching into one of over 45 specialty areas (e.g., Family Medicine, Cardiology, Psychiatry, etc.). This match process is governed by and operationalized through the Canadian Residency Matching Service (CaRMS) along with the various PGME programs of

⁷ Fraser Salish. (2014). Regional Health and Wellness Plan. “Blending the best of two worlds in health: Modern Medicine and Ancestral Teaching and Ways”. <https://www.fnha.ca/Documents/FNHA-Fraser-Salish-Regional-Health-and-Wellness-Plan.pdf>

⁸ Fraser Partnership Accord between Fraser Salish Regional Caucus, Fraser Health Authority, First Nations Health Authority. (2020). <https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Topics/Aboriginal-Health/Cultural-safety/Signed-Partnership-Accord-2020---2023.pdf?rev=89b13c6becb04219a1c846c9ca7485e0>

⁹ BC Family Doctors. (2022). Ongoing medica coverage on BC’s Family Doctor Shortage. <https://bcfamilydocs.ca/ongoing-media-coverage-on-bcs-family-doctor-shortage-2/>

each Canadian university. Students must complete a minimum of two (2) years (Family Medicine) to six (6) years (other specialty and subspecialties) of residency, followed by rigorous certification assessments and licensure requirements before they can enter the workforce as licenced physicians.

Students choose their specialty of interest but are not always matched to their first PGME program choice. Data nationally, however, shows strong matching support for graduates entering Family Medicine (FM) – especially at the institution in which they completed their MD.¹⁰

We propose to capitalize upon this with a program tailored to encourage a high number of graduates choosing Family Medicine and doing their FM residencies within BC.

The small number of students who choose not to (eventually) enter a PGME program upon completion of the MD program will not be able to practice medicine in Canada but may find employment in related fields and/or may decide to pursue additional education (e.g. PhD).

- **Delivery methods:**

The program will be delivered primarily in-person at the SFU Surrey campus and in surrounding clinical and community settings. The mix of delivery locations and methods will evolve over the course of the program. To start, students will have the majority of their learning take place in-person in the classroom, though they will undertake in-person off-campus clinical experiential learning and community-immersive experiences from the program's beginning. As the program progresses, the amount of time spent in the classroom will gradually diminish and the time spent in clinical experiential learning will increase. Students will be expected to engage with content asynchronously during self-directed learning blocks.

- **Program strengths:**

The proposed MD program boasts many strengths. First and foremost, the program is being developed with a robust curriculum centred in the principles of generalism, to help deliver competent physicians who can meet the preventive and primary health care needs of people living in British Columbia. Students will undertake longitudinal experiential learning from the start of the program, helping to create an educational experience that is community-based, and that teaches them how to work in and value longitudinal, team-based primary care. The program also embeds Indigenous knowledge systems in learning, research, and

¹⁰ CaRMS. (2023). 2023 CaRMS Forum Data. <https://www.carms.ca/data-reports/r1-data-reports/>.

practices, giving students the ability to navigate issues of respect, relevance, reciprocity and responsibility, and ensuring they can meet the health needs of the diverse communities in BC.

- **Level of support and recognition:**

The SFUMS has engaged in considerable dialogue with other Canadian medical schools, medical education experts, proposed program partners, and many others as it has laid the foundations for establishing this program.

Engagement with the Dean, Vice-Deans, and Faculty members at the University of British Columbia – Faculty of Medicine has been ongoing and conducted in collaboration with the Ministries of Health and of Post-Secondary Education and Future Skills. A Memorandum of Understanding was signed by members of SFU and UBC Faculty of Medicine outlining the collaboration.

Additional visioning and planning support has been made available by Toronto Metropolitan University, Cumming School of Medicine at University of Calgary, Michael G. DeGroote School of Medicine at McMaster University, and the Northern Ontario School of Medicine.

The BC Ministries of Health and of Post-Secondary Education and Future Skills have been engaged in project design since the SFUMS planning process began. Both have supported the SFUMS and are active in supporting the MD program's development through participation in the project board. Strong support for the SFUMS has been evidenced through formal news releases about the project, including the November 28th, 2022, public announcement which occurred on SFU's Surrey campus with Premier David Eby,¹¹ the February 20th, 2024, Speech from the Throne,¹² and the February 22nd, 2024, BC Budget¹³. Additionally, since new healthcare degrees require review and approval by both Ministries, they will continue to be engaged throughout the degree granting approval process and through the early stages of program delivery.

- **Related programs:**

There are currently 17 accredited medical schools in Canada. Two new medical schools have been proposed for 2025 enrollment – Toronto Metropolitan University, and University of Prince Edward Island (affiliated with Memorial

¹¹ Government of BC, Office of the Premier. (November 28, 2022). New SFU Medical School Moves Forward to Train Family Doctors of Tomorrow. <https://news.gov.bc.ca/releases/2022PREM0067-001809>.

¹² Austin, Janet, Lieutenant Governor. (February 20, 2024). Speech from the Throne. <https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/42nd-parliament/5th-session/throne-speech>.

¹³ Conroy, Katrine, Minister of Finance. (February 22, 2024). Budget 2024 Speech. <https://www.bcbudget.gov.bc.ca/2024/speech.htm>

University of Newfoundland). Dalhousie University is also launching a new affiliated regional medical campus in 2025 at Cape Breton University. In recent weeks, Alberta announced a rural medicine-focused expansion of the University of Calgary Cumming School of Medicine out of the University of Lethbridge.

In Western Canada, other existing medical schools include:

- University of Alberta – Faculty of Medicine and Dentistry
- University of British Columbia – Faculty of Medicine
- University of Calgary – Cumming School of Medicine
- University of Saskatchewan – College of Medicine
- University of Manitoba – Max Rady College of Medicine

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2 Credential Recognition and Nomenclature

2.1 Post-secondary recognition:

The Doctor of Medicine (MD) is recognized in Canada and internationally as the credential one earns upon successful completion of medical school and is required to pursue further training in a residency program (PGME).

The proposed program name was revised from Undergraduate Medical Education (UGME) to Medical Doctor (MD) program between the Notice of Intent and this proposal based on feedback received. The actual program name does vary across this country, with the largest group of medical schools using either Medical Doctor Program or Doctor of Medicine Program as their program name (see breakdown in Appendix 8.4). A handful of others use Undergraduate Medical Education or a similar variation (e.g., Medical Doctor Undergraduate Program at UBC). It should be noted that even at schools that use the “MD program” name, the term “UGME” for describing programmatic operations and to distinguish from postgraduate medical education (PGME/residency) is still ubiquitous.

2.2 Industry/employer recognition:

The formal degree of Doctor of Medicine from a CACMS-accredited Canadian medical school is a requirement for the standard pathway of licensure from the Medical Council of Canada (MCC). SFU currently holds Applicant status with CACMS and is meeting monthly with the CACMS secretariat while working towards Preliminary Accreditation, a status that would allow the program to admit students.

Students who are near the completion of the program will write the national Medical Council of Canada Qualifying Examination (MCCQE Part 1).¹⁴ It is offered three or four times a year and is a summative assessment of medical knowledge and clinical decision making at a level expected of a medical student at graduation from medical school. Following this, graduate physicians are eligible for supervised practice in a residency program. In order to become a Licentiate of the Medical Council of Canada (LMCC), students must pass the MCCQE Part 1 and meet other LMCC eligibility criteria.¹⁵

Completion of an MD also is a requirement for entry into Postgraduate Medical Education, part of the standard pathway to certification and full licensure. A full breakdown of MCC requirements is detailed in Appendix 8.3.

3 Curriculum/Program Content

3.1 Program Structure:

The program structure is informed by several organizing principles, each of which contributes to the overall approach to program design and guides program content. These include:

- Continuity:
 - The curriculum allows growth in and demonstration of outcome competencies, professional identity and deeper learning of content through continuity of patient care (e.g., students have their own “patient panel”); this allows students to be “responsible” (with direct supervision, and under the responsibility of a family physician preceptor) for a small group of patients for the duration of the program;
 - Longitudinal relationships with a panel of patients will contribute to fostering a professional identity of as a comprehensive family physician

¹⁴ Medical Council of Canada. (2024). MCCQE Part I. <https://mcc.ca/examinations-assessments/mccqe-part-i/>

¹⁵ Medical Council of Canada. (2024). LMCC. <https://mcc.ca/credentials-and-services/pathways-to-licensure/lmcc/>

- and will expose students to the benefits of longitudinal relationships and continuity of care;
- The program prioritizes consistency of setting (e.g., continuity clinics and minimizing the number of clinics and hospitals through which students rotate);
- The program will focus on curriculum delivery by a core group of clinician educators who are well-supported by the program to deliver the curriculum as intended, with special guest educators as needed;
- Students will interact regularly within smaller cohorts of classmates. The case-based learning approach that forms an essential component of the program will take place in groups of ~8 students and clinical skills learning in groups of ~3-4 students.
- Generalism:
 - This term has been defined by the Royal College of General Practitioners as: ‘expertise in whole person medicine, which requires an approach to the delivery of health care that routinely applies a broad and holistic perspective to the patient’s problems;’¹⁶
 - The curriculum will expose students to important concepts in generalism and family medicine such as continuity, complexity, communication, health system function, and comprehensive care;
 - With Family Medicine and other generalist specialties as the focal point of the program, generalism will be a feature of most learning experiences (clinical, community, classroom, and simulated); however, the competencies (knowledge, skills and attitudes) that will be developed will serve as a foundation for application to any residency/specialization;
 - There is strong evidence that accessible and equitable health care is enhanced by a strong generalist workforce and one method to achieve this is to graduate physicians capable of, and interested in, practicing generalism;^{17,18}
 - Generalism is most associated with comprehensive family medicine (general practice).
- Integration:
 - All curricular content will be grounded in clinical relevance;

¹⁶ Royal College of General Practitioners UK. Medical Generalism: Why Expertise in Whole Person Medicine Matters. 2012; London, p.3.

¹⁷ Andermann A. Taking action on the social determinants of health in clinical practice: a framework for health professionals. *CMAJ*. 2016;188(17-18):E474-E83.

¹⁸ Starfield B. Primary care and equity in health: the importance to effectiveness and equity of responsiveness to peoples' needs. *Humanity & Society*. 2009;33(1-2):56-73

- Health care needs rarely present or are met within one discipline or area of foundational science. Traditional UGME curricula tend to be fragmented and have siloed discipline-based teaching¹⁹;
- The curriculum will focus on common presentations that often cross disciplinary boundaries rather than specific diseases or conditions (e.g., “chest pain” rather than “myocardial infarction” or heart attack);
- Learning will focus on clinical presentations and clinical relevance; this method increases student understanding of the connection between normal and abnormal structure and function (anatomy, physiology, pathophysiology etc.) and clinical manifestations;
- Integration supports development of clinical competence in the context of the needs of the whole patient within their broader environment.
- Flexibility:
 - A focus on flexibility will allow for personalized learning and increased student agency, supporting admission of a diverse cohort of students with a wide range of strengths and abilities;
 - The ways and time frames in which students achieve the program learning outcomes will be more flexible to support the diversity of learners;
 - Flexibility will be achieved through the policy framework, through scheduling, through regular meetings between students and coaches/mentors and in curricular opportunities such as electives.
- Spiral:
 - Program content and context will be deliberately revisited multiple times with increasing complexity (e.g., normal structure/function, abnormal structure/function, increasing acuity and/or chronicity, complexity/multimorbidity in preparation for clerkship);
 - A spiralled curricular teaching, learning and assessment approach will support integration of knowledge through repetition and reinforcement by allowing students to revisit essential concepts and contexts multiple times;
 - A spiralled approach accommodates diverse learners and pace of learning through the ability to revisit topics in different contexts and formats.
- Anti-Oppressive and Trauma-Informed:
 - Program content, processes and pedagogies will be created, monitored and reviewed to be free from harmful racist, sexist, and ableist ideologies;

¹⁹ Brauer DG & Ferguson KJ (2015) The integrated curriculum in medical education: AMEE Guide No. 96, Medical Teacher, 37:4, 312-322.

- Racist legacies in medicine and society that lead to inequities and barriers to care will be challenged and new ways of care for the decades ahead discussed;
 - Program content, processes and pedagogies will be trauma-informed;
 - This aligns with our program goal of producing graduates who are committed to inclusive, accessible and culturally safe patient care and allyship in the communities they serve.
- Inclusive of Diverse Perspectives, Including Those of People with Lived and Living Experience:
 - “Patients,” people and communities with lived experience will be included as active participants in curriculum and assessment;
 - Health care issues that are prominent in communities in British Columbia, and specifically in Fraser Health, will shape key topics of the curriculum.

Program Structure:

The MD Program includes 131 weeks of instructional time across three years.

The full curriculum consists of the following mandatory courses which map to the three academic years of the program (note: there are no optional or additional courses in the program) and include:

- MEDI 410 – Foundations of Medical Practice (58). “FMP” (Year 1, August to August; Summer Term, Fall Term, Spring Term, Summer Term)
- MEDI 420 – Extensions of Medical Practice (54) “EMP” (Year 2, September to August; Fall Term, Spring Term, Summer Term)
- MEDI 430 – Consolidation of Medical Practice (36). “CMP” (Year 3, September to May; Fall Term, Spring Term)

The three MEDI courses are intentionally designed as omnibus courses (rather than a series of concurrent smaller courses) to allow for effective and purposeful integration both vertically and horizontally through the curriculum. That is, the overarching objective of all instruction and learning is to scaffold and deliver learning for students to increasingly become competent in the practice of medicine. Integrated curricula have a range of benefits including increased motivation of learners, improved retention and understanding of key concepts, promotion of professional identity formation, and ease of transition to interdependent practice. Integration supports more authentic and meaningful learning; in other words, students will learn the content in ways that it will be authentically used in practice.¹²

There is a strong and effective precedent for the use of omnibus courses at SFU. In the Faculty of Education's teacher education program (which is also a post-degree program with students who have already demonstrated academic success and competence in their undergraduate degree), the first course, EDUC 400, is a 15-credit course that spans the full first semester. Students have a variety of experiences within this course: some with the whole cohort (400+ students), some that are in Professional Learning Communities (PLCs) of 32 students, some that are in small groups, some that are self-directed, and some that are contained in 3 blocks of experiential learning in community settings. There is considerable flexibility and variability in how students progress through the term, but the focus is on developing core professional competencies (knowledge, skills and attitudes) of professional practice. In the second semester of the program, students take two omnibus courses (EDUC 401: Introduction to Classroom Teaching and EDUC 402: Studies of Educational Theory and Practice), which are delivered in an integrated manner (they must be taken concurrently) but separated to more easily document weeks of practicum experience required for certification. Students take a third omnibus course, EDUC 405, also covering a full semester, to complete their program.

Unlike “traditional” models of medical student education where students engage in didactic classroom-based learning for the first half of their curriculum and then transition to full immersion in clinical experiential learning for the second half, the MD program structure integrates knowledge acquisition, skill building and application to clinical care throughout. This design of MD curriculum promotes holistic, authentic, integrated, spiraled and longitudinal learning in a way that more closely reflects and aligns with the continuous learning and practice quality improvement in which practicing health care professionals engage throughout their careers. As such, there is a progression from small to large amounts of clinical learning and a similar reduction in the scaffolding provided by structured classroom-based learning throughout the curriculum.

Competency-based medical education literature acknowledges the risks of siloed learning by students within a framework of small courses. There is increasing consensus that for professional growth toward a successful medical career, year-long courses more effectively support longitudinal development of authentic whole-task abilities towards the program's milestones and competencies. The competencies required for medical practice, such as clinical reasoning, communication, advocacy, team leadership, anti-racism, systems of health care and patient management are complex, and it requires time to integrate clinical knowledge, skills and attitudes into models of care. The programmatic assessment approach also follows the principle of competency-based education and aligns with the new paradigm being adopted in Canadian and American schools of medicine. This approach means students must

demonstrate satisfactory progress in achieving the described program competency milestones through a variety of assessment modalities by the end of each course to be eligible for progression to the next course. These milestones map to the key program competencies for graduation. Therefore, curriculum and assessment focus on authentic partial or whole tasks that students perform in a real or simulated environment to support individual learning trajectories.^{13,14,15,16}

The competency-based, longitudinal and vertically integrated structure also means there is no WQB requirement built into the completion of this program. Although the MD Program is an undergraduate program, it does not lead to a bachelor's degree, and the MD is distinct enough to sit alongside other WQB-exempt undergraduate credentials such as diplomas and certificates.

3.2 Core Courses:

Required courses for the MD Program consist of three new multi-term MEDI courses offered within the SFUMS. These include:

MEDI 410 – Foundations of Medical Practice (58)

An introduction to foundational concepts/approaches to medical practice with focus on foundational medical knowledge and simulated clinical learning. Most learning takes place in classrooms, simulated clinical spaces and labs. Students will participate (under direct supervision) in patient care in a longitudinal Family Medicine clinic experience weekly and will engage in two blocks of intensive, immersive learning.

MEDI 420 – Extensions of Medical Practice (54)

An application of foundational concepts via experiential clinical learning undertaken across a variety of healthcare settings. Applied learning will be supported by continued small-group classrooms, labs, and simulated clinical care encounters. Weekly participation in the longitudinal clinic will also continue. Students will have the opportunity to undertake multiple elective experiences. Prerequisite: MEDI 410.

MEDI 430 – Consolidation of Medical Practice (36)

A capstone course where students will consolidate foundational concepts and applied learning via increasingly complex patient presentations. Learning will highlight advanced aspects of patient care, systems, and the challenges of care across all levels. MEDI 430 takes place mostly in clinical care supervised locations. Students will choose elective areas to enhance their grounding for the next stage of their career. Prerequisite: MEDI 420.

3.3 Existing and New Courses:

New required courses consist of: MEDI 410, MEDI 420, MEDI 430.

There are no existing required or elective courses for this program.

3.4 Curriculum and Program Goals:

Program Goals:

The educational goals of the program include:

- Biomedical Knowledge:
 - to provide a comprehensive understanding of the biomedical sciences and other relevant disciplines as a foundation for clinical medicine.
- Social Sciences Knowledge:
 - to provide an understanding of human relationships and behaviours, social processes and culture, root causes of health inequities, population health, complex modes of action like teamwork and the interplay between biological processes and social context as a foundation for clinical medicine.²⁰
- Clinical Competence:
 - to develop clinical competencies (knowledge, skills and attitudes) necessary for assessing, diagnosing, communicating and treating; and working with other health and community professionals to manage medical conditions.
- Professional Identity Formation, and Professionalism:
 - to foster a strong professional identity in support of future physicians who are empathetic, ethical and professional and who take a patient-centered, culturally humble approach to caring for patients and their families.
- Interdisciplinary Collaboration:
 - to promote via effective communication, collaboration and advocacy, a model of teamwork among all healthcare professionals in support of

²⁰ Behavioral and Social Science Expert Panel. Behavioral and Social Science Foundations for Future Physicians. 2011 Washington, DC Association of American Medical Colleges; <https://www.aamc.org/download/271020/data/behavioralandsocialsciencefoundationsforfuturephysicians.pdf>.

integrated, longitudinal, responsive and coordinated patient and community-centred care.

- Primary and Generalist Clinical Practice:
 - to ensure that graduates have the ability to meet the prevention and primary care needs of communities within the Fraser Health region and beyond.
- Health of Indigenous Peoples:
 - to understand the unique health approaches and needs of Indigenous communities in BC and support integrated and wholistic health practices to address those needs, through self and team learning, reflection, and experiential involvement with Indigenous peoples.
- Community Engagement and Advocacy:
 - to instill a sense of social responsibility to determinants of health, public health, community service and advocacy for diverse populations in Fraser Health and BC by and supporting inclusive, accessible and culturally safe care and allyship.
- Increased numbers of physicians who represent Indigenous and under-represented communities:
 - to recruit, admit, support, and educate physicians that reflect the diversity of the population of BC, and to increase the number of Indigenous physicians for BC.
- Community-Based Learning:
 - to immerse learners in clinical and community environments from an early stage and throughout the program; to provide opportunities to learn with and from a variety of clinicians, medical professionals and professionals in training, including other cohort members, more junior or senior medical students, residents, community members, Indigenous Elders and knowledge keepers, affiliated community health organizations and patients.

To achieve the educational goals, the program will be competency-based. Program competencies include the knowledge, skills and attitudes required for and associated with the ability required to proceed to the next stage of learning (residency) and eventually to professional practice. The focus of the program will be on purposeful learning and programmatic assessment, scaffolding progressive and systemic development of a set of competencies with well-articulated milestones, all clearly

described within a detailed set of core learning outcomes. While the program is time-limited, there will be opportunities for unique learning plans to support students with individual needs that arise over the three years of study.

The CanMEDS (Canadian Medical Education Directives for Specialists) competency framework²¹ describes the core abilities required of practicing physicians to meet the health care needs of the people they serve. The framework describes seven physician roles: Medical Expert, Communicator, Collaborator, Health Advocate, Leader, Scholar and Professional. CanMEDS has been adapted for family medicine (CanMEDS-FM) as well as for MD Programs centred in Family Medicine: CanMEDS-Family Medicine Undergraduate 2019 ([CanMEDS-FMU 2019](#)). Given its relevance to an MD program focused on generalism, CanMEDS-FMU serves as a useful starting point for a competency framework for the MD program.²² The program is also committed to ensuring alignment with the CanMEDS-Family Medicine Indigenous Health Supplement²³. In this way, the MD Program is structured to support longitudinal development of the competencies required to begin medical residency education and licensure in Family Medicine, or any other medical career specialty.

An expanded description of these competencies adapted from Weston, Hubinette & Horrey (2019) is as follows:

- Medical Expert:
 - SFUMS MD graduates, as skilled generalists, will be able to provide high quality, responsive, community-adaptive care across the life cycle, from prevention to palliation, in multiple settings, and for diverse populations (with appropriate supervision). Students will draw knowledge from best practice and evidence and make recommendations on diagnosis, treatment and prevention to apply to the values and needs of patients. They value continuity of care with their patients and collaboration with other health care providers to optimize outcomes. They use compassionate, patient-centred care when assessing and managing patient concerns, forming relationships with patients, families, other health care

²¹ Royal College of Physicians and Surgeons of Canada. 2024. CanMEDS: Better standards, better physicians, better care. <https://www.royalcollege.ca/en/canmeds/canmeds-framework.html>

²² Weston W, Hubinette M, Horrey K, eds. CanMEDS-FMU 2019: Undergraduate competencies from a family medicine perspective. Mississauga, ON: The College of Family Physicians of Canada; 2019.

²³ Kitty D, Funnell S, eds. CanMEDS-FM Indigenous Health Supplement. Mississauga, ON: The College of Family Physicians of Canada; 2020.

professionals, and communities. They advocate for improvements to living conditions, resources, access and care.

- Communicator:
 - SFUMS MD graduates will foster therapeutic relationships with patients, their families and communities. This involves the dynamic exchanges that occur before, during and after the medical encounter that facilitate gathering and sharing essential information for effective patient-centred health care. As Communicators, MD graduates will demonstrate shared decision-making that is culturally sensitive and find common ground in addressing the health care needs and goals of the patient.
- Collaborator:
 - SFUMS MD graduates will work with patients, health care teams, other health professionals, and communities to deliver safe, quality evidence based, inclusive, and culturally sensitive patient care.
- Leader:
 - SFUMS MD graduates will use their leadership and management skills as integral participants in health care and community organizations. They actively contribute to visioning, implementing and maintaining a high-quality health care system with other health professionals and communities. They do so by leading within teams to deliver excellent patient care through their activities as clinicians, scholars and teachers.
- Health Advocate:
 - SFUMS MD graduates will contribute to mobilizing resources and working with patients, families and communities to obtain, improve and deliver accessible and inclusive services for the communities we serve.
- Scholar:
 - SFUMS MD graduates will demonstrate, in all areas of medicine and care, a lifelong commitment to excellence in practice through continuous active learning and teaching others; gathering, combining and evaluating validity and applicability of evidence; and contributing to creating, translating and disseminating new and re-validated existing knowledge.

- Professional:
 - SFUMS MD graduates are committed to the health and well-being of patients, families, communities, society, colleagues and selves. They will demonstrate this through actions that show competent medical practice, accountability, respect, humility, sensitivity and ethical behaviour, mitigating power dynamics with patients, the profession, their colleagues, and society.

The program's overall organizing framework will be guided by the program goals and AFMC competencies with the twelve [Association of Faculties of Medicine of Canada Entrustable Professional Activities](#) (EPAs) being used to demonstrate the key tasks a medical graduate must perform to transition into residency education.²⁴ As an evolving education standard, most Canadian (and an increasing number of American) medical schools are adopting EPAs as an approach to transition from high level programmatic goals into a framework for assessment and application of competencies into work-based learning. Our program will be at the leading edge of a small group of medical schools who use EPAs as curriculum and assessment strategies across all courses in the MD Program.

Together, the program goals, CanMEDS competencies and AFMC EPAs create a program structure to support student learning and successfully transition to post-graduate medical education.²⁵

Program Curriculum:

Curriculum will be developed integrating the program's principles, goals and accreditation competencies. The curriculum development will also be guided by the Committee on Accreditation of Canadian Medical Schools' curriculum requirements²⁶ as well as the Medical Council of Canada's (MCC) set of examination objectives.²⁷ Given this, the following areas which are all supportive of

²⁴ Touchie, C., 2021. *AFMC Entrustable Professional Activities for the Transition from Medical School to Residency*, The Association of Faculties of Medicine of Canada. https://www.afmc.ca/wp-content/uploads/2022/10/AFMC_Entrustable-Professional-Activities_EN_Final.pdf

²⁵ As an example, by the end of the program, learners will be able to:

- Perform clinical assessments using clinical reasoning and an understanding of patient context to arrive at a working diagnosis (under supervision) (Medical Expert) (EPA 1-3)
- Co-develop a management plan tailored to the patient's goals of care, values, and context. (Medical Expert) (EPA 5)
- Initiate assessment and management of a patient who requires emergent care, seeking help as appropriate (Medical Expert) (EPA 8)

²⁶ Data Collection Instrument (DCI). The Committee on Accreditation of Canadian Medical Schools. <https://cacms-cafmc.ca/for-schools-with-visits-in-2024-2025/#1670356791621-fde44243-a277>

²⁷ *MCC Examination Objectives*. Medical Council of Canada. <https://mcc.ca/objectives/>

comprehensive clinical care will be represented in the curriculum; all topics will be explored in the context of, and as directly relevant to, clinical medicine, health and wellbeing:

- Medical foundational sciences, organ systems, and social sciences including biomedical, behavioural and social aspects of health;
- All phases of the life cycle and continuity of care;
- Prevention, rehabilitation, palliation, acute and chronic care;
- Clinical judgement, critical thinking, decision making, problem solving;
- Health systems, interprofessional care, structural competency;
- The socio-ecology of health, including population health, determinants of health, planetary health;
- Broader societal impacts on health: (e.g., climate change, toxic drug supply, lack of affordable housing, etc.);
- Scholarship, quality improvement, research, evidence-informed medicine, Technology/AI; Scientific method, research;
- Personal and professional aspects of medical care, ethical/legal aspects of medicine, professionalism, professional identity formation/ “physicianship”, teamwork, leadership;
- Cultural humility, cultural safety, Indigenous ways of knowing and caring, EDI and anti-oppression.

The content above will form the basis of the small group case-based learning approach. Content and context will intentionally increase in complexity, and spiral throughout the curriculum. This will be planned and co-developed by a group of curriculum developers that includes patients and community members, education experts and clinicians – most importantly, generalists and other health care professionals.

This approach supports progressive achievement toward clinical competence through the intentional and deliberate sequencing of active learning opportunities, processes and assessment.

Toward the end of the program, all students write the Medical Council of Canada Qualifying Examination (MCCQE) which tests their clinical reasoning and management skills. Note that this is a national requirement of licensure and not a process of progression in the MD Program. However, the program and students will

be informed by the rich data feedback on student achievement from the MCC after each examination cycle, which will be used in programmatic evaluation and for continuous quality improvement.

Learning Methodologies and the Learning Environment:

The learning environment will consist of a variety of classroom, laboratory and clinical settings. Students will learn from a variety of teachers, many of whom will be family physicians and other generalists, as well as designated specialists and health care professionals. Longitudinal relationships will be fostered with clinical faculty members to support their growth and development as teachers, and to further reinforce a positive learning environment.

Developing the student as a successful professional and person is equally important to the MD Program. Students will bring reflections of their clinical experience back to the classroom for sessions on the challenges facing health professionals such as burnout, wellness, imposter syndrome, leading within teams, understanding and addressing bias and racism, and career and financial success.

Specifically, the learning environment will expose students to the following teaching and learning methodologies:

- Small Group Case-based Simulated Learning:
 - The core methodology of classroom-based simulated learning is facilitated case-based learning centred around common and/or important clinical presentations. This clinical presentation list is derived from the MCC objectives, the College of Family Physicians of Canada Priority Topics²⁸ as well as published literature that describes the most commonly encountered conditions in family medicine and primary care. Woven into these cases will be thematic content that reflects authentic patient and population contexts and concepts.
- Simulated Clinical Learning:
 - Students will have the opportunity to learn communication skills, clinical skills and patient management skills in simulated clinical settings with volunteer patients. ‘standardized’ patients, and simulated patients. Students will be supported in descriptions,

²⁸ Crichton T, Schultz K, Lawrence K, Donoff M, Laughlin T, Brailovsky C, Bethune C, van der Goes T, Dhillon K, Péliissier-Simard L, Ross S, Hawrylyshyn S, Potter M. Assessment Objectives for Certification in Family Medicine. Mississauga, ON: College of Family Physicians of Canada; 2020

demonstrations, role rehearsals and coaching, and providing feedback to their peers.

- Laboratory Learning:
 - Students will learn key practical anatomy in lab groups.
- Large Group Learning:
 - Students will occasionally learn in classroom-based large group settings. These will not be structured as passive ‘lectures’ but instead as active learning in the form of dialogue, debate, panel discussions, team-based learning and other modalities.
- Elective and Selective Learning:
 - Students are given designated time for student-selected exploration of patient and health care across a variety of locations. We envision most of these being with our clinical affiliates, however some will be in community settings for service and leadership, and others may choose research opportunities.
- Asynchronous Learning:
 - Students will supplement and augment class learning and clinical learning by reviewing provided or recommended asynchronous learning materials (e.g. podcasts, short virtual presentations). They will be expected to prepare for in-class and clinical learning by researching, reviewing and reporting on relevant literature from a variety of sources.
- Experiential Community-based Learning:
 - Students will spend time in various extra-clinical community-based settings learning via provision of service (i.e., ‘service learning’), engagement with projects and community initiatives and through guided observations.
- Clinical Patient Care Activities:
 - Students will spend increasing amounts of time participating in the care of patients, families and communities across a variety of settings. At this stage of their training, students will do this under the direct supervision of a variety of health care professionals including SFUMS-affiliated family physicians, specialists, nurses, physiotherapists, occupational therapists, dieticians, skilled

technicians, etc. Learners will get hands-on experience participating in the provision care to their ‘own’ panel of patients.

Programmatic Assessment:

To assess the development of milestones and competencies, the programmatic assessment approach will employ a variety of educational assessments including:

- Written exams (e.g. multiple-choice questions, short answer questions) and assignments to monitor growth in foundation knowledge and clinical reasoning;
- Workplace-based assessments to monitor growth in specific clinical skills, as well as communication, teamwork and professionalism;
- Standardized clinical assessment (e.g. objective structured clinical examinations, simulated procedural skills, etc.);
- Portfolio (informed self-assessments, reflections, learning plans).

Because each assessment method maps to one or more competency, the program will be able to monitor knowledge and skills development as students progress across the program. Students must meet criteria for each assessment by the end of each course to progress to the next. Each individual assessment tool will be purposefully selected to provide meaningful feedback to the student and the program about their development and progression towards yearly milestones and graduation. Student learning will be monitored by portfolio coaches and assessment of progression will be made by a progression committee at 4 specified time points (exact times TBD) within each year. The programmatic assessment plan is designed to engage students and promote learning with monthly feedback. Students, portfolio coaches, and select MD Program leadership will have access to student dashboards (e-portfolios) to ensure students are progressing, and to identify opportunities for targeted skills development (course correction). Portfolio coaches will be key in the program’s support to students as they develop skills in informed self-assessment, reflection, and learning plan development. Students not following the expected trajectory will be identified early and offered enhanced learning support (additional academic and personal assessments, support for health challenges or other personal issues arising that impact learning, remediation and coaching, mentorship, etc).

With the MD Program’s commitment to ongoing quality improvement, there will be development and implementation of a robust program evaluation framework. The program evaluation process (separate from the student assessment process) will have its own governance committee, lead, unique tools and standards and communication. Evaluation will be used to continually improve and follow the processes in many post-secondary education institutions – drawing from the leads in industry and health

care delivery. Through this, the MD Program will ensure the ongoing refinement of how the curriculum delivers learning, supports reaching the program's educational goals, and ensures the voices of faculty, students, leaders, community, patients and our affiliates are heard, valued and drive advancement to meeting our vision, goals and quality education experiences.

3.5 Work experience/field/practicum placement:

All MD programs in Canada and internationally have a minimum of one year of learning in a clinical care environment (often termed “Clerkship” and “Elective” learning) alongside other health professionals and under the direct supervision of clinical faculty. This learning typically takes place in the second half of the program (i.e., starting in year 3 in a four-year program, or the 18-month mark in a three-year model) and the final year of program studies. Some schools in the USA have moved this into the start of the second year of a 4-year program. Many programs in Canada and the USA have also incorporated early clinical learning into their curricula in an effort to be more integrated. It is novel to have a longitudinal clinical ‘continuity clinic’ experience where students have their ‘own’ (directly supervised) patient panel in MD programs; however, this is a feature of most family medicine PGME (residency) programs in Canada.

While this is not a typical “work experience” or “practicum”, it is a total immersive learning experience across a variety of clinical care domains that offer direct patient care and allows the student to translate their core knowledge, skills and abilities into the delivery of care for patients and families. Again, this experience only takes place under direct supervision as medical students, under their educational licenses, lack status as registered health professionals and cannot practice medicine without supervision.

The goal of this experiential learning is to allow students to achieve an understanding of the core domains of clinical care (e.g., care of children, maternity care, etc.) and to have exposure to a variety of medical and surgical specialties as well as interprofessional team-based care. The student is also expected to partake in the assessment and care (acute or ongoing) of specific patient conditions as listed by the MD Program. These core patient care scenarios are aligned with national licensure requirements and allow students to understand the core care conditions that often cross disciplines of medicine and are representative of those seen frequently by generalists and family physicians in Canada.

Much of the clinical learning will take place in community- and hospital-based settings alongside family physicians and other specialist physicians, as well as other health care professionals from a variety of professions. All clinical care learning is scheduled by the program in consultation with clinical learning sites. Following

these experiences most students will have achieved the level of clinical skill required by the MD Program to graduate.

As with all other aspects of the program, assessment for clinical experiences is competency based. Student progress, in terms of their overall learning, the type/number of patient encounters, and the type/number of required skills demonstrated, is tracked longitudinally. Assessment tracking dashboards allow the program to be alerted to both individual student and cohort gaps early.

4 Program Resources

4.1 Target audience and enrollment plan:

The enrollment plan and entrance requirements have been designed and aligned to support the program goals. The program will primarily target students with the scholarly aptitude to handle the demands of the program and ultimately become competent clinicians. However, to ensure a diversity of applicants, there will be flexibility in how aspirants can demonstrate their scholarly aptitude and a specific stream for Indigenous applicants will be created. Finally, subsequent stages in the admissions process (still under development) will select for aspirants who have connections to communities within BC and who have the desire and aptitude to become family physicians and other generalist specialists skilled in providing and participating in team-based, comprehensive, longitudinal care responsive to the health and wellness needs of Fraser Health and BC's diverse communities.

Geographically, the primary target audience for this program is students who reside within BC who wish to pursue a career in medicine locally (within the Fraser region and/or within BC), particularly those planning to pursue residencies in Family Medicine and other generalist specialties. Furthermore, the approach to MD Program admissions will be designed to attract students who will embody the school's values and who will reflect the populations they will serve. As detailed in the tables in Appendix 8.3, demand for seats from qualified applicants is high.

Programs are enriched by having students from diverse backgrounds and regions. While the primary focus of the target population will be on serving the needs of British Columbia, the program will also admit students from across Canada, particularly those interested in Family Medicine and generalist specialties.

Initially, it is anticipated the program will start with 48 students and increase to 64 in the second year.

	2026/2027	2027/2028	2028/2029
Year 1 Students	48	64	64

Year 2 Students	-	48	64
Year 3 Students	-	-	48
Totals	48	112	176

It is further anticipated that the cohort size will increase to a steady state intake of 120 learners in 2036. These future cohort sizes/timings will be developed in collaboration with the Ministries of Health and Post-Secondary Education and Future Skills. MD Program enrollments will be included in the annual enrollment targets that go to Senate via the Senate Committee on Enrollment Management and Planning (SCEMP).

4.2 Resources:

The MD Program is new and will require net new resources for the SFUMS (faculty, staff, learning and student support resources, specialized spaces and equipment etc.) and, when/where there is downstream impact, for SFU departments (library resources, advancement etc.).

SFU worked closely with the Provincial Government and representatives of the Ministries of Health and of Post-Secondary Education and Future Skills ('the Ministries') to develop the vision and proposed scope of the Medical School. These were then formally communicated through submission of a business case to the Province. Following the initial submission of the business case in May 2023, the SFUMS engaged in 4 months of validation and review cycles to ensure that the financial ask was aligned with the expectations of the SFU executive team, the Ministries and the Treasury Board. These review cycles concluded in September 2023 and all feedback gathered from the negotiations with government partners was applied to the financial assumptions and final submission. The SFU President and Provost, the Acting Dean of the SFU Medical School, and several other senior leaders of SFU have been meeting individually with members of the Provincial Government and the Ministries. From these, there has been a strong commitment to fully support the SFUMS, including a commitment to access contingencies as required. The SFUMS has maintained communication with funders, including providing quarterly reports and justifiable financial forecasts on operating expenses. This ongoing dialogue has ensured that the SFUMS has and will continue to access the funding required to cover all operating costs. The accountability structure established by this ongoing communication has also offset the risks of operational spending exceeding future budget allocations. In collaboration with SFU's central finance department, the SFUMS will continue to contain all expenses and revenues. Current and future funding allocated by the Provincial Government and the Ministry

of Post-Secondary and Future Skills for the SFUMS will be earmarked to ensure it is spent accordingly. Any additional funding required by the SFUMS, due to unforeseen expenses, will be requested from the Province before the expenses are incurred.

5 Program Review and Academic/Administrative Oversight

All MD programs in Canada are accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS), and established schools therefore must establish and maintain robust structures for program evaluation and continuous quality improvement. For new medical schools, this process is even more exhaustive, as they must receive preliminary accreditation from CACMS before the first students are even admitted.

The SFUMS anticipates achieving preliminary accreditation in Fall 2025 after submitting a self-study in Fall 2024 and undergoing a CACMS site visit in Spring/Summer 2025. These initial steps will ensure the SFUMS, in the eyes of its peers, meets the stringent national requirements, and is of sufficient quality to allow the program to begin operations. A subsequent review will happen after the first cohort has started classes (2026-2027) to ensure the school is fulfilling its obligations and incorporating the new students' feedback into the reporting. If successful, the school will move from preliminary to provisional status. Full accreditation status will be achieved following another self-study and site visit during the first cohort's final year of studies (2029). The first time that full accreditation is granted, it is for a five-year period (through 2034); thereafter, programs are accredited for 8 years (to 2042). In accordance with section 6 of SFU's Senate Guidelines for External Reviews of Academic Units, the SFUMS intends to work with the appropriate internal oversight bodies to allow for the alignment of accreditation process timelines with SFU's normal 7-year external review schedule.

In addition to these longer-term cyclical reviews that the CACMS has established, medical schools must engage in and be able to demonstrate continuous programmatic evaluation and quality improvement. As such, the SFUMS is developing a robust program evaluation framework to allow it to engage in regular and ongoing evaluation and education research. This will allow the school to continuously iterate and improve its offerings.

The program evaluation framework will incorporate the key principles of the medical school's stated mandate. Co-production of the evaluation framework will include membership from academic and administrative contributors as well as partners from

the wider community, health equity-seeking groups, and clinical and health system partners.

Methods, data collection, timelines, and reporting will reflect the most contemporary approach to educational evaluation. The evaluation framework will be structured to allow for regular reporting to students, faculty, administration, community, and policy partners. Evaluation metrics will be tied to the outputs, outcomes, and impacts of a socially accountable organization. They will include results related to individuals' actions (e.g., learning milestones), systems (e.g., curriculum effectiveness) and the school as a whole (e.g., effects on community health).

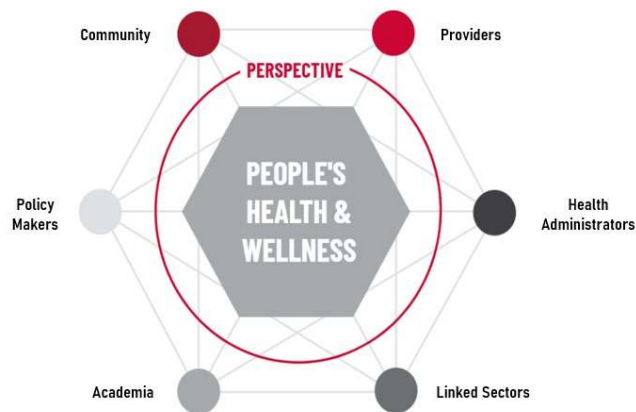
Careful consideration of Indigenous ways of knowing, reconciliation and inclusion will be made to ensure the evaluation framework supports the creation of an inclusive learning environment that acknowledges and addresses historical injustices and disparities, fostering a more equitable health care system that benefits everyone. Evaluation strategies and processes will have dedicated leadership, resources and system structures to allow for the proposed comprehensive evaluation activities.

6 Program Consultation

The SFUMS, mandated by the government to train physicians to serve in primary care contexts, has approached program consultation using the Partnership Pentagonam Plus framework. This framework was originally outlined by Charles Boelen for the World Health Organization in 2000 and is now widely accepted among Canadian medical schools and serves as the cornerstone for socially accountable health education²⁹. Through ongoing engagement with the communities outlined in the six (6) pillars, SFUMS is well positioned to enhance healthcare quality and access in the Fraser region while also continuing to learn from and adapt to evolving needs.

The timelines of all engagements that have taken place since 2022 are provided in *Appendix 8.4 figure 1*. The nature of the engagements with each of the groups outlined in the partnerships pentagram plus is further described in the text below.

²⁹ [partnership_pentagram_plus.pdf\(utoronto.ca\)](https://utoronto.ca/partnership_pentagram_plus.pdf)

Figure 1: Partnership Pentagonam Plus Framework**Community: SFU & Fraser Valley Communities**

In the fall of 2021, SFU began engagement with the internal SFU community for the proposed SFUMS. In a themed summary report, SFU's Morris J. Wosk Centre for Dialogue captured the views and ideas from SFU students, faculty and staff during an online information session hosted in October 2021. Building on the feedback received in 2021, the Centre for Dialogue was reengaged to organize an additional series of information sessions and engagements hosted in March and April 2023 to gather further feedback. From these sessions, a second report focused on integrations with the Surrey community, research, and Indigenous values and ways of knowing was produced (*What we Heard Report Summary attached in Appendix 8.4*).

The SFU internal community has engaged in the process of developing the formal business case which was submitted to government in May 2023 and revised and resubmitted in August 2023. Working groups, which included invited members from across all SFU faculties, gathered to articulate the vision for the SFUMS from December 2022 to May 2023.

The SFUMS has also sought to build on the Surrey Campus' strong existing relationship with the surrounding community to gather feedback about the medical school. This has included conversations with the City of Surrey and community organizations such as the Surrey Urban Indigenous Leadership Council (SUILC). The SFUMS has also actively been planning community engagement sessions which will be hosted in Surrey, Hope, and Abbotsford in March and April 2024. Leadership also plans to invite specific feedback on elements of the medical school planning. For example, the admissions committee recently hosted a focus group in Feb 2024 (*Admission Focus Group Summary attached in Appendix 8.4*).

Providers: Physicians and Professional Associations

To engage individual physicians and gather feedback, two workshops have been hosted. In December 2022, SFU and Fraser Health Authority hosted a physician visioning session for doctors from the Fraser community. In June 2023, following the submission of the business case, SFU leaders hosted a ‘Case-Writing’ Workshop that brought together physicians and SFU Health Sciences faculty members interested in helping to shape the case-based curriculum to the local BC context.

The SFUMS has also sought to build partnerships and gather feedback from physician organizations. SFUMS Acting Dean, Dr. David Price, and Acting Associate Deans, Dr. Maria Hubinette and Dr. Evan Adams, have ongoing professional relationships with the physician community and are leading these efforts. In November and December 2023, Dr. Price met with Doctors of BC and Resident Doctors of BC and has since continued discussions about physician participation as clinical faculty. SFUMS leadership have also met with several regional Divisions of Family Practice (Surrey, North Delta, Ridge Meadows, White Rock, and Burnaby) to discuss student placements in local clinics not affiliated with health authorities and Dr. Adams has led these discussions with First Nations Health Authority clinics. In June 2023, SFUMS leaders also met with the Rural Coordination Centre for BC (RCCBC) and have continued discussions about placing future medical students in rural settings, as this is an accreditation requirement. Letters of support from Doctors of BC, RCCBC, and several Divisions of Family Practice were attached to SFU’s business case to government.

Policymakers: Government Bodies, Ministry of Post-secondary and Future Skills, and Ministry of Health

Discussions with the provincial government about a potential medical school at SFU date back over 10 years. Strong support for the proposed SFUMS has been evidenced through formal news releases about the project, including the November 28th, 2022, public announcement which occurred on SFU’s Surrey campus with Premier David Eby. The SFU Medical School has also been deeply committed to building trusting relations with First Nations and Métis leaders. This is especially important considering the findings of the *In Plain Sight Report*³⁰ which identified Indigenous-specific racism in BC’s health system.

The BC Ministry of Health and the Ministry of Post-Secondary Education and Future Skills have been actively engaged in the vision of the medical school since

³⁰ [In-Plain-Sight-Summary-Report.pdf \(gov.bc.ca\)](https://www2.gov.bc.ca/gov/content/skilledtrades/education/in-plain-sight-summary-report.pdf)

the school's inception through participation in the Champions Table and Project Steering Committee. Both Ministries have also actively supported the development of the business case submitted in May 2023 and the adjustments that were made in August 2023. New degrees related to healthcare such as Doctor of Medicine (MD) require review and approval by both the Ministry of Health and the Ministry of Post-Secondary Education and Future Skills. Both Ministries will continue to meet with SFU on a bi-weekly basis as the program goes through the process of receiving degree-granting authority and through the initial stages of program delivery.

Health Administrators: Fraser Health Authority and First Nations Health Authorities

The government mandated that the SFUMS partner with Fraser Health Authority (FHA) and First Nations Health Authority (FNHA) as the first health authority partners. Like the provincial government, both health authorities have been engaged since the initial visioning stage. In addition to ongoing discussion, two joint visioning sessions have been hosted with Fraser Health Authority in March 2023 and November 2023.

As the SFUMS looks towards accreditation, senior leadership will continue to meet with the leaders of these organizations. This will support efforts towards affiliation agreements that will allow SFUMS students to learn in their clinical settings. We received letters of support from both organizations (*Appendix 8.4*).

Academia: Collaboration with SFU Faculties, Other Medical Schools, and Other BC Institutions

In developing the operational plan for the SFUMS and the MD program, the SFU team has sought to learn from institutions that are leading innovations in medical education including Toronto Metropolitan University, Cumming School of Medicine at University of Calgary, Michael G. DeGroote School of Medicine at McMaster University, and the Northern Ontario School of Medicine. In addition to ongoing discussions with these schools, members of the SFUMS leadership team have also had site visits to the University of Calgary (May 2023) and McMaster University (Jan 2024).

Engagement with the Dean, Vice-Deans, and Faculty members at University of British Columbia – Faculty of Medicine is ongoing. A Memorandum of Understanding was signed by SFU and UBC's Faculty of Medicine outlining the collaboration and how students will collaborate in clinical settings. A letter of support from UBC for the MD program is attached (*Appendix 8.4*).

In addition to close partnership with UBC, the SFUMS has also engaged in discussions with British Columbia Institute of Technology (BCIT), Kwantlen Polytechnical University (KPU), Thompson Rivers University (TRU), University of the Fraser Valley (UFV), and Douglas College. For example, discussions with BCIT have explored the possibility of using the BCIT simulation labs to support immersive learning. Letters of support from BCIT, Douglas College, and KPU are attached (*Appendix 8.4*). We will seek further collaborations with institutions that offer health training programs to support nursing, midwifery, physical therapy, occupational therapy, speech language pathology, and dietetics in the progress of developing the MD program's team-based care curriculum.

Linked Sectors & Non-Profits: Industry Leaders & Organizations

In March 2023, the SFUMS also conducted a survey of community organizations regarding barriers to accessing healthcare in BC (*Survey summary attached in Appendix 8.4*). This provided additional insights used by the Curriculum Committee in designing a culturally sensitive curriculum.

In efforts to build collaborative partnerships and begin capacity-building to support the medical school program, the SFUMS team has initiated meetings with community, non-profit and for-profit organizations. Preliminary exploration meetings have occurred with several hospital and health-related foundations to determine non-operational funding opportunities to support advancement of medical education, particularly in the areas of student clinical education and training. These include Surrey Hospital Foundation, Royal Columbian Hospital Foundation, Peace Arch Hospital Foundation, Heart & Stroke Foundation, Fraser Valley Health Care Foundation and Diamond Foundation. In addition to these Fraser hospitals, St. Paul's Hospital Foundation has come forth expressing interest to explore funding support in areas of clinical training and clinical research opportunities.

In terms of building community partnerships, exploratory meetings with non-profit organizations are ongoing including BC Health Communities, Health Data Coalition of BC, BC Health Coalition, Surrey Health Solutions – Lookout Society, Surrey Hospice Society, Canadian Mental Health Association (CMHA) Surrey District, Fraser Region Aboriginal Friendship Centre, Indspire Foundation, Canadian Primary Care Research Network, and BC Network Environment for Indigenous Health Research (BC NEIHR). Pallium Canada, a national non-profit, has also come forward with expressed interest to explore opportunities to support clinical training curriculum in the areas of palliative care education; however, additional conversations are required to determine feasibility and alignment with the MD program curriculum.

Additional preliminary meetings were also held with affiliated-health organizations such as LifeLabs, Fraser Orthopedic Institute, Synergy Physiotherapy Rehabilitation Centre, Neuromotion Surrey Centre, to explore potential opportunities for interdisciplinary collaboration. Evidence of Student Interest and Labour Market Demand

7 Evidence of Student Interest and Labour Market Demand

Across Canada, there is strong evidence of student interest in medical education as represented in the large volume of applications these programs receive for a small number of places. At the University of British Columbia (UBC), admissions for the 2023/24 academic year received 2915 applications. Of those applicants, 800 were interviewed and 308 were admitted. This represents an admissions rate of 10.56%.³¹ UBC's admissions rate is similar to other medical education programs in Canada, highlighting that there is high interest nationally resulting in competitive processes for aspiring students. *(See Appendix 8.3- Table 1: Acceptance Rates for All Canadian Medical Education Programs in 2022/23 cycles).*

Admissions data published by UBC provides further insight into how competitive the applicant pool was at UBC, including the academic history of students who were not successful. This data shows that from 2019 to 2021 there was a large pool of applicants with strong academic records and MCAT scores who were not accepted *(See Appendix 8.3- Table 2: Number of Medical Program Applicants not accepted to UBC by overall grade averages & Table 3: Medical Program Applicants not accepted to UBC average MCT performance)*. This data verifies that in each of these years, there was a large pool of academically competitive, BC-based applicants that will meet SFU's admissions criteria who were not accepted to UBC.

Following graduation, students from the MD program will be prepared to enter a residency where they will specialize in a field of medicine. The MD program is the first step required to prepare students for careers as physicians. Introducing this program at SFU is aligned with the Stronger BC plan³² and is a pillar of the Ministry of Health's strategy to expand the healthcare workforce and increase patient access.³³

The MD program is being designed with a focus on generalist medicine, meaning SFUMS graduates will be well-suited to fill positions as the family doctors and community health leaders that are urgently needed in BC and across Canada. In

³¹ [Interim Statistics \(ubc.ca\)](https://www.ubc.ca/interim-statistics)

³² news.gov.bc.ca/files/StrongerBC_Economic_Plan_2022.pdf

³³ [New health workforce strategy improves access to health care, puts people first | BC Gov News](https://www.bccdc.ca/newsroom/news/2022-09-14-new-health-workforce-strategy-improves-access-to-health-care-puts-people-first)

recent years, Canada's health care workers have faced unprecedented levels of burnout and turnover.³⁴ This trend has led to worsening conditions for the healthcare workforce and decreased access to health services for citizens. While BC has experienced recent success with attracting new physicians to reduce pressure on the healthcare system, it is estimated that approximately 900,000 residents of British Columbia are still without a family physician.³⁵ While family physician shortages are felt across the province, data suggests this problem is greatest in the Fraser region. All three of the health service delivery areas that comprise the Fraser region, have significantly fewer doctors per 10,000 people than the provincial average (*See Appendix 8.3- Table 4: Number of family physicians and specialist physicians per 10,000 populations in BC health service delivery areas (HSDA)*).

Looking forward, demand for physicians is expected to continue to increase as BC's population grows. The most recent Canadian census revealed that BC has one of the fastest growing provincial populations with an increase of 7.6% between 2016 and 2021.³⁶ Projections from BC Stats predict that the population of BC will continue to grow from 5.5 million in 2023 to an estimated 7.2 million in 2040.³⁷ A large portion of this growth is predicted to occur in the Fraser Valley where physician shortages are already most pronounced. SFU's MD program, situated on the Surrey campus, will focus on preparing physicians to serve in this region.

These trends align with labour market expectations for physicians. WorkBC³⁸ estimates that general practitioners and family physicians will have an employment growth rate of 1.1% through to 2027 and 1.9% from 2027-2032. This will amount to 3,460 new jobs for family physicians over the next ten years.³⁹ Specialist physicians are also expected to grow by 1.9% from 2027-2032 resulting in 3160 new job openings. Labour demand for physicians is also expected to increase, driven by BC's

³⁴ <https://www.canada.ca/en/employment-social-development/news/2023/06/canada-is-addressing-current-and-emerging-labour-demands-in-health-care.html>

³⁵ [BC's health minister expects wait for family doctor to 'speed up' over next year | The Province](#)

³⁶ [Population and population growth rate, provinces and territories, 2011 to 2016 and 2016 to 2021 \(statcan.gc.ca\)](#)

³⁷ [BC Population Estimates & Projections \(shinyapps.io\)](#)

³⁸ [Province of British Columbia. \(2022\). Labour Market Outlook.](#)

³⁹ [Province of British Columbia. \(2022\). Labour Market Outlook.](#)

aging population which will require increased care, and more family doctors retiring or moving to part-time work.⁴⁰

Evidence of labour market demand is further supported by the letter from Fraser Health which articulates the need for BC to train new doctors (*See Appendix 8.4*).

⁴⁰ [More doctors practising family medicine in BC - Business in Vancouver \(biv.com\)](https://www.biv.com/news/2019/05/20/more-doctors-practising-family-medicine-in-bc/)



SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Medical Doctor (MD) Program

Full Program Proposal
8 - Appendices

March 15, 2024
SFU Medical School

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SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Medical Doctor (MD) Program

Appendix 8.1a - Calendar Entry

March 15, 2024
SFU Medical School

Appendix 8.1 – Calendar Entry

Medical Doctor Program

DOCTOR OF MEDICINE

This program, located at the Surrey campus, leads to a Doctor of Medicine degree.

Admission Requirements

All prospective candidates must possess a completed undergraduate bachelor's degree, in any discipline, from a recognized post-secondary institution. Applicants who have at least 90 graded units and will complete their degree by April 30 of the year that admission to the MD program is sought are eligible for consideration.

Applicants for the MD Program must be Canadian citizens or Permanent Residents. Recognizing that individuals may take different paths to a career in medicine, applicants can choose to apply to the Doctor of Medicine Undergraduate program via the following options:

- Grade Point Average (GPA) Only
- Medical College Admission Test (MCAT) Only
- GPA and MCAT

GPA Only

Applicants seeking admission via the GPA only option must complete the following:

- An undergraduate degree in any discipline from a recognized post-secondary institution, with a minimum Adjusted GPA threshold of 3.67 (based on a 4.33 grading scale or equivalent). The adjusted GPA is calculated on the applicant's best 60 graded units of the last 90 units of their degree. This must include at least 30 units of upper division course work with the last 90 units completed in no more than 4 calendar years.
- Pre-requisite courses*:
 - 2 Life Sciences Courses (minimum 3 units each, with at least 1 course that is 200 level or higher).
 - 2 Social Science Courses (minimum 6 units, any level)
 - 1 Indigenous Studies Course. This will be a pre-requisite for the 2027 admission year, but for the 2026 admission year, this will be a pre-enrolment requirement.

- All pre-requisites must be included in the 60 unit Adjusted GPA calculation, regardless of when the courses were completed.
- A grade of B- or better must be achieved on all pre-requisite courses.
- In addition to the pre-requisite courses, courses in critical reasoning and general science are strongly recommended.

*For the full list of qualifying pre-requisite courses, see admissions website.

MCAT Only

Applicants seeking admission via the MCAT only option must complete the following:

- An undergraduate degree in any discipline from a recognized post-secondary institution.
- The MCAT (Medical College Admissions Test), with a minimum score of 505, with at least a minimum of 123 in each section of the test. Test scores must be achieved within 5 years of application. Applicants are permitted a maximum of 2 attempts with the most recent attempt used for application evaluation.
- Pre-requisite courses*:
 - 2 Social Science Courses (minimum 6 units, any level)
 - 1 Indigenous Studies Course. This will be a pre-requisite for the 2027 admission year, but for the 2026 admission year, this will be a pre-enrolment requirement.
- A grade of B- or better must be achieved on all pre-requisite courses.

*See admissions website for full list of qualifying courses.

GPA & MCAT

Applicants seeking admission via the GPA & MCAT option must complete the following:

- An undergraduate degree in any discipline from a recognized post-secondary institution, with a minimum Adjusted GPA threshold of 3.33 (based on a 4.33 grading scale or equivalent). The adjusted GPA is calculated on the applicant's best 60 graded units of the last 90 units of their degree. This must include at least 30 units of upper division course work with the last 90 units completed in no more than 4 calendar years.
- The MCAT (Medical College Admissions Test), with a minimum score of 495, with at least a minimum of 123 in each section of the test. Test scores must be achieved within 5 years of application. Applicants are permitted a maximum of 2 attempts with the most recent attempt used for application evaluation.
- Pre-requisite courses:
 - 2 Social Science Courses (minimum 6 units, any level)

- 1 Indigenous Studies Course. This will be a pre-requisite for the 2027 admission year, but for the 2026 admission year, this will be a pre-enrolment requirement.
- All pre-requisites must be included in the 60 unit Adjusted GPA calculation, regardless of when the courses were completed.
- A grade of B- or better must be achieved on all pre-requisite courses.

Selection

Admission into the MD program is competitive. The minimum admission requirements establish the threshold for admission but do not guarantee acceptance. GPA and/or MCAT scores alone will not be used to rank applicants. In addition to the academic requirements above, applicants may be assessed on their work/volunteer/community experience, other achievements, letters of reference and other related documentation. Preference will be given to applicants who are residents of British Columbia. After the initial review, some applicants will be selected for an interview.

For detailed information on admission requirements and process, visit the admissions website.

Indigenous Pathway Applicants

Simon Fraser University welcomes applications from qualified Indigenous Canadian applicants (Status Indian, Non-Status Indian, Métis and Inuit). Indigenous applicants can apply either to the general admission pathway or to the Indigenous admission pathway. Applicants applying for admission via the Indigenous Pathway must meet minimum admission requirements and provide documentation of Aboriginal heritage (First Nations, Metis or Inuit) to be considered for admission. Documentation could include, but is not limited to, Indian or Metis status cards, official Inuit identification, official letters from Aboriginal organizations, or a combination of proofs. For more information see admissions website.

Essential Skills

Applicants who meet the academic and non-academic standards set by the University must also exhibit the potential to excel as future physicians. Applicants must demonstrate their intellectual, physical, and emotional capabilities without compromising essential aspects of the program. These capabilities include learning, communication, knowledge integration, patient safety and quality, and professionalism.

Students with Disabilities

In accordance with SFU's commitment to accessibility in education, applicants with disabilities are encouraged to apply to the MD program if they have the skills and abilities to meet the core requirements of a medical degree. Applicants with disabilities will be considered in accordance with SFU's Accessibility for Students with Disabilities Policy (GP26). This policy does not eliminate the need for evaluation or the need to meet essential learning outcomes.

Minimum Grades

This program and its courses are competency based. Students are evaluated on SFU's [competency grading scale](#). Required competencies and milestones that mark progress toward achievement of competencies are clearly outlined. Assessment will be programmatic; that is, all assessment modalities will indicate progress toward milestones and competencies.

Students will be able to monitor their progress with regular support from a program coach. The program will closely monitor the progress of individual students and the whole cohort to identify areas of concern early to ensure individual learning enhancement plans are developed as necessary.

Student progress is deemed to be "Satisfactory" unless it is identified as failing to meet expectations.

Program Requirements

Students must complete all of:

Year 1:

MEDI 410 – Foundations of Medical Practice (58)

Year 2:

MEDI 420 – Extensions of Medical Practice (54)

Year 3:

MEDI 430 – Consolidation of Medical Practice (36)

Post Acceptance Requirements

Upon acceptance, students should review the University's immunization policy and ensure compliance.

It is also the responsibility of all students (and parent or guardian for students under 19 years of age) who work with children and/or vulnerable adults, or have unsupervised access to children and/or vulnerable adults, during the course of a certificate, diploma or degree program, to authorize a criminal record check (CRC) through Simon Fraser University, for the Ministry of Public Safety and Solicitor General as per a legislative requirement under the British Columbia Criminal Records Review Act which took effect January of 2012. This authorization is submitted to the Criminal Records Review Program for review.

Transfer Requests

Transfer Requests from students at other medical schools will not be considered.

Elective Courses

There are no elective or additional courses in the MD program.

SFU Medical School Admission

Supporting Evidence and Recommendations

Minimum Admissions Requirements Preamble

In designing the minimum admission requirements for the SFU Medical School, it was imperative to take values-based approach and recognize the diverse paths individuals may take to pursue a career in medicine, including the various barriers they may encounter. Careful consideration was given to the inherent challenges associated with both the Medical College Admission Test (MCAT) and Grade Point Averages (GPAs). To address this, the school offers three application options:

1. GPA Only
2. MCAT Only
3. GPA + MCAT

These options allow the SFU Medical School to strike a balance between maintaining a degree of open access to applicants while selecting for a predetermined level of demonstrated academic rigor. It is acknowledged that this is the first iteration of the minimum admissions requirements, and the Medical School is committed to the ongoing review of applicant and matriculant data to inform the refinement of admissions policies and processes that align with our program goals, with potential for the development of additional pathways to ensure equitable access to medical education for qualified candidates.

THE SFU MEDICAL SCHOOL ADMISSIONS CONTEXT

All admissions systems are institutionally unique, responsive to the specific influences, communities, politics, and laws that govern the local context. The SFU Medical School Admission System is no different, beholden to institutional values and priorities that will guide its development.

The medical school has articulated a commitment to the following foundational values:

- **Curriculum and Learning Experiences aligned with Generalism:** Creating, delivering and continually improving medical education with a focus on the core values of Generalism while supporting learning that delivers to future clinicians and scholars in Family Medicine
- **Scholastic Excellence:** Developing education that promotes medical student success across the full range of relevant assessments and tests of knowledge including those that occur outside of or subsequent to undergraduate training (i.e., residency match, licensing, certification, continuing professional development).
- **Professional Excellence:** Developing education that promotes medical student achievement of skill, knowledge, and attitude across the full range of medical competencies (i.e., leadership, professionalism, advocacy, scholarship, communication, collaboration, medical expertise).
- **Equity, Diversity, Inclusivity, Accessibility, and Indigenous Reconciliation (EDIA-IR):** Ensuring people from a broad set of sociodemographic and cultural backgrounds are represented and able to thrive in the medical school and ensuring that the organization's actions and services to the public contemplate the needs and desired outcomes for all.
- **Defensibility:** Ensuring policies and practices are legal and justifiable.
- **Transparency:** Ensuring that the policies and practices that define educational operations at the medical school are clear to members of the university community and public.

- **Resource Efficiency:** Creating education systems that optimize the use of financial, space, and human resources available to the medical school.
- **Institutional Concordance:** Aligning and harmonizing education policy and practice with the broader pan-Canadian medical education landscape.

These values are reflected through a series of stated admissions priorities:

1. To identify and admit applicants who will be successful in medical school and become competent clinicians.
2. To develop medical education that serves the Fraser Health Region and other BC residents, particularly communities/populations who are underserved.
3. To admit applicants who are committed to pursue family medicine and other generalist specialties especially in team-based, community care settings.
4. To advance health care delivery by admitting and educating applicants who show a commitment to a team-based culture and work model.
5. To design an admissions process which will balance the need to identify applicants who have high motivation, academic ability and a commitment to inclusive, accessible and culturally safe care.
6. To welcome those communities and applicants who have been and continue to be underrepresented in medicine, especially Indigenous learners.
7. To ensure defensibility throughout.
8. To be grounded in, and continually improved from, evidence and emerging sector-wide best practices.

THE ADMISSIONS POLICY EVIDENCE LANDSCAPE

Admissions policies can be conceptualized within a two-part hierarchy consisting of admissions criteria and admissions procedures. Each category is composed of options, each of which is regularly associated with the perceived inculcation of specific values into the selection process. The most foundational selection policy category describes **admission criteria**, or the aspirant-level data that are requested and/or generated in any admissions process.

There are three main types:

- Academic criteria: Data pertaining to performance in previous periods of training, typically including permutations of the undergraduate grade point average (GPAs) and performances on standardized tests and key examinations. Academic criteria are espoused in the literature for the way they promote **scholastic excellence** within selection decisions (Siu & Reiter, 2009; Ferguson et al., 2002; Kreiter & Kreiter, 2007; Donnon et al., 2007).
- Non-academic criteria: Data pertaining to experiences accumulated by the aspirant prior to application, reflecting activities, life experiences and engagements outside of previous training. These are usually distilled via written statements of interest, interviews, situational judgement tests, and letters of reference, which are designed to illuminate applicant attributes, character, and features that may contribute to their ability to learn and practice medicine. Non-academic criteria are also described as promoting **professional excellence** within selection decisions (Siu & Reiter, 2009; Eva et al., 2004; 2009; Reiter et al., 2007; Albanese et al., 2003; Salvatori, 2001).
- Social accountability criteria: Data pertaining to applicants' social identity and lived experience. This includes data regarding applicant gender, sex, race, social economic status, (dis)ability, and rural or provincial residence. These data are championed within selection decisions for the way they promote medical student **diversity** and **accessibility** to the profession (Boelen and Wollard, 2009; Mullan et al., 2010; Ellaway et al., 2018).

In the second policy category, admission criteria are operationalized within **admissions procedures**. These are the ways in which the aspirant-level data are used to select individual candidates. Each admissions procedure can accommodate each type of criteria, either on its own or in combination with other criteria.

There are 4 main types:

- Actuarial methods: Procedures that involve mathematical processes to synthesize information to generate admission decisions. These processes are valued for their **legal defensibility**. However, they have been criticized because they do not always value **comprehensiveness** (i.e., holistic review) in selection (Martinho, 2012; Soemantri et al., 2020; van der Merwe et al., 2015; Terregino, 2015; Quinlivan et al., 2010; Dawes, 1979; Kreiter & Kreiter, 2007; McGaghie & Kreiter, 2005).
- Committee appraisal: Procedures that involve group review of applicant criteria to generate selection decisions. A committee often involves faculty, physicians, community members, and medical students. Committee appraisal is nearly always used to appraise non-academic criteria in combination with academic and/or social accountability criteria. These processes are valued for their **legal defensibility** and the way they promote **diversity** and **accessibility**, whereby review is conducted so

as to consider the many ways an applicant might be suitable for medicine and the learning environment. However, committee appraisal has been criticized because it is often less associated with downstream **scholastic excellence** than actuarial methods (AAMC, n.d.; Jerant et al., 2015; Kennedy et al., 2020; Zupanic et al., 2019; Witzburg & Sondheimer, 2013; Kreiter et al., 2018; Roadmap to Diversity and Educational Excellence, n.d.).

- **Lottery**: Procedures that utilize a weighted system in which an applicant's chances for admission increase in parallel with some criteria. Lotteries are valued for their **legal defensibility**, **resource-efficiency**, **fairness**, and the way they promote **accessibility**. All applicants are eligible to participate and have a chance of obtaining admission to medical school. Lottery systems may be used to widen access to medical school, but there is no guarantee of this outcome, and it will not assist widening access when the applicant pool is homogeneous. Evidence that lotteries promote or hinder **scholastic excellence** is equivocal (Schreurs et al., 2018; Oates & Goulston, 2012; Stasz et al., 2007; Wouters et al., 2018; Mulder et al., 2022).
- **Quotas**: Procedures that allocate seats for applicants of certain identities by the medical school. Quotas may be set based on region, race, or expressed intention to practice in underserved regions (Chiu, 2018; Matsumoto et al., 2016; van der Merwe et al., 2015; Grierson & Vanstone, 2021). Quotas always involve social accountability and academic data and may or may not also involve non-academic data. Quotas are valued for promoting **diversity** and **accessibility** (Hay et al., 2017; van der Merwe et al., 2016). Quotas do not always promote **institutional reputation (public perception)** - these procedures are often poorly perceived by individuals outside the target group (Harrison et al., 2006; Shaughnessy et al., 2016).

EVIDENCE FOR ADMISSIONS CRITERIA AND PROCEDURES MAPPED TO SFU VALUES

Value	Criteria	Procedures
EDIA-IR	Promoting: <i>Interviews, Personal Statements</i> Hindering: <i>GPA, MCAT</i>	Promoting: <i>Quotas, Committee-based Appraisal</i> Hindering: <i>Actuarial Methods</i> Equivocal: <i>Lotteries</i>
Scholastic Excellence	Promoting: <i>Academic Criteria Situational Judgement Tests, Interviews, MCAT</i>	Promoting: <i>Actuarial Methods</i> Hindering: <i>Committee-based Appraisal</i>
Professional Excellence	Promoting: <i>Interviews, Situational Judgement Tests, Experiences with 3rd party verification</i>	Promoting: <i>Committee-based Appraisal</i> Hindering: <i>Actuarial Methods</i>
Defensibility	Promoting: <i>Academic, Non-academic, Social Accountability (Pathways & Special Streams)</i>	Promoting: <i>Actuarial, Committee-based Appraisal, Lotteries, Quotas</i>
Transparency	-	-
Resource Efficiency	Promoting: <i>Academic Criteria</i> Hindering: <i>Interviews</i>	Promoting: <i>Actuarial Methods, Lotteries</i> Hindering: <i>Committee-based Appraisal</i>
Institutional Concordance	<i>All schools in Canada use or have used a combination of the criteria described</i>	<i>All schools in Canada use or have used a combination of the procedures described</i>

TENSIONS

The ways in which the options within and across admissions policy categories are organized relative to one another has the potential to offset or amplify the values inherent to each; such that the values that inform any one selection decision do not necessarily reflect an additive function of the values associated with the specific criteria or procedures that underpin it. This can lead to tensions between components of admissions systems designed to meet interrelated but parallel aims.

For instance, a **fair** admission system is one that is just, impartial, and reasonable. Many systems operationalize this value of fairness through the principle of **equality**, treating people in a manner that is free from unwarranted bias, discrimination, and favoritism by adhering to rules, standards, or principles that are applied consistently to all applicants regardless of their background, status, or circumstances (Lamont and Favor, 2017). This focus on equal application of the same rules to all, however, may not result in a system which widens access and increases the diversity within a class. Other systems operationalize **fairness** according to the principle of **equity**. These systems acknowledge that some applicants face structural inequities that constrain their opportunity to demonstrate merit (*vis-a-vis* scholastic and professional excellence). An admissions process that strives to be inclusive in order to admit a diverse class may need to take into consideration the specific needs, circumstances, and conditions of individuals or groups (De Freitas, Grierson, Vanstone 2019). An equitable system may need to be designed in a way which recognizes that different people have different starting points and face different barriers or advantages in the way they are able to demonstrate their achievements. An equitable approach would be one which distributes resources and opportunities in a manner that accounts for these differences.

There is a tension here between different definitions of fairness as either equality (applying rules consistently to all applicants) and equity (distributing resources and opportunities in a manner that accounts for differential opportunities to demonstrate merit). Research evidence may sometimes be silent on how they are conceptualizing fairness, requiring interpretation to whether the implicit operationalization of “fair” corresponds more closely to notions of equity or equality. Further to this, admissions scholars typically discuss the success or utility of an admissions criteria or procedure by assessing the **validity** of the purported relationship between the associated values and/or priorities and the outcomes of the admissions process (e.g., downstream student success, professionalism issues, class diversity, etc.). However, validity interpretations can be threatened by many factors, including measurement bias that results when different groups have the same level of ability but produce different scores on the measurement (Woo et al., 2023). For example, evidence showing that undergraduate GPA and MCAT performances are correlated with MCCQE Part 1 scores lends validity to the use of these measures in selecting students who are likely to pass their qualifying examinations (i.e., promoting **scholastic excellence**). However, that research also reveals differential attainment in MCAT scores as a function of applicant social identity features suggests that the tool does not contribute to an inclusive system that potentiates class diversity (i.e., hindering **EDIA-IR**). When examining measurement differences such as these, one must also determine whether they reflect differences in the ability of test-takers at the time they took the test. In the case of the MCAT, the evidence suggests that differential attainment results as a function of pervasive structural inequities inherent across society rather than emanating from a biased examination (Girotti et al., 2020; Davis et al., 2013).

To achieve all priorities, the medical school must thus develop a selection system that accentuates the ways in which criteria and procedures promote some values while offsetting the ways in which these same criteria and procedures hinder others. This optimization can be achieved through comprehensive appraisal of evidence, which helps decision-makers localize the source of tension (e.g., structural inequity in society vs bias within a test) and gives way to thoughtful mitigating strategies. In this regard, tensions spur thought, consideration, debate, and communication and do always impede schools from determining solutions that emphasize all priorities. In review of the SFU admissions landscape, one key tension stands out as especially salient: **Balancing commitments to EDIA-IR and selecting medical school students who have the potential for scholastic excellence and professional excellence in a resource-efficient manner.** In the section that follows, we consider the validity evidence associated with these priorities as it pertains to five “*in tension*” admissions criteria discussed at length in recent working group meetings: GPA, MCAT, MMIs, Personal Statements, and Prerequisite Courses. In addition to considering validity evidence related to the priorities, we also speculate on the presumed upstream impacts these criteria can have on aspiring medical students, highlight relevant balancing perspectives, and offer mitigating strategies that can be employed to offset the tension and achieve balance.

1. Grade Point Average

- **Evidence pertaining to scholastic excellence:** Numerous studies are explicit in highlighting the way in which GPA data are predictive of downstream success in medical training (Ellis, 2022; Siu & Reiter, 2009; Ferguson et al., 2002; Kulatunga-Moruzi & Norman, 2002; Kreiter & Kreiter, 2007; Donnon et al., 2007; Salvatori, 2001). Both the 2011 and 2018 Ottawa Consensus Statements on medical school selection note that “*prior academic attainment remains a universal feature of selection policies internationally and the strength of this evidence is strong*” (Patterson 2018). However, the strength of this evidence may be weakened by advancing grade inflation and institutional differences.
- **Evidence pertaining to professional excellence:** There are studies that have shown higher admissions GPAs are associated with fewer professionalism issues in training (Barber et al., 2022) and better clinical performances (Kulatunga-Moruzi & Norman, 2002).
- **Evidence pertaining to EDIA-IR priorities:** Research evidence highlights the way in which GPA is a social construct that reflects the systemic forms of oppression inherent throughout society. This is highlighted in evidence that shows differential attainment in GPA as a function of social identity features (Davis et al., 2013; Girotti et al., 2020; Lucey & Saguil 2020).
- **Implications for resource efficiency:** GPA criteria can be processed with relatively few resources. This is especially so when processed via actuarial methods.
- **Potential upstream impacts:**
 - Reliance on highest GPA measures will lead aspiring medical students to favour courses, programs and institutions that are perceived as easy to get good grades, unnecessarily repeat passed courses, and to do this at the expense of their personal interest, learning goals, or undergraduate training that would be beneficial to the profession (e.g., humanities).

- Reliance on highest GPA measures will lead aspirants in the same undergraduate programs to adopt a competitive, rather than a collaborative, attitude relative to one another.
 - Reliance on highest GPA measures will lead aspiring medical students to concentrate maximal time and energy on achieving high grades, rather than on paid employment, caregiving, athletics, arts, or well-being related activities that contribute to community, wellness, and society.
 - When GPA calculations are restricted to full course load semester, students will not reduce their course loads in legitimate times of need.
- **Balancing perspectives:**
- Meritocracy in this literature is conceptualized in terms of denoting who is most deserving of the reward of admission, rather than indicating which applicants have the capacity for success in medical school and the profession.
 - The validity evidence is challenged by differential standards across institutions, programs, and classes. Identical GPAs do not mean identical capabilities.
 - GPAs are generated for every undergraduate student, so do not pose any additional application barriers. That is, they do not need to study for, travel to, or prepare for an additional test.
 - Permitting GPA calculations on a reduced course load “with explanation” demands applicants to disclose potentially traumatic and distressing personal information to admissions committees without an understanding of how that information is processed or protected.
- **Mitigating strategies:**
- Adopt a conceptualization of merit that emphasizes the candidate’s suitability for medical school and the profession rather than one which emphasizes relative differences between candidates. This would involve prioritizing candidates who present a GPA that crosses a predetermined threshold rather than the candidates with the highest GPAs.
 - Afford GPA calculations on a subset of credits or undergraduate prerequisites (i.e., some credits count or do not count in the GPA calculation).
 - Do not require a full course load for GPA calculations.
 - Allow applicants to demonstrate their capacity for scholastic and professional excellence via a variety of methods.
- **Concordance with other Canadian Medical Schools:**
- Most Canadian medical schools publish a minimum GPA in their calendar which is well below the average GPA of a successful applicant. This is because many schools process GPAs via actuarial methods that imbue higher GPAs a greater advantage in determining the outcome. Therefore, published minimums are not reflective of the decision-making process.
 - In terms of minimums, Memorial publishes no minimum. Dalhousie (local applicants), Manitoba, McMaster, NOSM, Queen’s University of Alberta (local applicants), University of Calgary (local applicants) and UBC publish a GPA minimum between 3.0 and 3.3. McGill (PQ residents), University of Alberta (other provinces) and Ottawa publish a 3.5 minimum GPA. UBC (other provinces), Calgary (other provinces), University of Toronto, Saskatchewan, Western, Dalhousie (other provinces), and McGill (other provinces) have GPA minimums of

3.6 and above. (see table below):

No Minimum	Minimum 3.0 - 3.3	Minimum ≥ 3.5	Minimum ≥ 3.6
Memorial	DAL (local) U of Alberta (local) U of Calgary (local) UBC (local) Manitoba McMaster NOSM U Queen's	McGill (local) Ottawa U of Alberta (out of province)	U of Calgary (out of province) UBC (out of province) DAL (out of province) U of T Saskatchewan Western

- Many schools operationalize different GPA minimums for different populations, typically requiring lower GPAs from residents of their own/partnered provinces, active Canadian Forces members, Indigenous applicants, or graduates of associated pre-medical preparation programs.

2. MCAT

- **Evidence pertaining to scholastic excellence:** It is well-established that the MCAT predicts performance on pre-clerkship, graduation, and licensing exams (Prideaux et al., 2011, Paterson et al., 2018, Donnon et al., 2007, Hanson et al., 2022; Salvatori, 2001).
- **Evidence pertaining to professional excellence:** Students selected using a standardized aptitude test similar to MCAT were less likely to drop out of medical school than those selected during a period of time and more likely to graduate within one year of their expected graduation date, suggesting that MCAT scores are an effective way of selecting students prepared for the nature of medical study (Kraft et al., 2012; Hanson et al., 2022). MCAT Verbal Reasoning score is predictive of downstream communication skills (Kulatunga-Moruzi & Norman, 2002).
- **Evidence pertaining to EDIA-IR priorities:** Many commentaries criticize the MCAT for favouring certain types of candidates, while meta-syntheses of evidence point to the equivocal nature of this proposition and the need to add additional nuance (Cleland et al., 2023, Prideaux et al., 2011, Patterson et al., 2015, Patterson et al., 2018, Hansen et al., 2023; Lucey & Sagueil 2020). Rather than questions on the test, other features associated with the MCAT (e.g., examination fees; the need to travel to testing centres) are recognized barriers for low-income, rural, and remote applicants (De Freitas et al., 2021).
- **Implications for resource efficiency:** MCAT criteria can be processed with relatively few resources. This is especially so when processed via actuarial methods.

- **Potential upstream impacts:**
 - Reliance on highest MCAT measures will lead aspiring medical students to dedicate time and resources to MCAT studying at the expense of other activities (e.g., paid employment, community engagement, socialization, wellness).
- **Balancing perspectives:**
 - Meritocracy in this literature is conceptualized in terms of denoting who is most deserving of the reward of admission, rather than indicating which applicants have the capacity for success in medical school and the profession.
 - While MCAT scores do reveal differential attainment, the differences between applicant groups are smaller on the MCAT than other measures of academic performance (i.e., GPA). The predictive validity of the MCAT is comparable for students from different genders, races, and socioeconomic statuses (Busche et al., 2020; Hansen et al., 2023). Both findings suggest that while both tools are reflecting the impacts of structural oppression, the MCAT may counter these effects more strongly (Davis et al., 2013; Girotti et al., 2020; Lucey & Sagui 2020). This has been found in examinations of other standardized tests, which show that students from economically disadvantaged high schools or who encountered personal circumstances that resulted in lower GPAs have an opportunity to demonstrate their academic aptitude and gain entrance into competitive undergraduate institutions through high standardized test scores (Chetty, Deming & Friedman, 2023).
 - Certain ways of appraising the MCAT (e.g., valuing absolute highest score, allowing unlimited re-takes) can exacerbate inequities by privileging those with significant resources to deploy in achieving very high scores (Faiz et al., 2023).
 - Most Canadian aspiring medical students apply to >2 medical schools (AFMC, 2021), and we anticipate that many SFU applicants will also apply to UBC. Given that UBC, like other existing Canadian schools targeting English-speaking applicants, requires some portion of the MCAT, it is likely that most applicants will write regardless of whether it is an SFU Medical School admission requirement.
- **Mitigating strategies:**
 - Adopt a conceptualization merit that emphasizes the candidate's suitability for medical school and the profession rather than one which emphasizes relative differences between candidates. This would involve prioritizing candidates who present a MCAT score that crosses a predetermined threshold rather than the candidates with the highest MCAT scores.
 - Allow applicants to demonstrate their capacity for scholastic and professional excellence via a variety of methods.
 - Establish a policy to review only the most recent of multiple test scores or that limit admissions review to only the first or second attempt.
 - Provide fee assistance and preparatory courses for applicants in need.
- **Concordance with other Canadian Medical Schools:**
 - The current 11 Canadian medical schools targeting English applicants require the MCAT.
 - McMaster requires only the CARS (critical analysis and reasoning skills) section of the MCAT.

- French-language schools and schools serving Francophone patient populations (Laval, Montreal, Sherbrooke, McGill, Ottawa, NOSM) do not require the MCAT.
- Of the schools requiring MCAT scores, there are a wide variety of approaches to minimums. Some schools do not have a minimum MCAT score, or do not have a minimum MCAT score for preferred populations (i.e., in-province applicants, Indigenous, Armed Forces).
- Some MCAT minimums are relevant to a total score (e.g., Saskatchewan = 492, Dalhousie = 503). Others operationalize a minimum related to scores in each section; typically, between 124 and 128 and sometimes with one section allowed to be lower than others.
- Some schools do not publish their minimums (e.g., Queen's).
- Until 2024, the MCAT was optional at McGill who stated that a cumulative 508 score was competitive.
- Dalhousie has a unique system of calibrating MCAT and GPA scores on a sliding scale, which is different for in-province and out-of-province applicants.
- 6 schools have recency requirements for MCAT scores (within 5 years), others are silent on this requirement. Western only considers the most recent MCAT score.
- The Association of Faculties of Medicine of Canada (AFMC) has recently published a position statement against the use of the MCAT.

3. Prerequisite Courses:

- **Evidence pertaining to scholastic excellence:** There is substantial research evidence supporting the importance of fundamental science education in the development and application of clinical reasoning, particularly in very difficult, complex, or ambiguous cases (Bandiera et al., 2018, Castillo et al., 2018, Lisk et al., 2016, Kulasegaram et al., 2013, Norman et al., 2005, Woods et al., 2006, Woods 2007). In more recent years this literature has been extended to demonstrate the utility of foundational knowledge from behavioural and sociological sciences to support learning and performance in complex health systems (Chaudhary et al., 2019).
- **Evidence pertaining to professional excellence:** Research suggests that training in epistemology, culture, justice, and power supports the achievement of competence in roles beyond medical expert (Kuper et al., 2017).
- **Evidence pertaining to EDIA-IR priorities:** There is evidence that physicians can be trained to be strong health advocates through foundational education relevant to the social determinants of health and health equity (Hansen et al., 2023, Kumagai et al., 2018).
- **Implications for resource efficiency:** There is no comprehensive evidence base describing the resource implications of reviewing course prerequisites.
- **Potential upstream impacts:**
 - Aspiring medical students will take courses in defined prerequisites.

- **Balancing perspectives:**
 - Prerequisites requirements can be confounded by GPA minimum thresholds. Grades for humanities, philosophy, and language courses are often generated via variable scoring methods that rely on the subjective perspectives of instructors and teaching assistants. These courses are often avoided by aspiring medical students because of the difficulties this approach poses to assuring a strong mark.
- **Mitigating strategies:**
 - Require prerequisites that are not necessarily included in the GPA calculation.
- **Concordance with other Canadian Medical Schools:**
 - No Canadian medical school specifies a particular type of degree.
 - A completed four-year degree is required by Alberta, Saskatchewan, Manitoba, Western, NOSM, McGill, and Memorial. Three years of study, degree completion not necessary, is required by UBC, McMaster, Toronto, Queen's, and Ottawa. Dalhousie requires a completed degree but does not specify whether a three- or four-year degree is preferred. Calgary requires two years of study at the time of application.
 - There is a great deal of variance in the pre-requisite courses required by comparable institutions, although there is one clear pattern. Six schools (NOSM, Ottawa, Laval, McGill, Montreal, Sherbrooke) do not require the MCAT. Five of these schools require a long list of pre-requisites related to Biology, Chemistry, Mathematics, Physics. No school which requires the MCAT has any pre-requisites related to these topics. We can assume that MCAT-requiring schools have evaluated the MCAT to be demonstration of foundational knowledge in these areas. Some of these schools (e.g., Montreal) specify that requirements can be waived if a degree is achieved in sciences or natural sciences.
 - Some schools require pre-requisites in other topics. UBC requires 2 English courses; Toronto requires 2 Life Sciences, 1 Social Science, Humanities or Language course; Calgary requires an online Indigenous course offered by Coursera.

4. Multiple Mini-Interviews (MMI)

- **Evidence pertaining to scholastic excellence:** The MMI has been demonstrated to be a reliable assessment tool, with scores highly correlated with MCCQE performance (Eva et al., 2004; Eva, 2009; Knorr & Hissbach, 2014).
- **Evidence pertaining to professional excellence:** MMI scores are highly correlated with clinical performance (Reiter, 2007). However, MMI scores are not predictive of remediation for academic or professionalism challenges (Barber et al., 2022).
- **Evidence pertaining to EDIA-IR priorities:** High MMI scores are associated with being a woman, and aged 25 to 29 (Leduc et al., 2017). Indigeneity, rurality, being an English-language learner, and coming from a lower socioeconomic background are also associated with lower scores (Rees et al., 2016; Kelly et al., 2014; Jerant et al., 2015; Leduc et al., 2017).

- **Implications for resource efficiency:** MMIs are expensive and resource intensive to mount. They require significant human and financial resource from both the institution and the applicant.
- **Potential upstream impacts:**
 - Aspiring medical students will engage in interview preparation exercises. As with other commonly used medical school admissions tests, there is an industry of MMI preparatory courses, although their utility is questionable.
 - Aspiring medical students will orient their preparation around the values and constructs that they expect to resonate in the interview. MMI stem creation is thus a mechanism to influence pre-application behaviour and attitudes.
- **Balancing perspectives:**
 - MMI stems can be contextualized and deployed to assess unique locally relevant attributes (e.g., communication, ethical reasoning, and critical thinking skills). The precise characteristics assessed are malleable, with significant room for each school to design an MMI process that prioritizes the assessment of characteristics valued by that program.
 - The MMI is not a single instrument, it is a technique or a process that has a high degree of customizability by each individual program. Therefore, it is possible that the schools where disadvantage is observed have constructed the MMI to inculcate that disadvantage.
 - Candidates prefer MMIs. Survey responses from McMaster 2020 applicants who did not engage in the expected MMI due to the COVID-19 pandemic indicate that candidates dedicate significant resources to preparation and perceive the MMI as an opportunity to show the medical school “*who they really are*” as people (Grierson et al., *under review*).
 - The MMI can serve a mutual recruitment purpose, with the school having an opportunity to showcase their values and resources to applicants they hope will accept their offer.
- **Mitigating strategies:**
 - Limit the conduct of MMIs to later stages of the admission process, reducing the overall number of candidates that interview.
 - Offer MMIs synchronously, either over virtual platforms or in person. The proliferation of generative AI technology can challenge the integrity of asynchronous virtual MMI assessments.
 - Maximize inclusivity through stem creation and rater selection and training in an effort to reverse observed findings of disadvantage for Indigenous, rural, and English-language learning applicants.
- **Concordance with other Canadian Medical Schools:**
 - All existing schools have some form of interview. For most (14/17), that includes an MMI either as part of another interview process or the entirety of the interview process.
 - Western and Ottawa do a panel interview. Toronto has developed their own modified version of the MMI.

5. Personal Statements

- **Evidence pertaining to scholastic excellence:** There is evidence that personal or autobiographical statements are not predictive of academic success in medical school. (Ferguson et al., 2000, Albanese et al., 2003, Patterson et al., 2018), which may reflect that personal statements seldom focus on academic attributes. That said, personal statements do provide an opportunity to detail research achievements and awards which reflect an applicant's academic performance (Yang et al., 2022).
- **Evidence pertaining to professional excellence:** There is very little evidence supporting the predictive validity of personal statements on professional performance (Patterson et al., 2018, Prideaux et al., 2011). Particularly, personal statements have not been shown to predict performance in clinical environments (Dong et al., 2013; Kreiter & Axelson 2013).
- **Evidence pertaining to EDIA-IR priorities:** While personal statements do not necessarily request applicants to provide information about their social identities, they do provide ample opportunity for applicants to provide this information if they choose. This can take the form of a prevalent focus on descriptions of community engagement or reflections on barriers overcome. We could not locate any evidence on whether the use of personal statements widens access to medical school or results in more diverse medical school classes.
- **Implications for resource efficiency:** There is no consensus on how to evaluate these documents (Kulatunga-Moruzi & Norman, 2022), with institutions typically creating idiosyncratic systems that require significant human resource.
- **Potential upstream impacts:**
 - Personal statements encourage applicants to seek out experiences they think will “stand out” on applications. Sometimes this may encourage pro-social behaviour such as volunteering for important causes. Sometimes this may encourage anti-social behaviour such as lying (White, 2011, White, 2012) or participating in volunteer work that they are not truly committed to or do not perform in an adequate way.
- **Balancing perspectives:**
 - Candidates tend to appreciate this aspect of the admissions process and acceptability is high (Patterson et al., 2018).
 - Personal statements are susceptible to coaching, AI, and plagiarism which means they may advantage applicants with more resources (Siu & Reiter 2009, Wright 2015, White et al., 2012).
 - Evaluations of reliability in the scoring of these statements has been damning, with little inter-rater reliability demonstrated across multiple studies in multiple institutions (Albanese et al., 2003, Dore et al., 2006).
 - Applicants who have social capital (e.g., connections in the medical field) can use this to gain access to experiences which may be seen as valuable or legitimate by assessors (Wright, 2015), and which may not be available to less-resourced applicants (De Freitas et al., 2021).

- Efforts to construct strong personal statements might inspire behaviour which negatively impacts others. (Taylor et al., 2023). For instance, shadowing physicians is a very common activity that personal statements encourage (Taylor et al., 2023). This activity is more readily available to those with existing connections in the medical field, and which may not be helpful to the shadowed physician or may jeopardize patient comfort and confidentiality. Global health experiences are also commonly pursued in order to construct a strong personal statement. These experiences are also available to candidates with a high level of financial resource and little responsibility at home. They may remove paid work opportunities for local folks while also reinforcing colonial saviour tropes (Naidu, 2021).
- **Mitigating strategies:**
 - Construct clear prompts for verifiable information that reduces reliance on narrative self-report.
 - Explicitly describe the types of activities and relationships that are valued (and not valued) by the institution.
- **Concordance with other Canadian Medical Schools:**
 - Personal statements are the main way that non-academic qualities are assessed in Canada. They are used by almost all medical schools; Manitoba and McMaster are the exceptions. This category exhibits the most variance across Canadian medical schools and is typically the *least transparent* about how this information will be evaluated. The request for an autobiographical sketch with defined categories (e.g., employment, non-academic experience, research, awards) is common. A few schools require short essays about experiences, sometimes formed around question prompts.
 - The Quebec schools require the submission of a CV, formatted to a preferred template.
 - NOSM requires information about rural residence and identities which contribute to a “context score” alongside the autobiographical sketch.

SELECTING FOR INTEREST IN FAMILY MEDICINE

Research highlights that admission policies and selection approaches can be an important determinant of student likelihood to pursue a career in family medicine. Applicants who self-identify an interest in primary care and who grew up with a rural background are more likely to enter primary care, with stated interest in primary care being most predictive (Campos-Outcalt et al., 20024, Martini et al., 1994, Kost et al., 2015, Owen et al., 2002, Schierbel et al., 1996, Senf et al., 2005, Senf et al., 1997, Raleigh et al., 2022, Xu et al., 1996, Xu et al., 1997, Mitra et al., 2018). Through the purposeful collection and consideration of data pertaining to applicant origin and stated preferences for primary care practice, we may admit a cohort of students that improves the downstream interest in family medicine. Similarly, we may also include appraisal of attitudes towards and understanding of the importance of primary care and generalism, regardless of stated preference for a career in family medicine, as part of the applicant review process. In doing so, we may also better promote the matriculation of physicians engaged in all forms of specialist care who share our vision of generalism and active interdependence. These data may be collected via purposively constructed MMI prompts or through the implementation of a personal essay criteria. Similarly, MMI prompts and/or personal essays could be used to assess applicant understanding of and commitment to generalism. It is important here to articulate that improving graduate willingness to provide care to underserved communities should not stand as a justification for enhancing diversity in the medical profession. Rather, equitable admissions systems, in and of themselves, are a categorical imperative of our program. We value fairness and human dignity for all, regardless of the eventual practice choices of our graduates.

PROPOSED CALENDAR MINIMUMS

We propose use of the following minimum application requirements in the SFU calendar. The admissions process through which these elements will be used is described in the following section.

Academic Criteria:

1. Completed 120 credit (4-year) degree
2. Applicants may demonstrate their academic merit through their choice of GPA and/or MCAT score. The minimum requirements for each combination are:
 - a. Adjusted GPA only: ≥ 3.67 (on a 4.33 scale or equivalent) (see #5 for GPA calculation)
 - b. MCAT only: ≥ 505 , with a minimum of 123 in each section
 - c. If both are provided, GPA ≥ 3.33 (on a 4.33 scale or equivalent) and MCAT ≥ 495 with a minimum of 123 in each section
3. MCAT scores must not be older than 5 years.
4. SFUMS will only consider the applicant's first or second MCAT attempt within the 5-year period. If a second attempt is made, then that score will be used regardless of if it is lower than the first attempt.
5. GPAs are calculated using the applicant's best 60 credits of the last 90 achieved credits. The 60 units selected for GPA calculation must include ≥ 30 credits from upper-level courses. The last 90 credits must have been achieved in no more than 4 calendar years.
6. Prerequisite courses for all applicants include 2 courses in Social Science (any level) and completion of the Indigenous Studies course. The pre-requisite courses must be included in the 60 credits used to calculate the GPA. Additionally, the applicant must have achieved at least a B-minus grade in each pre-requisite course.
7. Applicants in the GPA-only stream have additional pre-requisite courses. These prerequisites include: 2 Life Sciences Courses (minimum 3 units each), with at least 1 course at a 200 level or higher. These courses need to be included in the 60 credits used to calculate the GPA. In addition to the pre-requisite courses, courses in critical reasoning and general science are strongly recommended but not required.

The above represents the minimum admission requirements for applicants to be considered for admission to medical school. The selection process, which may include elements such as Multiple Mini Interviews and personal statements will be subsequently developed in consultation with scholars with medical school admissions expertise and guided by a formal Admissions committee.

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SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Medical Doctor (MD) Program

Appendix 8.1b – Admissions Supplemental

March 15, 2024
SFU Medical School

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ADMISSION REQUIREMENTS

All prospective candidates must possess a completed undergraduate bachelor's degree, in any discipline, from a recognized post-secondary institution. Applicants who have at least 90 graded units and will complete their degree by April 30 of the year that admission to the MD program is sought are eligible for consideration.

Applicants for the MD Program must be Canadian citizens or Permanent Residents. Recognizing that individuals may take different paths to a career in medicine, applicants can choose to apply to the Doctor of Medicine Undergraduate program via the following options:

1. Grade Point Average (GPA) Option
2. Medical College Admission Test (MCAT) Option
3. GPA & MCAT Option

1. Grade Point Average (GPA) Option

Applicants seeking admission via the GPA only option must complete the following:

- An undergraduate degree in any discipline from a recognized post-secondary institution, with a minimum Adjusted GPA threshold of 3.67 (based on a 4.33 grading scale or equivalent). The adjusted GPA is calculated on the applicant's best 60 graded units of the last 90 units of their degree. This must include at least 30 units of upper division course work with the last 90 units completed in no more than 4 calendar years.
- Pre-requisite courses*:
 - 2 Life Sciences Courses (minimum 3 units each, with at least 1 course that is 200 level or higher).
 - 2 Social Science Courses (minimum 6 units total, any level)
 - 1 Indigenous Studies Course. This will be a pre-requisite for the 2027 admission year, but for the 2026 admission year, this will be a pre-enrolment requirement.
- All pre-requisites must be included in the 60 unit Adjusted GPA calculation, regardless of when the courses were completed.
- A grade of B- or better must be achieved on all pre-requisite courses.
- In addition to the pre-requisite courses, courses in critical reasoning and general science are strongly recommended.

*For the full list of qualifying pre-requisite courses, see admissions website.

2. MCAT Option

Applicants seeking admission via the MCAT only option must complete the following:

- An undergraduate degree in any discipline from a recognized post-secondary institution.
- The MCAT (Medical College Admissions Test), with a minimum score of 505, with at least a minimum of 123 in each section of the test. Test scores must be achieved within 5 years of application. Applicants are permitted a maximum of 2 attempts with the most recent attempt used for application evaluation.
- Pre-requisite courses*:
 - 2 Social Science Courses (minimum 6 units total, any level)
 - 1 Indigenous Studies Course. This will be a pre-requisite for the 2027 admission year, but for the 2026 admission year, this will be a pre-enrolment requirement.
- A grade of B- or better must be achieved on all pre-requisite courses.

*See admissions website for full list of qualifying courses.

3. GPA & MCAT Option

Applicants seeking admission via the GPA & MCAT option must complete the following:

1. An undergraduate degree in any discipline from a recognized post-secondary institution., with a minimum Adjusted GPA threshold of 3.33 (based on a 4.33 grading scale or equivalent). The adjusted GPA is calculated on the applicant's best 60 graded units of the last 90 units of their degree. This must include at least 30 units of upper division course work with the last 90 units completed in no more than 4 calendar years.
2. The MCAT (Medical College Admissions Test), with a minimum score of 495, with at least a minimum of 123 in each section of the test. Test scores must be achieved within 5 years of application. Applicants are permitted a maximum of 2 attempts with the most recent attempt used for application evaluation.
3. All pre-requisite courses:
 1. 2 Social Science Courses (minimum 6 units total, any level)
 2. 1 Indigenous Studies Course. This will be a pre-requisite for the 2027 admission year, but for the 2026 admission year, this will be a pre-enrolment requirement.
4. All pre-requisites must be included in the 60 unit Adjusted GPA calculation, regardless of when the courses were completed.
5. A grade of B- or better must be achieved on all pre-requisite courses.

SELECTION PROCESS SUMMARY

Our admission requirements help determine candidates who are prepared for our rigorous medical program, who possess the qualities necessary to become competent physicians, and who best embody the SFU SoM commitment to social accountability. Through constituent engagement and focus groups, the SFU SoM has identified social, interpersonal and intrapersonal qualities for becoming a competent physician that are aligned with our social accountability mandate pertaining to community connection and team-based primary care. These qualities emphasize cultural awareness, empathy, and communication in interpersonal interactions, as well as introspection and self-awareness in intrapersonal skills. We strongly believe that these qualities, in addition to academic preparedness, are crucial for effective and compassionate medical practice.

The SFU admissions process will seek to select applicants who possess the necessary characteristics to become competent physicians through the following steps:

1. **Determine Eligibility**

Applications will be assessed against the minimum admissions requirements to determine eligibility. As described in the University calendar entry, applicants will have flexibility (3 options) in how they demonstrate their academic eligibility for medical study.

Note: Applicants who self-identify as Indigenous are a high-priority group and thus, will proceed throughout the remaining steps of the admissions process in an Indigenous admissions stream which will be developed in collaboration with Indigenous communities and partners.

2. **Initial File Review**

After academic eligibility has been established, the next stage of the process is the file review conducted by the admissions committee, or a delegated selection subcommittee which may include school leaders, faculty members, and members of the community. This will be guided by a standardized scoring sheet which centres applicant features of highest priority in each admissions cycle and facilitates a resource-efficient review process. This tool will be developed by the Admissions Committee and revised each year to reflect changing priorities and continuous monitoring of in-program applicant data. Work is currently underway on SFU's EDI and Diversity Survey, the outcomes of which will inform efforts to identify priority populations for the medical school over the next several months. Additional consultation with priority communities will occur to further refine priority applicant features. Once the work is complete, the process will be brought back to the SFU Senate in Spring 2025 for review and final approval. Examples of applicant features that could be prioritized include rurality, ability to speak a language of one of our priority populations, community connection with priority groups and specific work experience related to healthcare and/or social care.

3. **Equal Probability Selection (if needed):**

The initial cohort of MD students starting in 2026 is to be 48 individuals. As such, and as a matter of resource feasibility, the SFU SoM aspires to identify approximately 150 candidates to invite to a multiple mini-interview. To achieve this approximate number, the admission process may rely on equal probability selection, which describes random equally-weighted selection from a defined cohort of eligible applicants. How equal probability selection will be operationalized will be determined as a function of the number of applicants identified via the active selection described in the above File Review section. Specifically:

- If the active file review selection process results in a candidate pool less than 150 applicants, then equal probability selection will be applied to the rest of the pool of candidates in order to select 150 eligible candidates to advance to the multiple mini-interview.
- If the active file review selection process results in a candidate pool greater than 200 applicants, the equal probability selection will be applied to the pool of preferred candidates until the pool to advance to multiple mini-interview includes 150 applicants.
- If the active file review selection process results in a candidate pool between 150 and 200 applicants, then no equal probability selection will be applied. In this case, all files will be manually reviewed to select 150 candidates for interview.

As the intake cohort increases from 48 to 120 over time, these target numbers will increase accordingly.

4. Multiple Mini-Interview

Applicants who are assessed most favourably in the initial portfolio review will be subsequently invited to an admissions multiple mini-interview (approximately 140 mins with several interviewers). The multiple mini-interview prompts will be purposively constructed to appraise applicant interpersonal skills; intrapersonal qualities; learning, thinking, and reasoning; knowledge integration; communication; professionalism; orientations to patient safety; orientations to serving priority communities; and understanding of and commitment to practicing family medicine. Notably, in several instances, mini-interview prompts will request applicants to reflect on the relationship between experiences detailed in their application files (e.g., social science pre-requisites, work experiences, community connections) and medical practice and/or their aspirations for a career in medicine.

5. Holistic File Review

After the multiple mini-interview, a holistic file review will be conducted by the Admissions Committee. Applicants will be ranked, and a score will be used to determine the applicants who will be moved forward for verification.

6. Verification

The last stage will involve a collation process, wherein the information provided by those applicants earmarked for an offer of admission is verified. This will involve contacting referees and an in-depth committee-based portfolio review. Issues related to application

accuracy or integrity will prompt consideration for removal of the applicant from the offer list.

DEVELOPMENT OF THE INDIGENOUS ADMISSIONS STREAM

Dr. Evan Adams, the Associate Dean of Indigenous Health for the SFU School of Medicine, played a pivotal role in developing the Indigenous Admissions Stream from November 2023 until his departure in May 2024. Dr. Adams was an integral member of the SFU School of Medicine Admissions Working Group, ensuring that efforts to develop both the General and Indigenous admissions streams were coordinated and aligned.

Dr. Adams engaged in numerous meetings and discussions with his counterparts at various medical schools across Canada. Notably, he participated in the Indigenous Deans Virtual Meeting and the Inaugural Indigenous Deans of Medicine, hosted by the National Consortium for Indigenous Medical Education (NCIME), where challenges faced by Indigenous applicants were discussed.

After thorough deliberation and consideration of diverse perspectives, it was ultimately decided that the SFU SoM minimum admission requirements would be standardized and adopted for both the General and Indigenous admissions streams.

Internally, Dr. Adams consulted with Simon Fraser University's (SFU) Indigenous Community Circle, which was developing the University's Indigenous Welcoming Procedure, and discussed the verification supports needed for self-identification. From these consultations, he proposed that the MD Program leverage the University's Indigenous Welcoming Procedure as part of the Indigenous Admissions Stream.

The leadership team is currently actively working to fill the vacant position and build out the unit with both Indigenous and non-Indigenous positions to continue the work of developing the Indigenous Admissions stream. Furthermore, we are developing a working alliance with the First Nations Health Authority, who will be helping to guide us in the working of this Indigenous stream. Although decisions have been made around minimum admission requirements, these may still be subject to change with new leadership.

The SFU School of Medicine remains committed to upholding Truth and Reconciliation. The institution pledges that any further development of the Indigenous Admissions Stream will be Indigenous-led and informed by Indigenous communities. This approach will be guided by the recommendations put forward by NCIME, ensuring that the process remains culturally sensitive and community focused.

This ongoing commitment reflects the SFU School of Medicine's dedication to creating an inclusive and equitable environment for all applicants, increasing the number of Indigenous physicians in the province of BC, and recognizing the importance of Indigenous leadership in shaping policies that affect Indigenous communities.

MD PROGRAM ADMISSIONS PROCESS - WEBSITE CONTENT (DRAFT)

The following describes the SFU School of Medicine admissions selection process for applicants who do not self-identify as Indigenous and/or who choose to apply through the general stream. Students who self-identify as Indigenous can choose to apply through the general stream or through the Indigenous admissions stream. Details about eligibility and admissions process for Indigenous applicants are available here [Link]. Admission for initial cohorts will be largely limited to residents of British Columbia. SFU School of Medicine is committed to accommodating applicant needs throughout the admissions process. Our statement of functional competencies needed for successful completion of medical school is available [Link]. If you have a disability that needs accommodation through the application process, please contact [X].

Admissions Process

Component 1: Determine Eligibility

1.a Applicants must demonstrate they are eligible for the Medical Doctor (MD) program at SFU by providing documentation of:

- Completed four-year undergraduate degree from an accredited institution which will be completed by April 30, 2026.
- BC residency, as marked through enrollment in the BC Medical Services Plan through possession of a BC Care Card/BC Services Card
- Canadian citizenship or permanent residency
- English language competence
- Pre-requisite courses:
 - Two Social Sciences courses (6 units total, any level),
 - One Indigenous Studies course (3 units, any level). In 2026, the Indigenous Studies course pre-requisite will be a pre-enrolment requirement. Starting in 2027, the Indigenous Studies pre-requisite must be achieved by the time of application. A minimum grade of B-minus must be achieved on all pre-requisite courses. Pre-requisite courses are included in GPA calculations.
- Applicants currently enrolled in an education program beyond the required four-year undergraduate degree (e.g. Master's or PhD degree) must successfully complete that program by July 15, 2026, to enroll in medical school.

1.b Applicants will choose one of three options through which to demonstrate their academic eligibility for medical school.

- **GPA Option:** Adjusted GPA with an average ≥ 3.67 (on a 4.33 scale) calculated using the applicant's best 60 units for the last 90 units of their undergraduate degree, including at least 30 units from 300- and 400-level courses. In this eligibility option, applicants must also include additional pre-requisites in their application: two Life Sciences courses (3 units each, with at least one ≥ 200 level), with a minimum grade of B-minus or better. Pre-requisite courses are included in GPA calculations.

- **MCAT Option:** MCAT score of ≥ 505 , with ≥ 123 in each test section. This score must have been achieved in the last 5 years. If an applicant has more than one MCAT attempt, SFU will use the score on the second attempt.
- **GPA and MCAT Option:** If both scores are submitted, the GPA must be ≥ 3.33 (on a 4.33 scale) and the MCAT score must be ≥ 495 with ≥ 123 in each test section. This option uses the same stipulations on GPA calculation (although without the additional Life Sciences pre-requisites) and number of MCAT attempts as stated above.

Adjudication of Component 1:

Based on this information, applicants will be deemed either 1) eligible for medical study at SFU or 2) not eligible for medical study at SFU. This is a binary categorization; no rank order or score will be based on this information and GPA or MCAT scores will not be considered further in the process. Specifically, there is no benefit to applicants accrued by presenting a higher GPA or MCAT score than the minimums stated above.

Component 2: Alignment with Institutional Priorities

The following non-academic information will be reviewed to invite applicants who align with institutional priorities to be interviewed:

Category	Format
Personal statement	≤ 400 -word vision statement of professional aspirations for future career in medicine.
Community Involvement	List of 0-3 communities to which the candidate belongs and/or contributes. This information will be provided in a standardized form to include a short description of role, duration alongside the name and contact information of a verifying community leader. "Community" can be considered broadly, and may include affinity related to geography, socio-demographic characteristics, interest, hobby, cause or commitment.
Employment roles	List of 0-5 employment roles for which a T4 or T4A was received. This information will be provided in a standardized form to include a short description of role, job title, company, duration (dates), number of hours per week, location of work.
List of additional languages spoken	List of languages in which the applicant is fluent, prepared to practice medicine, and capable of potentially performing a portion of a prospective multiple mini-interview in.
List of 5 character references	Names, contact information, and relationship for 5 character references who may be contacted by SFU. Community verifiers may also be listed as character references. Character references should know the applicant well from educational, professional, or extra-curricular interaction. They may not be family members or friends.

Interview spots are limited. If required, an **equal probability selection** process will be used to issue interview invitations.

Component 3: Multiple Mini-Interview

Approximately 150 applicants will be invited to participate in an in-person interview process.

The interview may consist of a series of interactions (e.g. multiple mini-interviews) with faculty, staff, community members and may also require interaction with another person or group of persons or the performance of a task. The applicant will be assessed based on their responses and/or actions.

Applicants who listed fluency in languages other than English in their non-academic submission may be asked to complete at least one portion of the interview process in that language. Applicants not able to demonstrate fluency in their declared languages during the interview process will be disqualified from further consideration.

Component 4: Committee Rank Order

Based on the information generated in Components 2 and 3, a committee will assemble a rank ordered list of applicants eligible for admission. This process will include a holistic file review including non-academic characteristics and interview scores.

Component 5: Verification and Collation

All information collected through the admissions process will be verified for applicants eligible for admission. This will include contacting character references and community verifiers, and ensuring fluency of languages has been demonstrated. During this process, the rank order list may be adjusted.

Offers of admission will be issued based on the final rank ordered list. Applicants should expect to receive offers of Admission from May onwards and will be required to respond to the offer within two weeks.

ENGLISH LANGUAGE REQUIREMENTS

English is the language of communication at the University and instruction in most programs. All applicants to the MD Program will be required to have demonstrated competence in the English language prior to admission. Applicants who have completed a bachelor's degree or higher at an institution where the language of instruction and examination was in English will meet the program's English language requirement.

Applicants who complete a bachelor's degree at an institution where the language of instruction and examination is not English must demonstrate English language competence through one of the following options:

Minimum Test Scores:

Internet-based TOEFL	93 with minimum of 20 in each category. TOEFL MyBest (super-scored) or TOEFL Essentials results will not be used. TOEFL iBT Home is accepted.
Paper-based TOEFL	580 AND TWE 5
IELTS (academic)	Overall band score of 7.0 of the academic (NOT general) test with a minimum of 6.5 in each section
CAEL	Overall 70; minimum 60 in each section
Pearson Academic (PTE)	Overall 65; minimum 60 in all of their sections
Cambridge English Qualifications	C1 Advanced - minimum score of 193 C2 Proficiency - minimum score of 200
Duolingo English Test (DET)	Provisionally through the Fall 2026 admission cycle: Duolingo English Test (DET) 130 overall with a minimum of 120 in each section

All test scores are valid for a period of two years from the date of the test.

Note: The requirements above are not currently listed in the SFU SoM calendar section but will be part of the package returning to Senate in the Spring for inclusion.

PRE-REQUISITE COURSES FOR ADMISSION

INDIGENOUS STUDIES COURSE

The SFU School of Medicine recognizes that understanding Indigenous cultures, histories, and perspectives is essential for fostering culturally competent and equitable healthcare. Therefore, applicants seeking admission to the MD Program must complete at least one Indigenous Studies course (minimum 3 units) that:

- Focuses on the history, culture, languages, knowledge systems, and contemporary issues of Indigenous peoples.
- Is designed and taught from Indigenous perspectives, involving Indigenous scholars, elders, and/or community leaders.
- Demonstrates a commitment to decolonization.

Course Examples (From SFU)

- INDG 101 – Introduction to Indigenous Studies
- INDG 110W – International Indigenous Lifewriting
- INDG 201W – Indigenous People’s Perspectives on History
- INDG 210 – Introduction to Indigenous Digital Media
- INDG 211 – Researching Residential Schools: An Analysis of RS in North America
- INDG 232 – Introduction to Ethnoecology in Indigenous Studies
- INDG 250 – Introduction to Indigenous Policy
- INDG 286 – Indigenous Peoples and British Columbia: An Introduction
- INDG 305 – Treaties in Canada
- INDG 325 – History of Aboriginal Peoples of North America to 1850
- INDG 333 – Indigenous Ethnozoology
- INDG 360 – Popular Writing by Indigenous Authors
- INDG 401 – Indigenous Peoples and Public Policy
- INDG 419 – Aboriginal/Indigenous Justice
- INDG 433 – Indigenous Environmental Justice and Activism

BC applicants can use the [BC Transfer Guide](#) to find evaluated courses at their home institution.

The SoM will be consulting with departments and faculties at SFU to expand this list. Additionally, the School of Medicine will collaborate with Indigenous communities and other Post-Secondary Institutions to provide additional options for applicants to fulfill this requirement.

Potential options currently being explored in the event that applicants do not have an Indigenous course option available at their home institution include:

Organization	Course Name	Notes	Hrs of Commitment
Athabasca University	INST 203 – Indigenous Studies https://www.athabascau.ca/syllabi/inst/inst203.html	\$1,163.50, for a person taking who has never taken a course at AU	n/a
PHSA	San'yas Anti-racism Indigenous Cultural Safety Training Program https://sanyas.ca/core-training/british-columbia	~\$300	10 hrs
U of A (Coursera)	Indigenous Canada, developed by the University of Alberta https://www.coursera.org/learn/indigenous-canada	Free to enroll, modest fee for completion certificate	24 – 36 hrs
UBC (EdX)	Reconciliation Through Indigenous Education https://pdce.educ.ubc.ca/reconciliation-2/	Free to enroll (\$50 USD completion certificate)	12 – 24hrs
U of T (Coursera)	Aboriginal Worldviews and Education https://www.coursera.org/learn/aboriginal-education#		13hrs

SOCIAL SCIENCE COURSES

The SFU School of Medicine encourages applicants to pursue a comprehensive undergraduate education that includes the study of social sciences. The inclusion of social sciences courses is beneficial for the study of medicine as it helps to:

- Build knowledge and understanding of the complexities of social systems and diverse world views; to help students navigate and influence societal challenges around the world.
- Develop understanding of how social scientists think, analyze issues, interpret evidence, and draw conclusions, enabling students to recognize and critique the issues that define contemporary societies.
- Prepare students to make connections between their field of study and the broader contexts of human society. To equip students with transferable skills in social critique, evaluation, and the synthesis of knowledge and understanding.

Applicants seeking admission to the MD Program must complete 2 transferrable Social Science Courses (minimum 6 units total, any level).

Subjects that may be used towards meeting the Social Sciences requirement include:

Archaeology

Critical Thinking

Criminology

Economics

Education

Gender Studies

Geography

History

Indigenous Studies

International Studies

Labour Studies

Linguistics

Political Science

Psychology and Cognitive Science

Sociology and Anthropology

SFU Medical School Admission

Supporting Evidence and Recommendations

Minimum Admissions Requirements Preamble

In designing the minimum admission requirements for the SFU Medical School, it was imperative to take a values-based approach and recognize the diverse paths individuals may take to pursue a career in medicine, including the various barriers they may encounter. Careful consideration was given to the inherent challenges associated with both the Medical College Admission Test (MCAT) and Grade Point Averages (GPAs). To address this, the school offers three application options:

1. GPA Option
2. MCAT Option
3. GPA + MCAT Option

These options allow the SFU Medical School to strike a balance between maintaining a degree of open access to applicants while selecting for a predetermined level of demonstrated academic rigor. It is acknowledged that this is the first iteration of the minimum admissions requirements, and the Medical School is committed to the ongoing review of applicant and matriculant data to inform the refinement of admissions policies and processes that align with our program goals, with potential for the development of additional pathways to ensure equitable access to medical education for qualified candidates.

THE SFU MEDICAL SCHOOL ADMISSIONS CONTEXT

All admissions systems are institutionally unique, responsive to the specific influences, communities, politics, and laws that govern the local context. The SFU Medical School Admission System is no different, beholden to institutional values and priorities that will guide its development.

The medical school has articulated a commitment to the following foundational values:

- **Curriculum and Learning Experiences aligned with Generalism:** Creating, delivering and continually improving medical education with a focus on the core values of Generalism while supporting learning that delivers to future clinicians and scholars in Family Medicine
- **Scholastic Excellence:** Developing education that promotes medical student success across the full range of relevant assessments and tests of knowledge including those that occur outside of or subsequent to undergraduate training (i.e., residency match, licensing, certification, continuing professional development).
- **Professional Excellence:** Developing education that promotes medical student achievement of skill, knowledge, and attitude across the full range of medical competencies (i.e., leadership, professionalism, advocacy, scholarship, communication, collaboration, medical expertise).
- **Equity, Diversity, Inclusivity, Accessibility, and Indigenous Reconciliation (EDIA-IR):** Ensuring people from a broad set of sociodemographic and cultural backgrounds are represented and able to thrive in the medical school and ensuring that the organization's actions and services to the public contemplate the needs and desired outcomes for all.
- **Defensibility:** Ensuring policies and practices are legal and justifiable.
- **Transparency:** Ensuring that the policies and practices that define educational operations at the medical school are clear to members of the university community and public.

- **Resource Efficiency:** Creating education systems that optimize the use of financial, space, and human resources available to the medical school.
- **Institutional Concordance:** Aligning and harmonizing education policy and practice with the broader pan-Canadian medical education landscape.

These values are reflected through a series of stated admissions priorities:

1. To identify and admit applicants who will be successful in medical school and become competent clinicians.
2. To develop medical education that serves the Fraser Health Region and other BC residents, particularly communities/populations who are underserved.
3. To admit applicants who are committed to pursue family medicine and other generalist specialties especially in team-based, community care settings.
4. To advance health care delivery by admitting and educating applicants who show a commitment to a team-based culture and work model.
5. To design an admissions process which will balance the need to identify applicants who have high motivation, academic ability and a commitment to inclusive, accessible and culturally safe care.
6. To welcome those communities and applicants who have been and continue to be underrepresented in medicine, especially Indigenous learners.
7. To ensure defensibility throughout.
8. To be grounded in, and continually improved from, evidence and emerging sector-wide best practices.

THE ADMISSIONS POLICY EVIDENCE LANDSCAPE

Admissions policies can be conceptualized within a two-part hierarchy consisting of admissions criteria and admissions procedures. Each category is composed of options, each of which is regularly associated with the perceived inculcation of specific values into the selection process. The most foundational selection policy category describes **admission criteria**, or the aspirant-level data that are requested and/or generated in any admissions process.

There are three main types:

- Academic criteria: Data pertaining to performance in previous periods of training, typically including permutations of the undergraduate grade point average (GPAs) and performances on standardized tests and key examinations. Academic criteria are espoused in the literature for the way they promote **scholastic excellence** within selection decisions (Siu & Reiter, 2009; Ferguson et al., 2002; Kreiter & Kreiter, 2007; Donnon et al., 2007).
- Non-academic criteria: Data pertaining to experiences accumulated by the aspirant prior to application, reflecting activities, life experiences and engagements outside of previous training. These are usually distilled via written statements of interest, interviews, situational judgement tests, and letters of reference, which are designed to illuminate applicant attributes, character, and features that may contribute to their ability to learn and practice medicine. Non-academic criteria are also described as promoting **professional excellence** within selection decisions (Siu & Reiter, 2009; Eva et al., 2004; 2009; Reiter et al., 2007; Albanese et al., 2003; Salvatori, 2001).
- Social accountability criteria: Data pertaining to applicants' social identity and lived experience. This includes data regarding applicant gender, sex, race, social economic status, (dis)ability, and rural or provincial residence. These data are championed within selection decisions for the way they promote medical student **diversity** and **accessibility** to the profession (Boelen and Wollard, 2009; Mullan et al., 2010; Ellaway et al., 2018).

In the second policy category, admission criteria are operationalized within **admissions procedures**. These are the ways in which the aspirant-level data are used to select individual candidates. Each admissions procedure can accommodate each type of criteria, either on its own or in combination with other criteria.

There are 4 main types:

- Actuarial methods: Procedures that involve mathematical processes to synthesize information to generate admission decisions. These processes are valued for their **legal defensibility**. However, they have been criticized because they do not always value **comprehensiveness** (i.e., holistic review) in selection (Martinho, 2012; Soemantri et al., 2020; van der Merwe et al., 2015; Terregino, 2015; Quinlivan et al, 2010; Dawes, 1979; Kreiter & Kreiter, 2007; McGaghie & Kreiter, 2005).
- Committee appraisal: Procedures that involve group review of applicant criteria to generate selection decisions. A committee often involves faculty, physicians, community members, and medical students. Committee appraisal is nearly always used to appraise non-academic criteria in combination with academic and/or social accountability criteria. These processes are valued for their **legal defensibility** and the way they promote **diversity** and **accessibility**, whereby review is conducted so

as to consider the many ways an applicant might be suitable for medicine and the learning environment. However, committee appraisal has been criticized because it is often less associated with downstream **scholastic excellence** than actuarial methods (AAMC, n.d.; Jerant et al., 2015; Kennedy et al., 2020; Zupanic et al., 2019; Witzburg & Sondheimer, 2013; Kreiter et al., 2018; Roadmap to Diversity and Educational Excellence, n.d.).

- **Lottery**: Procedures that utilize a weighted system in which an applicant's chances for admission increase in parallel with some criteria. Lotteries are valued for their **legal defensibility**, **resource-efficiency**, **fairness**, and the way they promote **accessibility**. All applicants are eligible to participate and have a chance of obtaining admission to medical school. Lottery systems may be used to widen access to medical school, but there is no guarantee of this outcome, and it will not assist widening access when the applicant pool is homogeneous. Evidence that lotteries promote or hinder **scholastic excellence** is equivocal (Schreurs et al., 2018; Oates & Goulston, 2012; Stasz et al., 2007; Wouters et al., 2018; Mulder et al., 2022).
- **Quotas**: Procedures that allocate seats for applicants of certain identities by the medical school. Quotas may be set based on region, race, or expressed intention to practice in underserved regions (Chiu, 2018; Matsumoto et al., 2016; van der Merwe et al., 2015; Grierson & Vanstone, 2021). Quotas always involve social accountability and academic data and may or may not also involve non-academic data. Quotas are valued for promoting **diversity** and **accessibility** (Hay et al., 2017; van der Merwe et al., 2016). Quotas do not always promote **institutional reputation (public perception)** - these procedures are often poorly perceived by individuals outside the target group (Harrison et al., 2006; Shaughnessy et al., 2016).

EVIDENCE FOR ADMISSIONS CRITERIA AND PROCEDURES MAPPED TO SFU VALUES

Value	Criteria	Procedures
EDIA-IR	Promoting: <i>Interviews, Personal Statements</i> Hindering: <i>GPA, MCAT</i>	Promoting: <i>Quotas, Committee-based Appraisal</i> Hindering: <i>Actuarial Methods</i> Equivocal: <i>Lotteries</i>
Scholastic Excellence	Promoting: <i>Academic Criteria Situational Judgement Tests, Interviews, MCAT</i>	Promoting: <i>Actuarial Methods</i> Hindering: <i>Committee-based Appraisal</i>
Professional Excellence	Promoting: <i>Interviews, Situational Judgement Tests, Experiences with 3rd party verification</i>	Promoting: <i>Committee-based Appraisal</i> Hindering: <i>Actuarial Methods</i>
Defensibility	Promoting: <i>Academic, Non-academic, Social Accountability (Pathways & Special Streams)</i>	Promoting: <i>Actuarial, Committee-based Appraisal, Lotteries, Quotas</i>
Transparency	-	-
Resource Efficiency	Promoting: <i>Academic Criteria</i> Hindering: <i>Interviews</i>	Promoting: <i>Actuarial Methods, Lotteries</i> Hindering: <i>Committee-based Appraisal</i>
Institutional Concordance	<i>All schools in Canada use or have used a combination of the criteria described</i>	<i>All schools in Canada use or have used a combination of the procedures described</i>

TENSIONS

The ways in which the options within and across admissions policy categories are organized relative to one another has the potential to offset or amplify the values inherent to each; such that the values that inform any one selection decision do not necessarily reflect an additive function of the values associated with the specific criteria or procedures that underpin it. This can lead to tensions between components of admissions systems designed to meet interrelated but parallel aims.

For instance, a **fair** admission system is one that is just, impartial, and reasonable. Many systems operationalize this value of fairness through the principle of **equality**, treating people in a manner that is free from unwarranted bias, discrimination, and favoritism by adhering to rules, standards, or principles that are applied consistently to all applicants regardless of their background, status, or circumstances (Lamont and Favor, 2017). This focus on equal application of the same rules to all, however, may not result in a system which widens access and increases the diversity within a class. Other systems operationalize **fairness** according to the principle of **equity**. These systems acknowledge that some applicants face structural inequities that constrain their opportunity to demonstrate merit (*vis-a-vis* scholastic and professional excellence). An admissions process that strives to be inclusive in order to admit a diverse class may need to take into consideration the specific needs, circumstances, and conditions of individuals or groups (De Freitas, Grierson, Vanstone 2019). An equitable system may need to be designed in a way which recognizes that different people have different starting points and face different barriers or advantages in the way they are able to demonstrate their achievements. An equitable approach would be one which distributes resources and opportunities in a manner that accounts for these differences.

There is a tension here between different definitions of fairness as either equality (applying rules consistently to all applicants) and equity (distributing resources and opportunities in a manner that accounts for differential opportunities to demonstrate merit). Research evidence may sometimes be silent on how they are conceptualizing fairness, requiring interpretation to whether the implicit operationalization of “fair” corresponds more closely to notions of equity or equality. Further to this, admissions scholars typically discuss the success or utility of an admissions criteria or procedure by assessing the **validity** of the purported relationship between the associated values and/or priorities and the outcomes of the admissions process (e.g., downstream student success, professionalism issues, class diversity, etc.). However, validity interpretations can be threatened by many factors, including measurement bias that results when different groups have the same level of ability but produce different scores on the measurement (Woo et al., 2023). For example, evidence showing that undergraduate GPA and MCAT performances are correlated with MCCQE Part 1 scores lends validity to the use of these measures in selecting students who are likely to pass their qualifying examinations (i.e., promoting **scholastic excellence**). However, that research also reveals differential attainment in MCAT scores as a function of applicant social identity features suggests that the tool does not contribute to an inclusive system that potentiates class diversity (i.e., hindering **EDIA-IR**). When examining measurement differences such as these, one must also determine whether they reflect differences in the ability of test-takers at the time they took the test. In the case of the MCAT, the evidence suggests that differential attainment results as a function of pervasive structural inequities inherent across society rather than emanating from a biased examination (Girotti et al., 2020; Davis et al., 2013).

To achieve all priorities, the medical school must thus develop a selection system that accentuates the ways in which criteria and procedures promote some values while offsetting the ways in which these same criteria and procedures hinder others. This optimization can be achieved through comprehensive appraisal of evidence, which helps decision-makers localize the source of tension (e.g., structural inequity in society vs bias within a test) and gives way to thoughtful mitigating strategies. In this regard, tensions spur thought, consideration, debate, and communication and do always impede schools from determining solutions that emphasize all priorities. In review of the SFU admissions landscape, one key tension stands out as especially salient: **Balancing commitments to EDIA-IR and selecting medical school students who have the potential for scholastic excellence and professional excellence in a resource-efficient manner.** In the section that follows, we consider the validity evidence associated with these priorities as it pertains to five “*in tension*” admissions criteria discussed at length in recent working group meetings: GPA, MCAT, MMIs, Personal Statements, and Prerequisite Courses. In addition to considering validity evidence related to the priorities, we also speculate on the presumed upstream impacts these criteria can have on aspiring medical students, highlight relevant balancing perspectives, and offer mitigating strategies that can be employed to offset the tension and achieve balance.

1. Grade Point Average

- **Evidence pertaining to scholastic excellence:** Numerous studies are explicit in highlighting the way in which GPA data are predictive of downstream success in medical training (Ellis, 2022; Siu & Reiter, 2009; Ferguson et al., 2002; Kulatunga-Moruzi & Norman, 2002; Kreiter & Kreiter, 2007; Donnon et al., 2007; Salvatori, 2001). Both the 2011 and 2018 Ottawa Consensus Statements on medical school selection note that “*prior academic attainment remains a universal feature of selection policies internationally and the strength of this evidence is strong*” (Patterson 2018). However, the strength of this evidence may be weakened by advancing grade inflation and institutional differences.
- **Evidence pertaining to professional excellence:** There are studies that have shown higher admissions GPAs are associated with fewer professionalism issues in training (Barber et al., 2022) and better clinical performances (Kulatunga-Moruzi & Norman, 2002).
- **Evidence pertaining to EDIA-IR priorities:** Research evidence highlights the way in which GPA is a social construct that reflects the systemic forms of oppression inherent throughout society. This is highlighted in evidence that shows differential attainment in GPA as a function of social identity features (Davis et al., 2013; Girotti et al., 2020; Lucey & Saguil 2020).
- **Implications for resource efficiency:** GPA criteria can be processed with relatively few resources. This is especially so when processed via actuarial methods.
- **Potential upstream impacts:**
 - Reliance on highest GPA measures will lead aspiring medical students to favour courses, programs and institutions that are perceived as easy to get good grades, unnecessarily repeat passed courses, and to do this at the expense of their personal interest, learning goals, or undergraduate training that would be beneficial to the profession (e.g., humanities).

- Reliance on highest GPA measures will lead aspirants in the same undergraduate programs to adopt a competitive, rather than a collaborative, attitude relative to one another.
 - Reliance on highest GPA measures will lead aspiring medical students to concentrate maximal time and energy on achieving high grades, rather than on paid employment, caregiving, athletics, arts, or well-being related activities that contribute to community, wellness, and society.
 - When GPA calculations are restricted to full course load semester, students will not reduce their course loads in legitimate times of need.
- **Balancing perspectives:**
- Meritocracy in this literature is conceptualized in terms of denoting who is most deserving of the reward of admission, rather than indicating which applicants have the capacity for success in medical school and the profession.
 - The validity evidence is challenged by differential standards across institutions, programs, and classes. Identical GPAs do not mean identical capabilities.
 - GPAs are generated for every undergraduate student, so do not pose any additional application barriers. That is, they do not need to study for, travel to, or prepare for an additional test.
 - Permitting GPA calculations on a reduced course load “with explanation” demands applicants to disclose potentially traumatic and distressing personal information to admissions committees without an understanding of how that information is processed or protected.
- **Mitigating strategies:**
- Adopt a conceptualization of merit that emphasizes the candidate’s suitability for medical school and the profession rather than one which emphasizes relative differences between candidates. This would involve prioritizing candidates who present a GPA that crosses a predetermined threshold rather than the candidates with the highest GPAs.
 - Afford GPA calculations on a subset of credits or undergraduate prerequisites (i.e., some credits count or do not count in the GPA calculation).
 - Do not require a full course load for GPA calculations.
 - Allow applicants to demonstrate their capacity for scholastic and professional excellence via a variety of methods.
- **Concordance with other Canadian Medical Schools:**
- Most Canadian medical schools publish a minimum GPA in their calendar which is well below the average GPA of a successful applicant. This is because many schools process GPAs via actuarial methods that imbue higher GPAs a greater advantage in determining the outcome. Therefore, published minimums are not reflective of the decision-making process.
 - In terms of minimums, Memorial publishes no minimum. Dalhousie (local applicants), Manitoba, McMaster, NOSM, Queen’s University of Alberta (local applicants), University of Calgary (local applicants) and UBC publish a GPA minimum between 3.0 and 3.3. McGill (PQ residents), University of Alberta (other provinces) and Ottawa publish a 3.5 minimum GPA. UBC (other provinces), Calgary (other provinces), University of Toronto, Saskatchewan, Western, Dalhousie (other provinces), and McGill (other provinces) have GPA minimums of

3.6 and above. (see table below):

No Minimum	Minimum 3.0 - 3.3	Minimum ≥ 3.5	Minimum ≥ 3.6
Memorial	DAL (local) U of Alberta (local) U of Calgary (local) UBC (local) Manitoba McMaster NOSM U Queen's	McGill (local) Ottawa U of Alberta (out of province)	U of Calgary (out of province) UBC (out of province) DAL (out of province) U of T Saskatchewan Western

- Many schools operationalize different GPA minimums for different populations, typically requiring lower GPAs from residents of their own/partnered provinces, active Canadian Forces members, Indigenous applicants, or graduates of associated pre-medical preparation programs.

2. MCAT

- **Evidence pertaining to scholastic excellence:** It is well-established that the MCAT predicts performance on pre-clerkship, graduation, and licensing exams (Prideaux et al., 2011, Paterson et al., 2018, Donnon et al., 2007, Hanson et al., 2022; Salvatori, 2001).
- **Evidence pertaining to professional excellence:** Students selected using a standardized aptitude test similar to MCAT were less likely to drop out of medical school than those selected during a period of time and more likely to graduate within one year of their expected graduation date, suggesting that MCAT scores are an effective way of selecting students prepared for the nature of medical study (Kraft et al., 2012; Hanson et al., 2022). MCAT Verbal Reasoning score is predictive of downstream communication skills (Kulatunga-Moruzi & Norman, 2002).
- **Evidence pertaining to EDIA-IR priorities:** Many commentaries criticize the MCAT for favouring certain types of candidates, while meta-syntheses of evidence point to the equivocal nature of this proposition and the need to add additional nuance (Cleland et al., 2023, Prideaux et al., 2011, Patterson et al., 2015, Patterson et al., 2018, Hansen et al., 2023; Lucey & Sagueil 2020). Rather than questions on the test, other features associated with the MCAT (e.g., examination fees; the need to travel to testing centres) are recognized barriers for low-income, rural, and remote applicants (De Freitas et al., 2021).
- **Implications for resource efficiency:** MCAT criteria can be processed with relatively few resources. This is especially so when processed via actuarial methods.

- **Potential upstream impacts:**
 - Reliance on highest MCAT measures will lead aspiring medical students to dedicate time and resources to MCAT studying at the expense of other activities (e.g., paid employment, community engagement, socialization, wellness).
- **Balancing perspectives:**
 - Meritocracy in this literature is conceptualized in terms of denoting who is most deserving of the reward of admission, rather than indicating which applicants have the capacity for success in medical school and the profession.
 - While MCAT scores do reveal differential attainment, the differences between applicant groups are smaller on the MCAT than other measures of academic performance (i.e., GPA). The predictive validity of the MCAT is comparable for students from different genders, races, and socioeconomic statuses (Busche et al., 2020; Hansen et al., 2023). Both findings suggest that while both tools are reflecting the impacts of structural oppression, the MCAT may counter these effects more strongly (Davis et al., 2013; Girotti et al., 2020; Lucey & Saguil 2020). This has been found in examinations of other standardized tests, which show that students from economically disadvantaged high schools or who encountered personal circumstances that resulted in lower GPAs have an opportunity to demonstrate their academic aptitude and gain entrance into competitive undergraduate institutions through high standardized test scores (Chetty, Deming & Friedman, 2023).
 - Certain ways of appraising the MCAT (e.g., valuing absolute highest score, allowing unlimited re-takes) can exacerbate inequities by privileging those with significant resources to deploy in achieving very high scores (Faiz et al., 2023).
 - Most Canadian aspiring medical students apply to >2 medical schools (AFMC, 2021), and we anticipate that many SFU applicants will also apply to UBC. Given that UBC, like other existing Canadian schools targeting English-speaking applicants, requires some portion of the MCAT, it is likely that most applicants will write regardless of whether it is an SFU Medical School admission requirement.
- **Mitigating strategies:**
 - Adopt a conceptualization merit that emphasizes the candidate's suitability for medical school and the profession rather than one which emphasizes relative differences between candidates. This would involve prioritizing candidates who present a MCAT score that crosses a predetermined threshold rather than the candidates with the highest MCAT scores.
 - Allow applicants to demonstrate their capacity for scholastic and professional excellence via a variety of methods.
 - Establish a policy to review only the most recent of multiple test scores or that limit admissions review to only the first or second attempt.
 - Provide fee assistance and preparatory courses for applicants in need.
- **Concordance with other Canadian Medical Schools:**
 - The current 11 Canadian medical schools targeting English applicants require the MCAT.
 - McMaster requires only the CARS (critical analysis and reasoning skills) section of the MCAT.

- French-language schools and schools serving Francophone patient populations (Laval, Montreal, Sherbrooke, McGill, Ottawa, NOSM) do not require the MCAT.
- Of the schools requiring MCAT scores, there are a wide variety of approaches to minimums. Some schools do not have a minimum MCAT score, or do not have a minimum MCAT score for preferred populations (i.e., in-province applicants, Indigenous, Armed Forces).
- Some MCAT minimums are relevant to a total score (e.g., Saskatchewan = 492, Dalhousie = 503). Others operationalize a minimum related to scores in each section; typically, between 124 and 128 and sometimes with one section allowed to be lower than others.
- Some schools do not publish their minimums (e.g., Queen's).
- Until 2024, the MCAT was optional at McGill who stated that a cumulative 508 score was competitive.
- Dalhousie has a unique system of calibrating MCAT and GPA scores on a sliding scale, which is different for in-province and out-of-province applicants.
- 6 schools have recency requirements for MCAT scores (within 5 years), others are silent on this requirement. Western only considers the most recent MCAT score.
- The Association of Faculties of Medicine of Canada (AFMC) has recently published a position statement against the use of the MCAT.

3. Prerequisite Courses:

- **Evidence pertaining to scholastic excellence:** There is substantial research evidence supporting the importance of fundamental science education in the development and application of clinical reasoning, particularly in very difficult, complex, or ambiguous cases (Bandiera et al., 2018, Castillo et al., 2018, Lisk et al., 2016, Kulasegaram et al., 2013, Norman et al., 2005, Woods et al., 2006, Woods 2007). In more recent years this literature has been extended to demonstrate the utility of foundational knowledge from behavioural and sociological sciences to support learning and performance in complex health systems (Chaudhary et al., 2019).
- **Evidence pertaining to professional excellence:** Research suggests that training in epistemology, culture, justice, and power supports the achievement of competence in roles beyond medical expert (Kuper et al., 2017).
- **Evidence pertaining to EDIA-IR priorities:** There is evidence that physicians can be trained to be strong health advocates through foundational education relevant to the social determinants of health and health equity (Hansen et al., 2023, Kumagai et al., 2018).
- **Implications for resource efficiency:** There is no comprehensive evidence base describing the resource implications of reviewing course prerequisites.
- **Potential upstream impacts:**
 - Aspiring medical students will take courses in defined prerequisites.

- **Balancing perspectives:**
 - Prerequisites requirements can be confounded by GPA minimum thresholds. Grades for humanities, philosophy, and language courses are often generated via variable scoring methods that rely on the subjective perspectives of instructors and teaching assistants. These courses are often avoided by aspiring medical students because of the difficulties this approach poses to assuring a strong mark.
- **Mitigating strategies:**
 - Require prerequisites that are not necessarily included in the GPA calculation.
- **Concordance with other Canadian Medical Schools:**
 - No Canadian medical school specifies a particular type of degree.
 - A completed four-year degree is required by Alberta, Saskatchewan, Manitoba, Western, NOSM, McGill, and Memorial. Three years of study, degree completion not necessary, is required by UBC, McMaster, Toronto, Queen's, and Ottawa. Dalhousie requires a completed degree but does not specify whether a three- or four-year degree is preferred. Calgary requires two years of study at the time of application.
 - There is a great deal of variance in the pre-requisite courses required by comparable institutions, although there is one clear pattern. Six schools (NOSM, Ottawa, Laval, McGill, Montreal, Sherbrooke) do not require the MCAT. Five of these schools require a long list of pre-requisites related to Biology, Chemistry, Mathematics, Physics. No school which requires the MCAT has any pre-requisites related to these topics. We can assume that MCAT-requiring schools have evaluated the MCAT to be demonstration of foundational knowledge in these areas. Some of these schools (e.g., Montreal) specify that requirements can be waived if a degree is achieved in sciences or natural sciences.
 - Some schools require pre-requisites in other topics. UBC requires 2 English courses; Toronto requires 2 Life Sciences, 1 Social Science, Humanities or Language course; Calgary requires an online Indigenous course offered by Coursera.

4. Multiple Mini-Interviews (MMI)

- **Evidence pertaining to scholastic excellence:** The MMI has been demonstrated to be a reliable assessment tool, with scores highly correlated with MCCQE performance (Eva et al., 2004; Eva, 2009; Knorr & Hissbach, 2014).
- **Evidence pertaining to professional excellence:** MMI scores are highly correlated with clinical performance (Reiter, 2007). However, MMI scores are not predictive of remediation for academic or professionalism challenges (Barber et al., 2022).
- **Evidence pertaining to EDIA-IR priorities:** High MMI scores are associated with being a woman, and aged 25 to 29 (Leduc et al., 2017). Indigeneity, rurality, being an English-language learner, and coming from a lower socioeconomic background are also associated with lower scores (Rees et al., 2016; Kelly et al., 2014; Jerant et al., 2015; Leduc et al., 2017).

- **Implications for resource efficiency:** MMIs are expensive and resource intensive to mount. They require significant human and financial resource from both the institution and the applicant.
- **Potential upstream impacts:**
 - Aspiring medical students will engage in interview preparation exercises. As with other commonly used medical school admissions tests, there is an industry of MMI preparatory courses, although their utility is questionable.
 - Aspiring medical students will orient their preparation around the values and constructs that they expect to resonate in the interview. MMI stem creation is thus a mechanism to influence pre-application behaviour and attitudes.
- **Balancing perspectives:**
 - MMI stems can be contextualized and deployed to assess unique locally relevant attributes (e.g., communication, ethical reasoning, and critical thinking skills). The precise characteristics assessed are malleable, with significant room for each school to design an MMI process that prioritizes the assessment of characteristics valued by that program.
 - The MMI is not a single instrument, it is a technique or a process that has a high degree of customizability by each individual program. Therefore, it is possible that the schools where disadvantage is observed have constructed the MMI to inculcate that disadvantage.
 - Candidates prefer MMIs. Survey responses from McMaster 2020 applicants who did not engage in the expected MMI due to the COVID-19 pandemic indicate that candidates dedicate significant resources to preparation and perceive the MMI as an opportunity to show the medical school “*who they really are*” as people (Grierson et al., *under review*).
 - The MMI can serve a mutual recruitment purpose, with the school having an opportunity to showcase their values and resources to applicants they hope will accept their offer.
- **Mitigating strategies:**
 - Limit the conduct of MMIs to later stages of the admission process, reducing the overall number of candidates that interview.
 - Offer MMIs synchronously, either over virtual platforms or in person. The proliferation of generative AI technology can challenge the integrity of asynchronous virtual MMI assessments.
 - Maximize inclusivity through stem creation and rater selection and training in an effort to reverse observed findings of disadvantage for Indigenous, rural, and English-language learning applicants.
- **Concordance with other Canadian Medical Schools:**
 - All existing schools have some form of interview. For most (14/17), that includes an MMI either as part of another interview process or the entirety of the interview process.
 - Western and Ottawa do a panel interview. Toronto has developed their own modified version of the MMI.

5. Personal Statements

- **Evidence pertaining to scholastic excellence:** There is evidence that personal or autobiographical statements are not predictive of academic success in medical school. (Ferguson et al., 2000, Albanese et al., 2003, Patterson et al., 2018), which may reflect that personal statements seldom focus on academic attributes. That said, personal statements do provide an opportunity to detail research achievements and awards which reflect an applicant's academic performance (Yang et al., 2022).
- **Evidence pertaining to professional excellence:** There is very little evidence supporting the predictive validity of personal statements on professional performance (Patterson et al., 2018, Prideaux et al., 2011). Particularly, personal statements have not been shown to predict performance in clinical environments (Dong et al., 2013; Kreiter & Axelson 2013).
- **Evidence pertaining to EDIA-IR priorities:** While personal statements do not necessarily request applicants to provide information about their social identities, they do provide ample opportunity for applicants to provide this information if they choose. This can take the form of a prevalent focus on descriptions of community engagement or reflections on barriers overcome. We could not locate any evidence on whether the use of personal statements widens access to medical school or results in more diverse medical school classes.
- **Implications for resource efficiency:** There is no consensus on how to evaluate these documents (Kulatunga-Moruzi & Norman, 2022), with institutions typically creating idiosyncratic systems that require significant human resource.
- **Potential upstream impacts:**
 - Personal statements encourage applicants to seek out experiences they think will “stand out” on applications. Sometimes this may encourage pro-social behaviour such as volunteering for important causes. Sometimes this may encourage anti-social behaviour such as lying (White, 2011, White, 2012) or participating in volunteer work that they are not truly committed to or do not perform in an adequate way.
- **Balancing perspectives:**
 - Candidates tend to appreciate this aspect of the admissions process and acceptability is high (Patterson et al., 2018).
 - Personal statements are susceptible to coaching, AI, and plagiarism which means they may advantage applicants with more resources (Siu & Reiter 2009, Wright 2015, White et al., 2012).
 - Evaluations of reliability in the scoring of these statements has been damning, with little inter-rater reliability demonstrated across multiple studies in multiple institutions (Albanese et al., 2003, Dore et al., 2006).
 - Applicants who have social capital (e.g., connections in the medical field) can use this to gain access to experiences which may be seen as valuable or legitimate by assessors (Wright, 2015), and which may not be available to less-resourced applicants (De Freitas et al., 2021).

- Efforts to construct strong personal statements might inspire behaviour which negatively impacts others. (Taylor et al., 2023). For instance, shadowing physicians is a very common activity that personal statements encourage (Taylor et al., 2023). This activity is more readily available to those with existing connections in the medical field, and which may not be helpful to the shadowed physician or may jeopardize patient comfort and confidentiality. Global health experiences are also commonly pursued in order to construct a strong personal statement. These experiences are also available to candidates with a high level of financial resource and little responsibility at home. They may remove paid work opportunities for local folks while also reinforcing colonial saviour tropes (Naidu, 2021).
- **Mitigating strategies:**
 - Construct clear prompts for verifiable information that reduces reliance on narrative self-report.
 - Explicitly describe the types of activities and relationships that are valued (and not valued) by the institution.
- **Concordance with other Canadian Medical Schools:**
 - Personal statements are the main way that non-academic qualities are assessed in Canada. They are used by almost all medical schools; Manitoba and McMaster are the exceptions. This category exhibits the most variance across Canadian medical schools and is typically the *least transparent* about how this information will be evaluated. The request for an autobiographical sketch with defined categories (e.g., employment, non-academic experience, research, awards) is common. A few schools require short essays about experiences, sometimes formed around question prompts.
 - The Quebec schools require the submission of a CV, formatted to a preferred template.
 - NOSM requires information about rural residence and identities which contribute to a “context score” alongside the autobiographical sketch.

SELECTING FOR INTEREST IN FAMILY MEDICINE

Research highlights that admission policies and selection approaches can be an important determinant of student likelihood to pursue a career in family medicine. Applicants who self-identify an interest in primary care and who grew up with a rural background are more likely to enter primary care, with stated interest in primary care being most predictive (Campos-Outcalt et al., 20024, Martini et al., 1994, Kost et al., 2015, Owen et al., 2002, Schierbel et al., 1996, Senf et al., 2005, Senf et al., 1997, Raleigh et al., 2022, Xu et al., 1996, Xu et al., 1997, Mitra et al., 2018). Through the purposeful collection and consideration of data pertaining to applicant origin and stated preferences for primary care practice, we may admit a cohort of students that improves the downstream interest in family medicine. Similarly, we may also include appraisal of attitudes towards and understanding of the importance of primary care and generalism, regardless of stated preference for a career in family medicine, as part of the applicant review process. In doing so, we may also better promote the matriculation of physicians engaged in all forms of specialist care who share our vision of generalism and active interdependence. These data may be collected via purposively constructed MMI prompts or through the implementation of a personal essay criteria. Similarly, MMI prompts and/or personal essays could be used to assess applicant understanding of and commitment to generalism. It is important here to articulate that improving graduate willingness to provide care to underserved communities should not stand as a justification for enhancing diversity in the medical profession. Rather, equitable admissions systems, in and of themselves, are a categorical imperative of our program. We value fairness and human dignity for all, regardless of the eventual practice choices of our graduates.

PROPOSED CALENDAR MINIMUMS

We propose use of the following minimum application requirements in the SFU calendar. The admissions process through which these elements will be used is described in the following section.

Academic Criteria:

1. Completed 120 credit (4-year) degree
2. Applicants may demonstrate their academic merit through their choice of GPA and/or MCAT score. The minimum requirements for each combination are:
 - a. Adjusted GPA only: ≥ 3.67 (on a 4.33 scale or equivalent) (see #5 for GPA calculation)
 - b. MCAT only: ≥ 505 , with a minimum of 123 in each section
 - c. If both are provided, GPA ≥ 3.33 (on a 4.33 scale or equivalent) and MCAT ≥ 495 with a minimum of 123 in each section
3. MCAT scores must not be older than 5 years.
4. SFUMS will only consider the applicant's first or second MCAT attempt within the 5-year period. If a second attempt is made, then that score will be used regardless of if it is lower than the first attempt.
5. GPAs are calculated using the applicant's best 60 credits of the last 90 achieved credits. The 60 units selected for GPA calculation must include ≥ 30 credits from upper-level courses. The last 90 credits must have been achieved in no more than 4 calendar years.
6. Prerequisite courses for all applicants include 2 courses in Social Science (any level) and completion of the Indigenous Studies course. The pre-requisite courses must be included in the 60 credits used to calculate the GPA. Additionally, the applicant must have achieved at least a B-minus grade in each pre-requisite course.
7. Applicants in the GPA-only stream have additional pre-requisite courses. These prerequisites include: 2 Life Sciences Courses (minimum 3 units each), with at least 1 course at a 200 level or higher. These courses need to be included in the 60 credits used to calculate the GPA. In addition to the pre-requisite courses, courses in critical reasoning and general science are strongly recommended but not required.

The above represents the minimum admission requirements for applicants to be considered for admission to medical school. The selection process, which may include elements such as Multiple Mini Interviews and personal statements will be subsequently developed in consultation with scholars with medical school admissions expertise and guided by a formal Admissions committee.

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Medical schools around the world experience tremendous application pressure, admissions officers are left with a complex and ethical challenge: *how to choose a few students from among many qualified applicants?* One approach that has been applied in many European medical schools to manage this issue of volume is an admissions lottery, which operates to make decisions about applicants in a random, albeit occasionally weighted, fashion (e.g., Schripsema et al., 2014; Urlings-Strop et al., 2011; Reibnegger et al., 2010). Lotteries are valued for their legal defensibility, resource-efficiency, fairness, and the way they promote accessibility. All eligible applicants have a chance of obtaining admission. As a result of the random nature of admission, applicants feel that they have all been treated the same way and that the selection process is transparent (Oates & Goulston, 2012). Lottery systems may be used to widen access to medical school, but there is no guarantee of this outcome, and it will not assist widening access when the applicant pool is quite homogeneous (Mulder et al 2022). Evidence that lotteries promote or hinder scholastic excellence is equivocal (Schreurs et al., 2018; Stasz & von Stolk, 2017; Wouters et al., 2018). Until the recent Queen's University announcement, with the exception of the McMaster University pandemic-related admissions adaption (Grierson et al., 2024), lotteries have not been implemented in Canadian medical education and remain contentious with respect to numerous conceptualizations of merit (Zhang, 2012; Wouters et al., 2018). In the following section, we provide an overview of three reflections concerning the potential application of a lottery as part of a larger criteria- and attribute-based admissions system.

Lotteries conceptualize merit in terms of the candidate's capability to succeed as a physician

In discussing lotteries, it is first important to remember the two ways that merit may be understood. In one conceptualization, merit reflects that one has those qualities and attributes that are essential for excellence in future medical practice; essentially that the candidate *has what it takes*. In another, merit denotes who is deserving of an offer relative to other candidates. A lottery that provides all eligible candidates – as determined by the established thresholds and prerequisites - with an equal chance at advancing in the selection systems holds the former conceptualization of merit; one which we openly endorse as more appropriate (DeFreitas, Grierson & Vanstone, 2019).

However, in review of the McMaster 2020 pandemic admissions adaptation (Grierson et al., 2024), we learned that the lottery was perceived negatively by those that benefitted from receiving an offer. Via open text responses, matriculants told us that the inclusion of a randomization process challenged their perception of their preparedness for medical education and a career as a physician. It made them feel as though they did not earn their place in the medical school. Notably in this adaptation, the lottery replaced the admissions interview entirely. As such, it is likely that the negative perceptions emanated from a recognition that one needs strong interpersonal skills to be a good physician, and that, without an interview, there was no moment in the selection process for the matriculant to feel that the medical school had validated their interpersonal qualities. In this regard, it would appear that aspiring physicians do not hold the admissions process up as only a determining step in their potential medical professional future, but also a key driver of their own self-image. This pushes us to consider the central role of the admissions process in inculcating a positive professional identity in medical trainees. This is a concern that needs to be attended to in deliberations about a lottery feature in the admission system. We hold that part of this concern is that applicants might not believe that they have the requisite interpersonal skills for the profession unless they outperform other applicants on some surrogate of interpersonal competence. That is, that they may hold the belief that one deserves to be a physician because their life experiences and interpersonal aptitudes are somehow *better* relative to others, rather than specifically aligned with the tenets of good professional medical practice.

Lotteries constrain the influence of applicant agency

A common complaint about admissions lotteries is they limit the degree to which applicants can actively demonstrate their suitability to the profession. They are effectively advanced or dismissed from the process without any additional opportunity, to that which has already been provided, to showcase their capabilities. This can be understandably frustrating for the candidates. We remind, however, that systems that centre applicant agency regular favour those with the resources to curate privilege around that agency. Consider: a fair admission system is one that is just, impartial, and reasonable. Many systems operationalize this value of fairness through the principle of equity. These systems acknowledge that some applicants face structural inequities that constrain their opportunity to demonstrate merit (*vis-a-vis* scholastic and professional excellence). An admissions process that strives to be inclusive to admit a diverse class may need to take into consideration the specific needs, circumstances, and conditions of individuals or groups (De Freitas, Grierson, Vanstone 2019). It must be designed in a way which recognizes that different people have different starting points and face different barriers or advantages in the way they are able to demonstrate their achievements. An equitable approach would be one which distributes resources and opportunities in a manner that accounts for these differences. A lottery does not actively do this. Any admissions process that aims to create access and improve diversity will need apply active measures to ensure these outcomes, whether in conjunction with a lottery or not. What a lottery does do, however, is simultaneously limit those with resources from curate privilege within active systems. Lotteries operationalize the value of fairness in terms of equality, treating people in a manner that is free from unwarranted bias, discrimination, and favoritism by adhering to standards that are applied consistently to all applicants regardless of their background, status, or circumstances (Lamont and Favor, 2017).

Lotteries can mitigate the upstream impacts of admissions policies

Aspiring physicians engage in a wide variety of behaviours to enhance the competitiveness of their applications. They shadow clinicians, choose courses with easier routes to high grades, pursue volunteer and health science research experiences, and will persist with full course loads during times of personal strife. These behaviours reflect strategies that are not always in the best interest or supportive of the applicants' health and well-being and which can be attributed to medical schools themselves. Generally speaking, policies are an important tool through which institutions can influence the behaviour of a target population (Tummers, 2019). Past studies confirm the impact of admission policies on student behaviour. Lin and colleagues (2014) determined that the aspiring physician's narrative is shaped by their understanding of the expectations of the medical school admissions process. That is, there may be a hidden curriculum in admissions processes, which leads applicants to model their behaviours based on their perceptions of what is valued in the selection process (White et al., 2012). Although some describe this pejoratively as applicants attempting to 'game the system,' this is in fact very rational behaviour for aspiring physicians given the limited number of spots available, and the lack of control they have over the parameters by which they will be judged.

If we assume that candidates will use any means available to them to influence the selection process (Patterson et al., 2018), as others have (Wouters et al., 2017; Stegers-Jager, 2018; De Freitas et al., 2019), the lottery helps circumvent this (Hofstee, 1983; Wouters et al., 2017) as long as it is not open to curation; for example, by providing additional tickets based on incoming academic success. Furthermore, if we assume that some behaviours aimed at achieving admission are maladaptive (e.g., not participating in social, community, wellness behaviours or sacrificing integrity and pursuit of curiosity or knowledge in favour of the highest possible grades), then designing a selection process where these outcomes are not rewarded will help discourage these behaviours.

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SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Medical Doctor (MD) Program

Appendix 8.2 - New Courses

March 15 2024
SFU Medical School

COURSE SUBJECT NUMBER

COURSE TITLE LONG — for Calendar/schedule, no more than 100 characters including spaces and punctuation

COURSE TITLE SHORT — for enrollment/transcript, no more than 30 characters including spaces and punctuation

CAMPUS where course will be normally taught: ☐ Burnaby ☒ Surrey ☐ Vancouver ☐ Great Northern Way ☐ Off campus

COURSE DESCRIPTION — 50 words max. Attach a course outline. Don't include WQB or prerequisites info in this description box.

An introduction to foundational concepts/approaches to medical practice with focus on foundational medical knowledge and simulated clinical learning. Most learning takes place in classrooms, simulated clinical spaces and labs. Students will participate (under direct supervision) in patient care in a longitudinal Family Medicine clinic experience weekly and will engage in two blocks of intensive, immersive learning.

REPEAT FOR CREDIT ☐ YES ☒ NO Total completions allowed Within a term? ☐ YES ☐ NO**LIBRARY RESOURCES**

NOTE: Senate has approved (S.93-11) that no new course should be approved by Senate until funding has been committed for necessary library materials. Each new course proposal must be accompanied by the email that serves as proof of assessment. For more information, please visit www.lib.sfu.ca/about/overview/collections/course-assessments.

RATIONALE FOR INTRODUCTION OF THIS COURSE

MEDI 410 is the first of three new courses required for the Medical Doctor (MD) Program for the proposed Simon Fraser University Medical School (SFUMS). The timing of three courses map directly to the three academic years of the program which include: MEDI 410: Year 1, August to August (Summer Term, Fall Term, Spring Term, Summer Term); MEDI 420: Year 2, September to August (Fall Term, Spring Term, Summer Term); and MEDI 430: Year 3, September to May (Fall Term, Spring Term).

The three MEDI courses are intentionally designed as omnibus courses (rather than a series of concurrent smaller courses) to allow for effective and purposeful integration both vertically and horizontally through the curriculum. This curriculum design of MD curriculum promotes holistic, authentic, integrated, spiraled and longitudinal learning in a way that more closely reflects and aligns with the continuous learning and practice quality improvement that practicing health care professions engage in throughout their careers. Further, there is a growing consensus that for professional growth to a successful career, year-long courses more effectively support longitudinal development of authentic whole-task abilities towards the program's milestones and competencies.

The unit totals for the courses are derived from Senate's recent definition of a unit (S.22-47), with MEDI 410's 58 units representing the equivalent of 36 to 54 hours of in-class and self-study time per week on average (18 units) over 3 terms, plus 4 units for the extra month of study in August at the start of the course.

SCHEDULING AND ENROLLMENT INFORMATION

Effective term and year (e.g. FALL 2016)

Term in which course will typically be offered ☒ Spring ☒ Summer ☒ Fall

Other (describe)

Will this be a required or elective course in the curriculum? ☒ Required ☐ Elective

What is the probable enrollment when offered? Estimate:

UNITS

Indicate number of units:

Indicate no. of contact hours: Lecture Seminar Tutorial Lab Other; explain below

OTHER

FACULTY

Which of your present CFL faculty have the expertise to offer this course?

WQB DESIGNATION

(attach approval from Curriculum Office)

PREREQUISITE AND / OR COREQUISITE



EQUIVALENT COURSES [For more information on equivalency, see Equivalency Statements under [Information about Specific Course components.](#)]

1. SEQUENTIAL COURSE [is not hard coded in the student information management system (SIMS).]

Students who have taken *(place relevant course(s) in the blank below (ex: STAT 100))* **first** may not then take this course for further credit.

2. ONE-WAY EQUIVALENCY [is not hard coded in SIMS.]

(Place relevant course(s) in the blank below (ex: STAT 100)) will be accepted in lieu of this course.

3. TWO-WAY EQUIVALENCY [is hard coded and enforced by SIMS.]

Students with credit for *(place relevant course(s) in the blank below (ex: STAT 100))* may not take this course for further credit.

Does the partner academic unit agree that this is a two-way equivalency? ☐ YES ☐ NO

Please also have the partner academic unit submit a course change form to update the course equivalency for their course(s).

4. SPECIAL TOPICS PRECLUSION STATEMENT [is not hard coded in SIMS.]

FEES

Are there any proposed student fees associated with this course other than tuition fees? ☐ YES ☒ NO

COURSE – LEVEL EDUCATIONAL GOALS (OPTIONAL)



RESOURCES

List any outstanding resource issues to be addressed prior to implementation: space, laboratory equipment, etc:

OTHER IMPLICATIONS

Final exam required ☐ YES ☒ NO

Criminal Record Check required ☒ YES ☐ NO

OVERLAP CHECK

Checking for overlap is the responsibility of the Associate Dean.
Each new course proposal must have confirmation of an overlap check completed prior to submission to the Faculty Curriculum Committee.

Name of Originator

Maria Hubinette

Simon Fraser University Medical School

MEDI 410 – Foundations of Medical Practice

Course Description

An introduction to foundational concepts/approaches to medical practice with focus on foundational medical knowledge and simulated clinical learning. Most learning takes place in classrooms, simulated clinical spaces and labs. Students will participate (under direct supervision) in patient care in a longitudinal Family Medicine clinic experience weekly and will engage in two blocks of intensive, immersive learning.

Course Details

This course introduces students to foundational concepts in medicine in a longitudinal course structure over 55 weeks. Students will begin with a 4-week orientation block where they are introduced to the school, resources, physical space, surrounding community and vision and goals of the program. They will engage in team building with their peers, and by connecting with faculty and staff begin to set the foundation for their community of learning. The goal of this orientation is for students to feel welcome, supported and engaged to begin learning in a non-competitive growth mindset community.

Learners will spend most of their time in small- and large-group learning, as well as having time for self-study/asynchronous learning. During this time, a key feature will be presentation-focused (e.g., chest pain) case-based learning in small groups. They will engage in thematic content through these cases to ensure that all material is clinically relevant and taught in the context of clinical care.

Early and longitudinal clinical learning will begin after the orientation block. Students will be introduced to their 'continuity clinic' where they will spend time regularly over the course of the program, caring for a panel of patients under the direct supervision of their preceptor. Students will be exposed to the benefits of longitudinal community-based care. Students will also spend time in the community learning from community organizations, from leaders in the community, and from guided observations. Students will engage in two immersive clinical experiences. Students will also have their first opportunity to engage in a longitudinal clinical selective; this could include such experiences as community-based mental health, addictions, maternity care, etc.

Grading/Assessment Details:

Foundations of Medical Practice is competency-based and will use multiple methods of assessment to assess student progression towards successful completion of the course. The course will use written exams (monthly mastery exams and progress tests) and assignments to monitor student's developing knowledge base and clinical reasoning skills, workplace-based assessments to monitor individual clinical skills and skills such as communication, teamwork,

and professional attributes, standardized exams (e.g. objective structure clinical examinations, etc.), and portfolio work (reflections and learning plans) to assess progress toward and achievement of yearly milestones. Students will be required to meet specific criteria outlined for each assessment modality by the end of each course to progress to the next. All requirements and criteria will be clearly outlined and easily accessible for students at the beginning of the course. Overall performance in the Foundations of Medical Practice course will be designated as "Pass or Fail."

The program of assessment supporting Foundations of Medical Practice will utilize an approach to assessment that ensures that students have opportunities to receive feedback early and often in the course. Summative assessment will be limited to moments of aggregated data rather than individual assessments. Students will be provided with learner dashboards and a coach who will support and monitor their learning. Student progression towards meeting course requirements will be reviewed 4 times per year by a Clinical Competence Committee. Any student deemed off-track will be provided with a learning plan and support for course correction.

COURSE SUBJECT NUMBER

COURSE TITLE LONG — for Calendar/schedule, no more than 100 characters including spaces and punctuation

COURSE TITLE SHORT — for enrollment/transcript, no more than 30 characters including spaces and punctuation

CAMPUS where course will be normally taught: ☐ Burnaby ☒ Surrey ☐ Vancouver ☐ Great Northern Way ☐ Off campus

COURSE DESCRIPTION — 50 words max. Attach a course outline. Don't include WQB or prerequisites info in this description box.

An application of foundational concepts via experiential clinical learning undertaken across a variety of healthcare settings. Applied learning will be supported by continued small-group classrooms, labs, and simulated clinical care encounters. Weekly participation in the longitudinal clinic will also continue. Students will have the opportunity to undertake multiple elective experiences.

REPEAT FOR CREDIT ☐ YES ☒ NO Total completions allowed Within a term? ☐ YES ☐ NO**LIBRARY RESOURCES**

NOTE: Senate has approved (S.93-11) that no new course should be approved by Senate until funding has been committed for necessary library materials. Each new course proposal must be accompanied by the email that serves as proof of assessment. For more information, please visit www.lib.sfu.ca/about/overview/collections/course-assessments.

RATIONALE FOR INTRODUCTION OF THIS COURSE

MEDI 420 is second of three new courses required for the Medical Doctor (MD) Program for the proposed Simon Fraser University Medical School (SFUMS). The timing of three courses map directly to the three academic years of the program which include: MEDI 410: Year 1, August to August (Summer Term, Fall Term, Spring Term, Summer Term); MEDI 420: Year 2, September to August (Fall Term, Spring Term, Summer Term); and MEDI 430: Year 3, September to May (Fall Term, Spring Term).

The three MEDI courses are intentionally designed as omnibus courses (rather than a series of concurrent smaller courses) to allow for effective and purposeful integration both vertically and horizontally through the curriculum. This curriculum design of MD curriculum promotes holistic, authentic, integrated, spiraled and longitudinal learning in a way that more closely reflects and aligns with the continuous learning and practice quality improvement that practicing health care professions engage in throughout their careers. Further, there is a growing consensus that for professional growth to a successful career, year-long courses more effectively support longitudinal development of authentic whole-task abilities towards the program's milestones and competencies.

The unit totals for the courses are derived from Senate's recent definition of a unit (S.22-47), with MEDI 420's 54 units representing the equivalent of 36 to 54 hours of in-class and self-study time per week on average (18 units) over 3 terms.

SCHEDULING AND ENROLLMENT INFORMATION

Effective term and year (e.g. FALL 2016)

Term in which course will typically be offered ☒ Spring ☒ Summer ☒ Fall

Other (describe)

Will this be a required or elective course in the curriculum? ☒ Required ☐ Elective

What is the probable enrollment when offered? Estimate:

UNITS

Indicate number of units:

Indicate no. of contact hours: Lecture Seminar Tutorial Lab Other; explain below

OTHER

FACULTY

Which of your present CFL faculty have the expertise to offer this course?

WQB DESIGNATION

(attach approval from Curriculum Office)

PREREQUISITE AND / OR COREQUISITE



EQUIVALENT COURSES [For more information on equivalency, see Equivalency Statements under [Information about Specific Course components.](#)]

1. SEQUENTIAL COURSE [is not hard coded in the student information management system (SIMS).]

Students who have taken *(place relevant course(s) in the blank below (ex: STAT 100))* **first** may not then take this course for further credit.

2. ONE-WAY EQUIVALENCY [is not hard coded in SIMS.]

(Place relevant course(s) in the blank below (ex: STAT 100)) will be accepted in lieu of this course.

3. TWO-WAY EQUIVALENCY [is hard coded and enforced by SIMS.]

Students with credit for *(place relevant course(s) in the blank below (ex: STAT 100))* may not take this course for further credit.

Does the partner academic unit agree that this is a two-way equivalency? ☐ YES ☐ NO

Please also have the partner academic unit submit a course change form to update the course equivalency for their course(s).

4. SPECIAL TOPICS PRECLUSION STATEMENT [is not hard coded in SIMS.]

FEES

Are there any proposed student fees associated with this course other than tuition fees? ☐ YES ☒ NO

COURSE – LEVEL EDUCATIONAL GOALS (OPTIONAL)



RESOURCES

List any outstanding resource issues to be addressed prior to implementation: space, laboratory equipment, etc:

OTHER IMPLICATIONS

Final exam required ☐ YES ☒ NO

Criminal Record Check required ☒ YES ☐ NO

OVERLAP CHECK

Checking for overlap is the responsibility of the Associate Dean.
Each new course proposal must have confirmation of an overlap check completed prior to submission to the Faculty Curriculum Committee.

Name of Originator

Maria Hubinette

Simon Fraser University Medical School

MEDI 420 – Extensions of Medical Practice

Course Description

An application of foundational concepts via experiential clinical learning undertaken across a variety of healthcare settings. Applied learning will be supported by continued small-group classrooms, labs, and simulated clinical care encounters. Weekly participation in the longitudinal clinic will also continue. Students will have the opportunity to undertake multiple elective experiences. Prerequisite: MEDI 410.

Course Details

MEDI 420 builds on foundational concepts from Foundations of Medical Practice (MEDI 410). While the majority of clinical learning occurs in a family medicine context, students will also participate in longitudinal and block-based active clinical learning within pre-selected specialities that support students achieving competency milestones. Students will continue in their 'continuity clinic', caring for a panel of patients under the direct supervision of their preceptor. Other clinical learning settings include urban and suburban community-based Family Medicine and specialty clinics; hospitals (inpatient and outpatient care); and rural Family Medicine and other general care health professional clinics and organizations. Students will take on-call responsibilities under direct faculty supervision across a spectrum of acute and chronic care areas of care. This applied learning will be supported by continued advanced and purposefully spiralled repeat team learning in small group classrooms; simulated clinical care encounters; and some labs (e.g. anatomy). Students will have the ability to undertake self-selected elective clinical, research or leadership elective experiences during weeks set aside as for these purposes. Students will continue on their journey of professional identity development and a deeper understanding and application of the tools for wellness (personal and team) and advancing change for new models of care and system governance.

Grading/Assessment Details:

Assessment in Extensions of Medical Practice is competency-based and will use multiple methods of assessment to assess student progression towards successful completion of the course. The course will focus on learning in the workplace and direct patient care, and utilize the following assessments to monitor student progression: (1) workplace-based assessments to monitor individual clinical skills and skills such as communication, teamwork, and professional attributes, (2) written exams (progress tests) and assignments to monitor student's developing knowledge base and clinical reasoning skills, (3) comprehensive or standardized exams (e.g. objective structure clinical examinations, etc.), and (4) portfolio work (reflections and learning plans) to assess progress toward and achievement of yearly milestones. Students will be required to meet specific criteria outlined for each assessment modality by the end of the course to progress to the next. All requirements and criteria will be clearly outlined and

easily accessible for students at the beginning of the course. Overall performance in the Extensions of Medical Practice course will be designated as "Pass or Fail."

The program of assessment supporting Extensions of Medical Practice will utilize an approach to assessment that ensures that students have opportunities to receive feedback early and often in the course. Summative assessment will be limited to moments of aggregated data rather than individual assessments. Students will be provided with learner dashboards and a coach who will support and monitor their learning. Student progression towards meeting course requirements will be reviewed 4 times per year by a Clinical Competence Committee. Any student deemed off-track will be provided with a learning plan and support for course correction.

COURSE SUBJECT NUMBER

COURSE TITLE LONG — for Calendar/schedule, no more than 100 characters including spaces and punctuation

COURSE TITLE SHORT — for enrollment/transcript, no more than 30 characters including spaces and punctuation

CAMPUS where course will be normally taught: ☐ Burnaby ☒ Surrey ☐ Vancouver ☐ Great Northern Way ☐ Off campus

COURSE DESCRIPTION — 50 words max. Attach a course outline. Don't include WQB or prerequisites info in this description box.

A capstone course where students will consolidate foundational concepts and applied learning via increasingly complex patient presentations. Learning will highlight advanced aspects of patient care, systems, and the challenges of care across all levels. MEDI 430 takes place mostly in clinical care supervised locations. Students will choose elective areas to enhance their grounding for the next stage of their career.

REPEAT FOR CREDIT ☐ YES ☒ NO Total completions allowed Within a term? ☐ YES ☐ NO**LIBRARY RESOURCES**

NOTE: Senate has approved (S.93-11) that no new course should be approved by Senate until funding has been committed for necessary library materials. Each new course proposal must be accompanied by the email that serves as proof of assessment. For more information, please visit www.lib.sfu.ca/about/overview/collections/course-assessments.

RATIONALE FOR INTRODUCTION OF THIS COURSE

MEDI 430 is the third of three new courses required to for the Medical Doctor (MD) Program for the proposed Simon Fraser University Medical School (SFUMS). The timing of three courses map directly to the three academic years of the program which include: MEDI 410: Year 1, August to August (Summer Term, Fall Term, Spring Term, Summer Term); MEDI 420: Year 2, September to August (Fall Term, Spring Term, Summer Term); and MEDI 430: Year 3, September to May (Fall Term, Spring Term).

The three MEDI courses are intentionally designed as omnibus courses (rather than a series of concurrent smaller courses) to allow for effective and purposeful integration both vertically and horizontally through the curriculum. This curriculum design of MD curriculum promotes holistic, authentic, integrated, spiraled and longitudinal learning in a way that more closely reflects and aligns with the continuous learning and practice quality improvement that practicing health care professions engage in throughout their careers. Further, there is a growing consensus that for professional growth to a successful career, year-long courses more effectively support longitudinal development of authentic whole-task abilities towards the program's milestones and competencies.

The unit totals for the courses are derived from Senate's recent definition of a unit (S.22-47), with MEDI 430's 36 units representing the equivalent of 36 to 54 hours of in-class and self-study time per week on average (18 units) over 2 terms.

SCHEDULING AND ENROLLMENT INFORMATION

Effective term and year (e.g. FALL 2016)

Term in which course will typically be offered ☒ Spring ☒ Summer ☒ Fall

Other (describe)

Will this be a required or elective course in the curriculum? ☒ Required ☐ Elective

What is the probable enrollment when offered? Estimate:

UNITS

Indicate number of units:

Indicate no. of contact hours: Lecture Seminar Tutorial Lab Other; explain below

OTHER

FACULTY

Which of your present CFL faculty have the expertise to offer this course?

WQB DESIGNATION

(attach approval from Curriculum Office)

PREREQUISITE AND / OR COREQUISITE



EQUIVALENT COURSES [For more information on equivalency, see Equivalency Statements under [Information about Specific Course components.](#)]

1. SEQUENTIAL COURSE [is not hard coded in the student information management system (SIMS).]

Students who have taken (*place relevant course(s) in the blank below (ex: STAT 100)*) **first** may not then take this course for further credit.

2. ONE-WAY EQUIVALENCY [is not hard coded in SIMS.]

(*Place relevant course(s) in the blank below (ex: STAT 100)*) will be accepted in lieu of this course.

3. TWO-WAY EQUIVALENCY [is hard coded and enforced by SIMS.]

Students with credit for (*place relevant course(s) in the blank below (ex: STAT 100)*) may not take this course for further credit.

Does the partner academic unit agree that this is a two-way equivalency? ☐ YES ☐ NO

Please also have the partner academic unit submit a course change form to update the course equivalency for their course(s).

4. SPECIAL TOPICS PRECLUSION STATEMENT [is not hard coded in SIMS.]

FEES

Are there any proposed student fees associated with this course other than tuition fees? ☐ YES ☒ NO

COURSE – LEVEL EDUCATIONAL GOALS (OPTIONAL)

RESOURCES

List any outstanding resource issues to be addressed prior to implementation: space, laboratory equipment, etc:

OTHER IMPLICATIONS

Final exam required ☐ YES ☒ NO

Criminal Record Check required ☒ YES ☐ NO

OVERLAP CHECK

Checking for overlap is the responsibility of the Associate Dean.

Each new course proposal must have confirmation of an overlap check completed prior to submission to the Faculty Curriculum Committee.

Name of Originator

Maria Hubinette

Simon Fraser University Medical School

MEDI 430 – Consolidation of Medical Practice

Course Description

A capstone course where students will consolidate foundational concepts and applied learning via increasingly complex patient presentations. Learning will highlight advanced aspects of patient care, systems, and the challenges of care across all levels. MEDI 430 takes place mostly in clinical care supervised locations. Students will choose elective areas to enhance their grounding for the next stage of their career. Prerequisite: MEDI 420.

Course Details

In this capstone experience, learners will consolidate and advance their competencies for foundational concepts in all the clinical, social and community drivers of health care delivery and ongoing improvement. Learning will highlight complex aspects of patient care, systems and challenges of local, provincial, national and global care; new models that are shaping care (i.e., artificial intelligence; device supportive care); and newly identified key or evolved models of disease and prevention using increasing complexity and acuity of patient presentations. Learning takes place mostly in clinical care supervised locations (e.g., community-based clinics, hospitals and other community-based locations). Students will be allowed to choose (with central oversight) the areas or aspects of medicine (patient care; research; leadership) to enhance their grounding in knowledge, skills and abilities needed for the next stage of their career (residency in PGME). Students will continue to participate in a longitudinal clinic experience weekly in addition to longitudinal and block-based immersive experiences. In addition, students will have elective opportunities. Students will return to class-based learning for the final four weeks to a curriculum purpose built that provides (through small group and simulated learning), educational experiences that prepare them for PGME and their future careers in medicine.

Grading/Assessment Details:

Assessment in Consolidation of Medical Practice is competency-based and will use multiple methods of assessment to assess student progression towards successful completion of the course and successful attainment of the core program competencies. The course will focus on learning in the workplace and direct patient care, and utilize the following assessments to monitor student progression: (1) workplace-based assessments to monitor individual clinical skills and skills such as communication, teamwork, and professional attributes, (2) written exams (progress tests) and assignments to monitor student's developing knowledge base and clinical reasoning skills, (3) standardized exams (e.g. objective structure clinical examinations, etc.), and (4) portfolio work (reflections and learning plans) to assess progress toward and achievement of yearly milestones. Students will be required to meet specific criteria outlined for each assessment modality by the end of the course to progress to the next. All requirements and criteria will be clearly outlined and easily accessible for students at the

beginning of the course. Overall performance in the Consolidation of Medical Practice course will be designated as "Pass" or "Fail."

The program of assessment supporting Consolidation of Medical Practice will utilize an approach to assessment that ensures that students have opportunities to receive feedback early and often in the course. Summative assessment will be limited to moments of aggregated data rather than individual assessments. Students will be provided with learner dashboards and a coach who will support and monitor their learning. Student progression towards meeting course requirements will be reviewed 4 times per year by a Clinical Competence Committee. Any student deemed off-track will be provided with a learning plan and support for course correction.

Example of Potential MEDI 410 Schedule

MEDI 410		
#	Dates	Week Type
Week 1	03-Aug-26	Orientation/Foundations
Week 2	10-Aug-26	Orientation/Foundations
Week 3	17-Aug-26	Orientation/Foundations
Week 4	24-Aug-26	Orientation/Foundations
Week 5	31-Aug-26	Presentation Based Learning
Week 6	07-Sep-26	Presentation Based Learning
Week 7	14-Sep-26	Presentation Based Learning
Week 8	21-Sep-26	Presentation Based Learning
Week 9	28-Sep-26	Presentation Based Learning
Week 10	05-Oct-26	Presentation Based Learning
Week 11	12-Oct-26	Presentation Based Learning
Week 12	19-Oct-26	Presentation Based Learning
Week 13	26-Oct-26	Presentation Based Learning
Week 14	02-Nov-26	Presentation Based Learning
Week 15	09-Nov-26	Presentation Based Learning
Week 16	16-Nov-26	Consolidation
Week 17	23-Nov-26	Presentation Based Learning
Week 18	30-Nov-26	Presentation Based Learning
Week 19	07-Dec-26	Presentation Based Learning
Week 20	14-Dec-26	Presentation Based Learning
Week 21	21-Dec-26	Winter Break
Week 22	28-Dec-26	Winter Break
Week 23	04-Jan-27	Presentation Based Learning
Week 24	11-Jan-27	Presentation Based Learning
Week 25	18-Jan-27	Presentation Based Learning
Week 26	25-Jan-27	Community FM/Health 1
Week 27	01-Feb-27	Community FM/Health 1
Week 28	08-Feb-27	Community FM/Health 1
Week 29	15-Feb-27	Community FM/Health 1
Week 30	22-Feb-27	Consolidation
Week 31	01-Mar-27	Pres Based with Long. Elective
Week 32	08-Mar-27	Pres Based with Long. Elective
Week 33	15-Mar-27	Pres Based with Long. Elective
Week 34	22-Mar-27	Pres Based with Long. Elective
Week 35	29-Mar-27	Pres Based with Long. Elective
Week 36	05-Apr-27	Pres Based with Long. Elective
Week 37	12-Apr-27	Pres Based with Long. Elective
Week 38	19-Apr-27	Pres Based with Long. Elective
Week 39	26-Apr-27	Spring Break
Week 40	03-May-27	Presentation Based Learning
Week 41	10-May-27	Presentation Based Learning
Week 42	17-May-27	Presentation Based Learning
Week 43	24-May-27	Community FM/Health 2
Week 44	31-May-27	Community FM/Health 2
Week 45	07-Jun-27	Community FM/Health 2
Week 46	14-Jun-27	Community FM/Health 2
Week 47	21-Jun-27	Consolidation
Week 48	28-Jun-27	Presentation Based Learning
Week 49	05-Jul-27	Presentation Based Learning
Week 50	12-Jul-27	Presentation Based Learning
Week 51	19-Jul-27	Presentation Based Learning
Week 52	26-Jul-27	Presentation Based Learning
Week 53	02-Aug-27	Presentation Based Learning
Week 54	09-Aug-27	Presentation Based Learning
Week 55	16-Aug-27	Consolidation
Week 56	23-Aug-27	Summer Break
Week 57	30-Aug-27	Summer Break

Half-Day Blocks	Pres Based Learning
1	Cont. Clinic
2	Community
3	Sim/ Labs
4	Sim/ Labs
5	Class
6	Class
7	Class
8	Class
9	Flexible
10	Flexible

Half-Day Blocks	Pres Based + Electives
1	Cont. Clinic
2	Elective
3	Community
4	Sim/ Labs
5	Class
6	Class
7	Class
8	Class
9	Flexible
10	Flexible

Half-Day Blocks	Community Care
1	Cont. Clinic
2	Clinic
3	Clinic
4	Clinic
5	Community
6	Community
7	Community
8	Community
9	Flexible
10	Flexible

LEGEND:

- Clinical Learning Experiences (incl a longitudinal "Continuity Clinic")
- Community: extra-clinical learning in a community setting
- Sim/Labs: incl clinical skills, simulation sessions, labs, "hands-on" learning
- Class: small group case-based, large group seminar, panel etc.
- Flexible: self-study, group work, learner support, mentorship, etc
- Sim/Class: could be either sim/labs or class

Example of Potential MEDI 420 Schedule

MEDI 420		
#	Dates	Week Type
Week 58	06-Sep-27	Pres Based with Long. Elective
Week 59	13-Sep-27	Pres Based with Long. Elective
Week 60	20-Sep-27	Pres Based with Long. Elective
Week 61	27-Sep-27	Pres Based with Long. Elective
Week 62	04-Oct-27	Pres Based with Long. Elective
Week 63	11-Oct-27	Pres Based with Long. Elective
Week 64	18-Oct-27	Pres Based with Long. Elective
Week 65	25-Oct-27	Pres Based with Long. Elective
Week 66	01-Nov-27	Consolidation
Week 67	08-Nov-27	Pres Based Learning/Orientation/Transition
Week 68	15-Nov-27	Pres Based Learning/Orientation/Transition
Week 69	22-Nov-27	**Longitudinal Ambulatory**
Week 70	29-Nov-27	Longitudinal Ambulatory
Week 71	06-Dec-27	Longitudinal Ambulatory
Week 72	13-Dec-27	Consolidation
Week 73	20-Dec-27	Winter Break
Week 74	27-Dec-27	Winter Break
Week 75	03-Jan-28	Longitudinal Ambulatory
Week 76	10-Jan-28	Longitudinal Ambulatory
Week 77	17-Jan-28	Hosp w Long Electives
Week 78	24-Jan-28	Hosp w Long Electives
Week 79	31-Jan-28	Hosp w Long Electives
Week 80	07-Feb-28	Hosp w Long Electives
Week 81	14-Feb-28	Hosp w Long Electives
Week 82	21-Feb-28	Hosp w Long Electives
Week 83	28-Feb-28	Hosp w Long Electives
Week 84	06-Mar-28	Hosp w Long Electives
Week 85	13-Mar-28	RURAL
Week 86	20-Mar-28	RURAL
Week 87	27-Mar-28	RURAL
Week 88	03-Apr-28	RURAL
Week 89	10-Apr-28	RURAL
Week 90	17-Apr-28	RURAL
Week 91	24-Apr-28	RURAL
Week 92	01-May-28	RURAL
Week 93	08-May-28	Consolidation
Week 94	15-May-28	Electives
Week 95	22-May-28	Electives
Week 96	29-May-28	Electives
Week 97	05-Jun-28	Electives
Week 98	12-Jun-28	Long. Amb. w Long. Electives
Week 99	19-Jun-28	Long. Amb. w Long. Electives
Week 100	26-Jun-28	Long. Amb. w Long. Electives
Week 101	03-Jul-28	Long. Amb. w Long. Electives
Week 102	10-Jul-28	Long. Amb. w Long. Electives
Week 103	17-Jul-28	Long. Amb. w Long. Electives
Week 104	24-Jul-28	Long. Amb. w Long. Electives
Week 105	31-Jul-28	Long. Amb. w Long. Electives
Week 106	07-Aug-28	Consolidation
Week 107	14-Aug-28	Consolidation
Week 108	21-Aug-28	Summer Break
Week 109	28-Aug-28	Summer Break

Half-Day Blocks	Pres Based + Electives
1	Cont. Clinic
2	Elective
3	Community
4	Sim/Labs
5	Class
6	Class
7	Class
8	Class
9	Flexible
10	Flexible

LEGEND:

Clinical Learning Experiences (incl a longitudinal "Continuity Clinic")

Community: extra-clinical learning in a community setting

Sim/Labs: incl clinical skills, simulation sessions, labs, "hands-on" learning

Class: small group case-based, large group seminar, panel etc.

Flexible: self-study, group work, learner support, mentorship, etc

Sim/Class: could be either sim/labs or class

Half-Day Blocks	Hosp w Long Electives
1	Cont. Clinic
2	Sim/Class
3	Community
4	Elective
5	Hosp
6	Hosp
7	Hosp
8	Hosp
9	Hosp
10	Flexible
11^	Hosp

^^On call, evening or weekend. Post-call day is flexible.

Half-Day Blocks	Long. Amb. w Long. Electives
1	Cont. Clinic
2	Sim/Class
3	Community
4	Elective
5	Hosp
6	Hosp
7	Hosp
8	Hosp
9	Hosp
10	Flexible
11^	Hosp

^^On call, evening or weekend. Post-call day is flexible.

Example of Potential MEDI 430 Schedule

MEDI 430		
#	Dates	Week Type
Week 110	04-Sep-28	Hosp w Long Electives
Week 111	11-Sep-28	Hosp w Long Electives
Week 112	18-Sep-28	Hosp w Long Electives
		Hosp w Long Electives
Week 113	25-Sep-28	
Week 114	02-Oct-28	Long. Amb. w Long. Electives
Week 115	09-Oct-28	Long. Amb. w Long. Electives
Week 116	16-Oct-28	Long. Amb. w Long. Electives
Week 117	23-Oct-28	Long. Amb. w Long. Electives
Week 118	30-Oct-28	Electives
Week 119	06-Nov-28	Electives
Week 120	13-Nov-28	Electives
Week 121	20-Nov-28	Electives
Week 122	27-Nov-28	Electives
Week 123	04-Dec-28	Electives
Week 124	11-Dec-28	Electives
Week 125	18-Dec-28	Winter Break
Week 126	25-Dec-28	Winter Break
Week 127	01-Jan-29	Electives
Week 128	08-Jan-29	Electives
Week 129	15-Jan-29	CaRMS
Week 130	22-Jan-29	CaRMS
Week 131	29-Jan-29	Hosp w Long Electives
Week 132	05-Feb-29	Hosp w Long Electives
Week 133	12-Feb-29	Hosp w Long Electives
Week 134	19-Feb-29	Hosp w Long Electives
Week 135	26-Feb-29	Hosp w Long Electives
Week 136	05-Mar-29	Hosp w Long Electives
Week 137	12-Mar-29	Long. Amb. w Long. Electives
Week 138	19-Mar-29	Long. Amb. w Long. Electives
Week 139	26-Mar-29	Longitudinal Ambulatory
Week 140	02-Apr-29	Longitudinal Ambulatory
Week 141	09-Apr-29	Consolidation
Week 142	16-Apr-29	Consolidation
Week 143	23-Apr-29	Consolidation
Week 144	30-Apr-29	Consolidation

Half-Day Blocks	Electives
1	Cont. clinic
2	Elective
3	Elective
4	Elective
5	Elective
6	Elective
7	Elective
8	Elective
9	Sim/Class
10	Flexible

Half-Day Blocks	Consolidation
1	Class
2	Class
3	Class
4	Class
5	Class
6	Class
7	Class
8	Class
9	Flexible
10	Flexible

LEGEND:

- Clinical Learning Experiences (incl a longitudinal "Continuity Clinic")
- Community: extra-clinical learning in a community setting
- Sim/Labs: incl clinical skills, simulation sessions, labs, "hands-on" learning
- Class: small group case-based, large group seminar, panel etc.
- Flexible: self-study, group work, learner support, mentorship, etc
- Sim/Class: could be either sim/labs or class



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Medical Doctor (MD) Program

Appendix 8.3 - Market Analysis

March 15, 2024
SFU Medical School

8.3 Market analysis – student interest and labour market demand

LMCC Eligibility Criteria

“A physician who meets the following requirements is enrolled in the Canadian Medical Register as an LMCC and receives a Certificate of Registration (a wallet-size plastic card). This certificate serves as official proof of registration. If the original Certificate of Registration is submitted to an MRA or other agency, it should be recovered by the owner for further use as required. A Testamur is also provided, which is intended for display purposes rather than as official proof of registration and is suitable for framing.

As of June 29, 2021, to be eligible for inclusion in the Canadian Medical Register a graduate in medicine must meet the following requirements:

1. Be a graduate from
 - a. a medical school accredited by the Committee on Accreditation of Canadian Medical Schools;
 - or
 - b. a medical school listed in the World Directory of Medical Schools, which includes a sponsor note indicating it is an acceptable medical school in Canada;
 - or
 - c. a United States School of Osteopathic Medicine accredited by the American Osteopathic Association.
2. Have been awarded a pass result on the MCC Qualifying Examination (MCCQE) Part I.
3. Have successfully completed the following, as deemed acceptable by the executive director and chief executive officer (CEO) of the MCC
 - a. at least 12 months of acceptable clinical medical postgraduate training;
 - or
 - b. at least 12 months of acceptable osteopathic clinical postgraduate training in a program accredited by the Accreditation Council for Graduate Medical Education.
4. Have the required medical credentials including verification of postgraduate training successfully source-verified through the MCC or, in exceptional circumstances, have provided evidence of the required medical credentials and postgraduate training that is deemed acceptable by the executive director and CEO.
5. Have paid the LMCC application fee to the MCC and not have any outstanding fees payable to the MCC.

Alternatively, to be eligible for inclusion in the Canadian Medical Register, a graduate in medicine can submit evidence of at least 12 months of clinical medical postgraduate training deemed acceptable by the executive director and CEO of the MCC and have successfully completed:

1. the Qualifying Examination prior to January 1, 1992;
or
2. the MCCQE Part I and the MCCQE Part II;
or
3. the MCCQE Part I and, during the years from 2013 to 2015, the MCC/College of Family Physicians of Canada (CFPC) harmonized examination.”

Source: Medical Council of Canada. 2024. LMCC. <https://mcc.ca/credentials-and-services/pathways-to-licensure/lmcc/>

Table 1: Acceptance Rates for Canadian Medical Education Programs in 2022/23 cycle

Canadian Medical Programs	Applications Received	Invited to Interview	Admitted Students	Admission Rate
University of British Columbia (UBC)	2558	800	288	11.26%
University of Calgary (Cumming)	1845	N/A	144	7.80%
University of Alberta	N/A	N/A	162	N/A
University of Saskatchewan	727	357	100	13.76%
University of Manitoba (Max Rady)	877	357	110	12.54%
University of Toronto	4319	633	259	6.00%
Western University (Schulich)	2415	485	171	7.08%
McMaster University (DeGroot)	5868	600	205	3.49%
Queen's University	5781	513	109	1.89%
University of Ottawa	4802	600	165	3.44%
Northern Ontario School of Medicine (NOSM)	1975	335	69	3.49%
McGill University	3695	673	215	5.82%
Universite de Sherbrooke	2852	N/A	219	7.68%
University Laval	N/A	N/A	N/A	N/A
Universite de Montreal	N/A	N/A	N/A	N/A
Dalhousie University	1777	N/A	132	7.43%
Memorial University	N/A	N/A	80	N/A

Source: [Medical School Acceptance Rates in Canada - Master Student](#)

Table 2: Number of Medical Program Applicants not accepted to UBC by overall grade averages

	2019		2020		2021	
	BC	OOP*	BC	OOP*	BC	OOP*
90.00-100% (A+)	81	207	77	263	101	309
85.00-89.99% (A)	317	388	357	445	410	461
80.00-84.99% (A-)	427	145	427	146	511	202
75.00-79.99% (B+)	165	28	179	26	233	29
70.00-74.99% (B)	39	9	25	10	29	4

This excludes applicants who withdrew their application or were rejected due to ineligibility.

*OOP= Out of Province Applicants

Source: [Final - MED 2025 Admissions Statistics - Website \(ubc.ca\)](#)

Table 3: Medical Program Applicants not accepted by UBC average MCAT performance

	2019	2020	2021
Critical Analysis & Reasoning Skills	126.63	126.64	126.71
Chemical & Physical Foundations of Biological Systems	127.86	127.89	128.00
Psychological, Social & Biological Foundations of Behavior	128.27	128.40	128.71
Biological & Biochemical Foundations of Living Systems	128.19	128.32	128.38
Overall Score	510.95	511.25	511.80

Source: [Final - MED 2025 Admissions Statistics - Website \(ubc.ca\)](#)

Table 4: Number of family physicians and specialist physicians per 10,000 populations in B.C. health service delivery areas (HSDA)

Health regions (B.C.)	Number of family physicians per 10,000 (2021)	Difference between family physicians reported by region and the provincial average (2021)	Number of specialist physicians per 10,000 (2021)	Difference between specialist physicians reported by region and the provincial average (2021)
East Kootenay	17	2.5	5	-4.7
Kootenay–Boundary	17	2.5	8	-1.7
Okanagan	15	0.5	13	3.3
Thompson/Cariboo	13	-1.5	9	-0.7
Fraser East	11	-3.5	6	-3.7
Fraser North	10	-4.5	9	-0.7
Fraser South	9	-5.5	7	-2.7
Richmond	11	-3.5	8	-1.7
Vancouver	18	3.5	33	23.3
North Shore/Coast Garibaldi	16	1.5	10	0.3
South Vancouver Island	18	3.5	16	6.3
Central Vancouver Island	15	0.5	9	-0.7
North Vancouver Island	19	4.5	8	-1.7
Northwest	18	3.5	4	-5.7
Northern Interior	15	0.5	8	-1.7
Northeast	10	-4.5	2	-7.7
B.C. Provincial Average Physicians per 10,000 people	14.5		9.7	

All values are rounded to the nearest whole number.

* This data excludes residents, physicians in the military, semi-retired and retired physicians as well as physicians who requested that their information not be published as of December 31 of the reference year.

Source: [Number of physicians and nurses per 10,000 population by health region, 2021 | CIHI](#)



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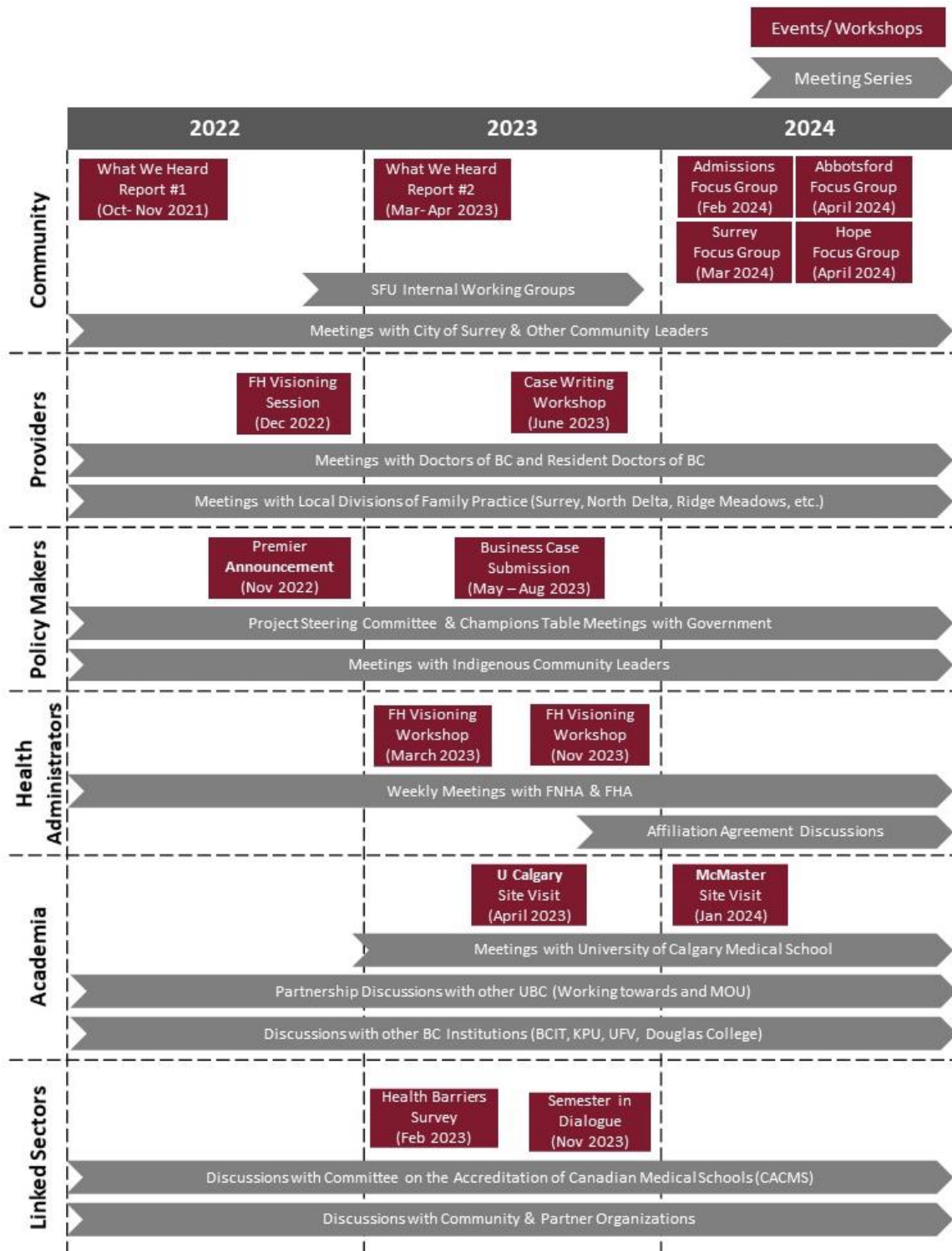
Medical Doctor (MD) Program

Appendix 8.4 - Consultation Comments and Letters of Support

March 15, 2024
SFU Medical School

8.4 Consultation Comments and Letters of Support

Figure 1: Timeline of program consultation engagements from 2022 to present



- Item 1: What we Heard Report (2023)
- Item 2: What we Heard Report Summary (2023)
- Item 3: Admission Focus Group Summary (Feb 2024)
- Item 4: Survey Results Summary from Barriers to Health Access Survey (2023)
- Item 5: Letter of Support from British Columbia Association of Community Health Centres
- Item 6: Letter of Support from BC College of Family Physicians
- Item 7: Letter of Support from BC Coroners Service
- Item 8: Letter of Support from BCIT
- Item 9: Letter of Support from Burnaby Division of Family Practice
- Item 10: Letter of Support from City of Surrey
- Item 11: Letter of Support from The College of Family Physicians of Canada
- Item 12: Letter of Support from Doctors of BC
- Item 13: Letter of Support from Douglas College
- Item 14: Letter of Support from Downtown Surrey Business Improvement Association
- Item 15: Letter of Support from First Nations Health Authority
- Item 16: Letter of Support from Fraser Health Authority
- Item 17: Letter of Support from Indigenous Services Canada
- Item 18: Letter of Support from Kwantlen First Nation
- Item 19: Letter of Support from KPU
- Item 20: Letter of Support from Métis Nation British Columbia
- Item 21: Letter of Support from MOSAIC
- Item 22: Letter of Support from National Consortium for Indigenous Medical Education
- Item 23: Letter of Support from Pegasus Institute
- Item 24: Letter of Support from Rural Coordination Centre of British Columbia
- Item 25: Letter of Support from Surrey Board of Trade
- Item 26: Letter of Support from Semiahmoo First Nation
- Item 27: Letter of Support from ^{s. 22}
- Item 28: Letter of Support from SFU-India Advisory Council
- Item 29: Letter of Support from Skwxwú7mesh Úxwumixw
- Item 30: Letter of Support from Tsleil-Waututh Nation
- Item 31: Letter of Support from UBC
- Item 32: Letter of Support from White Rock-South Surrey Division of Family Practice

WHAT WE HEARD REPORT

SFU Medical School Internal Engagements

March - April 2023



Background: A New Medical School at SFU

The British Columbia provincial government has committed to enhancing primary care and access to family doctors across B.C. Part of this work includes the creation of a [medical school at SFU](#) to educate the next generation of community level specialists, including family doctors who will competently and compassionately meet the needs of B.C.'s growing and diverse population, particularly in underserved and Indigenous communities.

SFU is working with the Ministry of Post-Secondary Education and Future Skills, the Ministry of Health, Fraser Health, the First Nations Health Authority, UBC and other partners to plan the new medical school, as part of a long-term solution to improve the health and wellness of all British Columbians.

Previous Community Engagement: 2021

In the fall of 2021, SFU began an internal community engagement process for what was then a proposed SFU Medical School. Among other questions, people were asked: What values/principles should guide our early planning? And what is your best advice for SFU as we move forward in planning for the proposed new medical school?

In a themed summary report, SFU's Morris J. Wosk Centre for Dialogue captured the views and ideas from SFU students, faculty and staff during an online information session on Oct. 18, 2021. The report, What We Heard, also captured feedback from a pair of targeted webinars and an online survey. The report is available [here](#). This wide-ranging input helped to inform the planning being undertaken through working groups in the four major areas of 1) curriculum; 2) space; 3) workforce; and 4) research. It is also informing further engagement with the SFU community.

In the current stage of planning and engagement with the SFU community, SFU is diving deeper into some key themes that emerged in the previous round of engagement. These include: different styles of teaching and team-based learning, building design & construction, support functions for the medical school, and expansion of the medical community through existing SFU faculty.

Other important themes that emerged from the 2021 engagement will also be explored further in subsequent phases of planning and engagement.

Internal SFU Community Engagement: 2023

Building on feedback received in 2021, SFU's Office of the Provost and Vice-President Academic (Provost's Office) worked with the Centre for Dialogue to organize an additional series of information sessions and engagements with SFU students, faculty and staff to provide updates, gather further feedback and explore how the SFU community can benefit from and be involved with the new medical school.

This work included a survey promoted to the entire SFU community, open from March 2nd to April 28th, 2023, as well as the following engagements with specific audiences:

- March 2, 2023 – *SFU Medical School: Information Session for Faculty, Staff and Students* including breakout discussions (virtual, on Zoom)
- March 28, 2023 – *SFU Medical School: Research-Focus – Faculty and Graduate Students* including breakout discussions (virtual, on Zoom)
- April 3, 2023 – *SFU Medical School: Indigenous Information Session* including lunch and round-table discussion with Indigenous SFU students, faculty and staff and SFU faculty and staff who serve Indigenous communities (in person, on SFU Burnaby campus)
- April 25, 2023 – *SFU Medical School: Creating Space and Building Pride in Surrey*, including presentation and breakout discussions with SFU students, faculty and staff (in person, on SFU Surrey campus)

Prior to each of these engagements, participants were notified of the SFU Medical School's five pillars, upon which the curriculum will be built:

1. Prepare graduates to meet the prevention and primary care needs of **diverse communities** and populations across B.C.
2. Educate physicians to work in team-based **primary care** settings that are patient-centered and socially accountable, through research-informed curriculum and pedagogy.
3. Commit to reciprocal **community partnerships** in the development and implementation of the medical school, its academic programs and research priorities.
4. Embed and equalize **Indigenous** knowledge systems in learning, research and practices.
5. Provide **community-based learning and research** opportunities.

About This Document

The following document contains five distinct What We Heard Reports including one for each of the four engagement sessions listed above, as well one for the community survey. This document is a compilation of the reports and does not seek to synthesize the feedback across the different engagements.

Each of the reports is a themed overview of the respective dialogues and survey, prepared by the Centre for Dialogue, to provide an overview and summary of participants' comments and ideas. For both virtual and in-person engagement sessions, note-takers were present in each of the breakout rooms / tables and the report contents are gleaned from those notes.

These reports do not provide an overall representation of public opinion, that of the community at SFU, nor institutional policies or positions. This report does not necessarily reflect the opinions of the Centre for Dialogue, or the University at-large. All feedback was compiled and analyzed without attribution to protect participants' privacy as much as possible and to encourage participants to share their authentic views.

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What We Heard Report: Information Session for Faculty, Staff and Students

Session Background

On March 2, 2023, from 3:00 – 4:30 p.m., 96 participants gathered virtually (out of 173 who registered) for an information session and engagement on the planning of the new SFU Medical School including SFU students, faculty, and staff.

The session began with a welcome from Elder Marie Hooper from the Kwikwetlem First Nation and opening comments from SFU President Joy Johnson. President Johnson was then joined by Wade Parkhouse, Provost and Vice-President Academic *pro tem*, and Roger Strasser, Interim Dean, SFU Medical School to present an update on the planning of the school and answer questions submitted by participants through the audience interaction platform, Slido.

Following the Q & A, participants had the opportunity to stay in the meeting to participate in further discussions. 29 participants stayed to join breakout rooms for a facilitated discussion of the following questions:

- What unique SFU values, assets or relationships will set our medical school apart from others?
- What impacts could the medical school have on local communities and the province that would make you proud?
- How could the SFU medical school benefit you? How would you like to be involved?

What We Heard

Throughout the dialogue, participants shared the following key themes in response to the discussion questions.

What unique SFU values, assets or relationships will set our medical school apart from others?

SFU's commitments to community engagement, equity, the United Nations Sustainable Development Goals, and Indigenization will set it apart.

- SFU already has a strong emphasis on community engagement and SFU is effective at collaborating with student organizations.
- Efforts of the medical school to Indigenize and decolonize health care will be supported by SFU's overall commitments to Indigenization and decolonization. There is, however, a disconnect between the university's goals of Indigenization and decolonization and what students are currently experiencing.

- SFU's strength in community engagement will also support the Indigenization and decolonization of health care, as community is at the centre of Indigenous health. True collaboration with Indigenous people will be essential to achieving health equity, not just parity.
- It will be important to establish ways to measure and track the success of the medical school's aspirations.

SFU's pedagogical approaches, including team-based learning, and integration of diverse perspectives, can set it apart.

- It is important that the medical school's approach be informed by diverse perspectives and life experiences, including BIPOC people and diverse gender identities. Medicine is often practiced from a cis-het perspective.
- SFU's diverse student body, including a variety of distinct faith and ethnic communities, is an asset that can support this integration of diverse perspectives.

SFU already has local community connections, and the Surrey area in particular presents further opportunities for engagement and collaboration.

- SFU has existing relationships with health authorities, community partners, and organizations in Surrey and the Fraser Valley which can be built upon.
- The location in Surrey will allow the school to work with a population that is distinct from that which UBC serves, and also presents a variety of opportunities for clinical experience.

The relatively smaller size of the SFU Surrey campus is an asset that can support collaboration.

- Compared to larger institutions such as UBC, the intimate and personal Surrey campus environment is a strength, and may encourage students to explore interdisciplinary ways of learning.
- Opportunities exist to collaborate on research across faculties including existing work on medical subjects.
- The SFU Surrey campus, however, has relatively fewer amenities and services compared to the SFU Burnaby campus. This aspect may need to be improved to make the campus more vibrant and attractive to potential students.

What impacts could the medical school have on local communities and the province that would make you proud?

Engage with community effectively: Work with the public to understand and address diverse community health needs. Connect students with community to create community engaged doctors and give students more control over placements.

- Engage with the immediate surrounding community in Surrey, including partnerships with Surrey municipal government.
- Focus on community-centred problems and tangible community impact in Surrey and elsewhere. Support for underserved and diverse communities of B.C. needs to be intentional, and address issues in a non-tokenistic way, with attention to cultural safety.
- Support Indigenous communities by educating health care workers who understand the community. Students need to hear Indigenous perspectives to gain understanding of communities and Indigenous medical practices, including from Indigenous health practitioners working directly with community members and those who are practicing in broader areas.
- Develop doctors who themselves will engage with the community, and take a holistic, relational, and personalized approach to their practice, including the development of empathetic relationships with underserved communities. Admissions can select for these qualities. There are three years to develop and evaluate a “feeder program” before the school opens.
- Give students more control over residency placements, compared to the existing matching system. This will allow them to work within the communities they desire and start establishing local roots where they will ultimately begin their practice.

Educate the public, and undergraduates, not just medical students, on health.

- Support public education on disease prevention, not just treatment.
- Lead the charge on opening medical research and articles to public access.
- Create community services and scaffolding to help the public understand how to interpret medical research.
- Make collaborative and educational opportunities available for undergraduates who may not be pursuing a career in medicine but are passionate about health.

Address the shortage of family doctors.

- Help make family doctors more available for residents of BC, and Surrey specifically.
- Design student recruitment with the recognition that some potential students may consider family practice to be less exciting than other medical fields.

Create a premier, well-recognized institution, producing skilled, well-rounded graduates.

- Take a rigorous approach to developing curriculum, to ensure it is top-tier.
- Educate students on public health and government relations, not just patient care. Physicians will need to collaborate with the public health sector and government.
- Educate students on disease prevention, not just treatment.

- Educate students in management and leadership, and teach them how to continue to acquire knowledge, skills, and behaviours after their program concludes.

“This generation will question everything and come up with radical solutions.”

How could the SFU medical school benefit you? How would you like to be involved?

Students, faculty and staff from different departments and roles were excited for the opportunity to support and collaborate with the school in creative ways. Specific examples included:

- Administrative and communications staff from the university were keen to support the medical school, including helping to tell the school’s story.
- A public health student wanted to help educate people about public health and preventative medicine.
- The development of the new school presents an opportunity to challenge the ways things are done in the university.
- The school can encourage collaboration across faculties to infuse the school with different perspectives, including on research. Doctors from the school can provide guest lectures for other faculties on relevant topics.

The school could have far-reaching benefits by improving medical care for general public, as well as specific populations such as those with rare disorders and Indigenous people.

- The school will provide greater access to family doctors and quality local health care.
- There is an opportunity for collaboration with the [Canadian Organization for Rare Disorders \(CORD\)](#), which runs programs to pair newly graduated doctors with people who have rare diseases.
- There is a great opportunity to decolonize teaching while also addressing the healthcare gap for Indigenous people on- and off-reserve.

“Decolonizing family physicians is so important.”

Students will benefit from having a single campus for classes, but with integration into the broader SFU community, and opportunities for real-word experience in the medical field.

- Schedule all classes at one campus to reduce transportation requirements for students.
- Ensure the school is integrated into the broader campus. Do not replicate the example of the Engineering school, which feels separate from the rest of SFU community. Facilitation exercises, such

as those that take place in [SFU's Semester in Dialogue Program](#), could help to address the issue of isolation.

"[As a current student,] I hope to get involved through extracurricular, clinical experience, research and volunteer opportunities. Getting into health care is difficult. Having one year of prior work experience is required. Getting the chance to shadow or gain clinical experience will allow me to get started on my career in the field."

What We Heard Report: Research-Focus - Faculty and Graduate Students

Session Background

On March 28, 2023, from 1:00 – 3:00 p.m., 56 participants gathered virtually (out of 70 who registered) for a research-focused information session and engagement on the planning of the new SFU Medical School including SFU graduate students and faculty.

The session began with a welcome from Elder Marie Hooper from the Kwikwetlem First Nation. Dugan O'Neil, Vice President, Research and International (VPRI), then presented an update on the planning of the medical school, followed by a Q & A.

Following the Q & A, participants had the opportunity to stay in the meeting to participate in further discussions. 9 participants stayed to join breakout rooms for a facilitated discussion of the following questions:

- How can your research program, or that of your department, school or faculty, help shape the research direction of our new medical school? Are you aware of existing research partnerships, facilities or other assets that would be of value to the research program of a new medical school?
- In what ways could your research, or that of your department, school or faculty, benefit from the creation of a medical school?
- Do you have any concerns about the impact of the SFU Medical School on research at SFU? Any suggestions that would address those concerns?
- How can we ensure that we build effective research linkages between existing SFU research programs and new programs created at the medical school?

What We Heard

Throughout the dialogue, participants shared the following key themes in response to the discussion questions.

How can your research program, or that of your department, school or faculty, help shape the research direction of our new medical school? Are you aware of existing research partnerships, facilities or other assets that would be of value to the research program of a new medical school?

SFU Medical School research and teaching can be infused with interdisciplinary perspectives and collaboration by:

- Incorporating the social sciences and lived experience into research.

- Collaborating with the School of Engineering Science, and more specifically with Biomedical Engineering, including on research in the areas of machine and deep learning.
- Collaborating with the SFU School of Interactive Arts and Technology on teaching and research related to the intersection between social and technical issues, and health communications. There is a demand for health communications professionals in Canada, but the current SFU curriculum in this area is insufficient to support students who seek to work in this field.
- Leveraging the expertise of SFU researchers who are already carrying out their research effectively.
- Recognizing the pre-existing issue at SFU of having many people teaching similar topics across faculties and campuses. Working to avoid unnecessary duplication of courses, while also leveraging existing expertise in the development and teaching of the medical school curriculum.
- Helping other faculties and researchers, who may only have a limited understanding of the medical system, to develop a more in-depth understanding, so they can better identify opportunities for collaboration.

Opportunities and assets to support SFU Medical School research and curriculum development include:

- Receiving support from the SFU Department of Research and Evaluative Services.
- Collaborating with Vancouver Coastal Health, who provides seed funding for research undertaken by their units.
- Recognizing the critical importance of personal relationship-building to partnerships and funding, and providing faculty and staff with the resources (including work-hours) to foster and maintain relationships.

“Partnerships follow individuals, not institutions.”

- Ensuring the school is attractive to potential collaborators by emphasizing how SFU Medical School research will be at the forefront of rapid technological changes in the health.
- Including practicing doctors in working groups to support the school’s development. They can bring direct experience and insights about systemic improvements to both community care and the day-to-day experience of doctors.
- Taking advantage of current opportunities for funding and research related to wearable healthcare technologies. For example, there are projects at SFU in collaboration with [Kwantlen Polytechnic University \(KPU\)](#) and the [British Columbia Institute of Technology \(BCIT\)](#) that are currently awaiting a funding decision.
- Learning from the [Equity Strategy for Canadian Institutes of Health Research \(CIHR\)](#) to develop equitable processes for the research program and to support the hiring, development, and retention of diverse faculty members.

Other potential partners included:

- [Arthritis Research Canada](#)
- [BC Supercluster Initiative](#)
- [Cambian](#)
- [Canadian Pain Society](#)
- [Chronic Pain Research Institute](#)
- [Fraser Health](#)
- [Google](#)
- [Lotte & John Hecht Memorial Foundation](#)
- [IBM Watson Health](#) (recently re-branded [Merative](#))
- [International Virtual Reality Healthcare Association \(IVRHA\)](#)
- Mindstrong (Company closed in 2023, tech assets sold to [SonderMind](#))
- [Pain BC](#)
- [Providence Research](#)
- [Stanford University Centre for Artificial Intelligence in Medicine & Imaging](#)
- [Tickit Health](#)
- [UnitedHealth Group](#)

In what ways could your research, or that of your department, school or faculty, benefit from the creation of a medical school?

Benefits from the SFU Medical School included:

- Strengthening relationships in Surrey both within SFU Surrey and externally. There is an opportunity for the medical school to connect all of the branches of the various schools and faculties. It will also catalyze external relationships in the area. Proximity and opportunities for in-person contact will support the development of these relationships.

“Collaboration is a body contact sport.”

- Accessing doctors through the school to support biomedical engineering research, specifically studying health-related wearables and instruments at the point of care.

- Creating opportunities for students to work in more practical settings, which may be relatively less available through the “pure sciences.”
- Providing a different, and practical, perspective to research designs through collaborations with medical faculty.
- Creating new funding opportunities for student research.
- Exemplifying how Indigenous ways of knowing can be integrated into curriculum and research. This could influence other faculties, and SFU as a whole.

**Do you have any concerns about the impact of the SFU Medical School on research at SFU?
Any suggestions that would address those concerns?**

Concerns about the SFU Medical School included:

- The overall financial cost of the school.
- Other faculties and departments will be excluded from the curriculum development process, partly because the SFU Medical School will want to maintain strict control over that process.
- Research collaborators or cross-appointed faculty members may be dissuaded if collaboration can only be undertaken on the school’s terms, and demonstrated in accordance with the school’s mission. Collaboration demands flexibility.
- The medical school could deprive other departments of resources, leading to factionalism and resentment towards the medical school. Cross-appointments of faculty may both be productive and an important tool to ensure the medical school is not siloed. However, they could be a drain on the resources of other departments. The medical school also needs to avoid exacerbating the issue of “two-tiered” faculty positions.
- Barriers or delays could be created for existing health research, as well as unintentional barriers for medical school collaborators from other departments on new research projects.
- Researchers may be pulled in different directions between Fraser Health’s research enterprise and that of the SFU Medical School. The school should seek out similar examples from other organizations to inform how this can be effectively navigated.

Policy / operational suggestions included:

- Creating mechanisms to maintain a diversity of research, including what UBC terms “social and behavioural research.”
- Ensuring all research collaborators are well aware of health-specific research ethics and their implications, and effective processes are in place for reviewing and approving the ethics of qualitative research proposals.

How can we ensure that we build effective research linkages between existing SFU research programs and new programs created at the medical school?

Suggestions for building effective research linkages included:

- Leaving enough space for research topics and programs to be emergent.
- Collaborating with partners to create “seed research opportunities” and grow them.
- Being confident in Canadian research and innovations. Avoiding the “Canada Syndrome” that requires validation from work outside of Canada to deem such research and innovations as trustworthy.
- Creating more opportunities to build greater awareness of existing research projects across the university. These could include “poster days”, and other events that create social connections among researchers, and help “put a face to a name”.
- Holding more events to create relationships and spark ideas among potential internal and external collaborators.

What We Heard Report: Indigenous Information Session

Session Background

Indigenous collaboration and perspectives are critical to the planning of the medical school. SFU has shared that First Nations, Inuit and Métis knowledge systems and perspectives will be embedded throughout the school. Also, SFU envisions its medical program as one where students and residents learn as part of a team in primary care and other community level settings, with strong connections to remote, rural, and Indigenous communities.

On April 3rd, 2023, from 12:30 – 2:45PM, at the Learning Hub in the Education Building on SFU Burnaby Campus, 18 participants including Indigenous SFU students, faculty and staff, as well as faculty and staff who serve Indigenous communities gathered for an information session and engagement on the planning of the new SFU Medical School.

This engagement session built upon themes that emerged during the previous engagement phase. In advance of the session, participants were sent a summary of these themes:

1. Opportunities for engagement and co-creation with Indigenous peoples throughout the development of the school.
2. Inclusive admissions and education for Indigenous people, including non-status and urban Indigenous people.
3. Curriculum and teaching informed by Indigenous medical practices (including training from Indigenous health practitioners, elders, and other knowledge holders) and community-specific care (including cultural safety training and community-embedded training).
4. Effective community engagement including partnerships with Indigenous organization.

The session began with a welcome from Elder Marie Hooper from the Kwikwetlem First Nation and opening comments from SFU President Joy Johnson. It was hosted by Chris (Syeta'xtn) Lewis, SFU's Director of Indigenous Initiatives and Reconciliation and Kris Magnusson, Dean, pro tem, Faculty of Education and Senior Advisor to the Provost.

The session was structured as an informal conversation where participants heard an overview and updates about the planning of medical school, followed by an open dialogue where participants were able to share their perspectives and ask questions.

What We Heard

Throughout the dialogue, participants shared the following key themes.

Medical students should be educated to provide empathetic care to BC's diverse communities, including, but not limited to Indigenous people:

- The school should focus on producing graduates with emotional intelligence, who bring this quality to their medical care. The school should provide education based not only on sciences, but also on how to interact with people of different cultures etc., including flexibility in the provision of care to meet the diverse needs of patients, especially equity-deserving groups.
- Medical students need to be trauma-informed, and the school should prioritize mental wellness and health care, as 60% of visits to primary health care are due to mental health, particularly depression, and anxiety.

"I would like for us to become known across Canada and the world for producing doctors with compassion."

"What we are trying to do is bring humanity back into medicine."

The school should produce graduates with an understanding of Indigenous culture and history:

- Curriculum development must consider the very low level or lack of knowledge of the average graduate, and among health care professionals, about Indigenous history, Canadian history, and legislation. One participant had previous experience administering a survey on this topic that highlighted this knowledge gap among graduates.
- This lack of knowledge about Indigenous people may be especially pronounced among doctors who are newcomers to Canada, or whose perception of Canada may be skewed by highly visible international representations, such as the Olympics, where Indigenous people are not prominently represented. This lack of familiarity leads to reliance on stereotypes.
- What works is when residents understand working in a trauma-informed way, understand Indigenous culture and history, and understand healing practice.
- A participant noted that while Indigenous patients are indeed looking for cultural safety and anti-racist approaches, the basics of medical care are a top priority – access to services and information, and follow-up from providers.

"We want our cuts mended-to. We want to be able to live a viable and reasonable life, with good, solid medical care"

In-community experience is critical to an understanding of Indigenous culture, history, and medical practices, and to addressing the health care needs of Indigenous communities.

- Urban, rural, and remote Indigenous people and communities need medical care. There is a considerable need right at our back door, as 60-80,000 Indigenous people live in the Vancouver area (many of whom are not Coast Salish nor from this area), but communities across the province need support. Indigenous people across Canada, including in the north and northern Ontario, and those who are Inuit and Métis, are also following the development of this school, both as potential students and as communities in need.
- Doctors who choose to practice in Indigenous communities with an understanding of the culture and history tend to do well, and continue to practice in the community, whereas those without that understanding often leave after a short period of time.
- There is an increasing number of patients from rural and remote communities who need to fly to receive health care. As a result, it is important to attract students to these communities to demonstrate the good and balanced life that can exist there.
- The idea of community-based practice means that 1) students need to be engaged with community right from day one, as soon as they enter the official program, and 2) they need to live in community.
- In-community learning will initially be developed in collaboration with the Fraser Health Authority and First Nations Health Authority, then broaden the scope to a provincial level. Participants emphasized the importance of achieving this broader reach, and some were disappointed by the limitation on the initial scope.

Examples of, and considerations for how this knowledge and cultural sensitivity could be fostered among students included:

- Indigenous learnings shouldn't be bolted-on, but rather mainstreamed into the program. The Truth and Reconciliation Commission Calls to Action already call for medical students to take a course on Indigenous content¹, but this is insufficient.
- Curriculum could include content on natural medicines and medicinal plants, and the campus could have a medicinal garden on-site.
- With particular relevance to the Business Case, and necessary funding for the school, the medical school should hire, and "pay for" the best teachers, who not only excel at teaching their subjects, but who also already have knowledge and understanding about cultural safety, and Indigenous history and culture. This would both support the training of non-Indigenous students as well as foster a safe learning space for Indigenous students.

¹ Truth and Reconciliation Commission Call to Action #24: We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

- Having high-quality teachers will also contribute to attracting the best students. Great teachers also need the staff to support them. The Indigenous Student Centre only has ten current staff to serve all of SFU, which is insufficient.
- Similarly, participants felt that by having an “Indigenous” focus, some may assume that the quality of the program is not as good. Therefore, it is important that the program is stellar, and that this excellence is strongly conveyed, to attract the best students and faculty.
- The [RESPECT](#) program, or something similar, could be mandatory for all students.
- Efforts to embed cultural safety and understanding could inform the work of the university beyond the medical school. There is a need to decolonize psychology, and funding could be provided for the medical school to collaborate with the psychology department to support this effort.
- [Johns Hopkins](#) and the [University of Alaska Anchorage](#) are examples of great Indigenous education programs. [St. Paul’s Hospital](#) is an example of where residents gain practical experience in trauma-informed work, with an understanding of Indigenous culture, history, and healing practices.

“We need every course to have Indigenous content. We need to raise the bar.”

There is a need to develop pathway(s) to attract Indigenous students to the school, and retain them once there:

- There is a need for Indigenous health practitioners, not just doctors, but also psychologists, mental health counsellors, and nurse practitioners.

“I don’t think you can create Indigenous approaches to healthcare without having more Indigenous doctors. It starts there because they bring that [cultural understanding and lived experience] to their medical care, but also to their teachings when they teach other students.”

- A pathway is not just an articulation of steps. It is an articulation of all of the supports needed to support you on that path.
- Creating / finding Indigenous student pathways to the Medical School is not easy. High school is too late. There need to be earlier entry points, starting at the elementary level, and funding for this needs to be included in the Business Case. When a child is recognized as having a gift, how can we be intentional about lifting them up and helping them down the path?
- External examples of such pathways included: 1) the [House of Science](#) in New Zealand which creates Science Kits to engage youth. One participant shared the idea of an Indigenous-focused kit in this model. 2) UBC’s engineering-focused [Geering Up](#) [sic] program engages in early outreach including to Indigenous communities; and 3) the [Northern Ontario School of Medicine University \(NOSM U\)](#) also develops early pathways for medical students.
- Entry requirements present an opportunity to create a variety of pathways: they could select for different kinds of knowledge, such as compassion, and not only limit selection to the best science

students. The availability of these pathways also needs to be well-communicated. A participant shared that students from Indigenous Language programs often go on to further post-secondary education, but these students may not be aware of medical education as an option that is available to them.

- There is an opportunity to use the existing Indigenous University Preparation Pathway (IUPP) program, other existing structures, or design something new.
- Development of pathways needs to be holistic. Housing costs, cost of living, tuition costs, and childcare can all be barriers to post-secondary attendance, especially in Metro Vancouver. 25% of Indigenous 21-year-olds have children. Funding, living allowances, tuition waivers, provision of childcare, and housing support could all help to address these barriers. A partnership with CMHC was identified as a possibility to address housing. The availability of a continuous program (without summer breaks) could also help address financial barriers, allowing students to complete the program quickly, and start working.

“People get lost in the gaps. We need to guard against this.”

- A stellar program, high-quality teachers, availability of third year admissions, and availability of a continuous program, could all help the school be competitive with other medical schools for the best students, whether Indigenous or not.
- The planning of the medical school needs to address trust, or lack of trust, in institutions among Indigenous communities was also identified as an area of importance, especially in consideration of the experience of residential schools. There is a danger in promising, but not delivering upon pathways and supports for Indigenous people.
- Support for Indigenous students, and cultural safety, are important to retention and setting students up for success. Support staff for Indigenous students must be part of the Business Plan. Professors’ class content can be harmful if not appropriately trauma-informed, particularly considering the colonial history and experience of Indigenous people within the medical system. An Elder could be present to support every class.

“It hurts a lot to be told that being Indigenous is a social determinant of health. It hurts a lot. So what do we give students to fall back on?”

What We Heard Report: Creating Space and Building Pride in Surrey

Session Background

On April 25, 2023, from 1:00 – 3:00 p.m., 40 participants gathered (out of 42 who registered) on SFU Surrey campus for an information session and engagement on the planning of the new SFU Medical School including SFU graduate students and faculty.

The session began with a welcome from Elder Marie Hooper from the Kwikwetlem First Nation. Stephen Dooley, Executive Director, SFU Surrey Campus, Kris Magnusson, Chair, Workforce Working Group for the SFU Medical School and Senior Advisor to the Provost, and Roger Strasser, Interim Dean, SFU Medical School then presented an update on the planning of the medical school, followed by a Q & A.

Following the Q & A, participants joined five breakout tables for facilitated discussions of the following questions:

- What would make you feel proud to have the SFU Medical School as part of the Surrey campus? How can the school contribute to the ‘Surrey campus vibe’?
- What are your concerns regarding space and infrastructure when the SFU Medical School joins the Surrey campus? What benefits can the school offer in relation to space and infrastructure of the Surrey campus?
- In what ways can the SFU Medical School add value to your group, department, or faculty? What do you see as some of the possible challenges?
- How might we successfully engage with the external Surrey community to deepen the sense of connection to the medical school?

What We Heard

Throughout the dialogue, participants shared the following key themes in response to the discussion questions.

What would make you feel proud to have the SFU Medical School as part of the Surrey campus? How can the school contribute to the ‘Surrey campus vibe’?

Elements of the ‘Surrey campus vibe’, which should be recognized and enhanced in the design of the SFU Medical School included:

- A small-town, mutually supportive atmosphere, where everyone knows each other across Faculties and departments, says hi to one another in the hallways, and are deeply interconnected, not siloed.
- Programs and teaching styles which are distinct from other campuses.

The intended purpose and impact of the SFU Medical School are sources of pride, and will contribute to the reputation of both the Surrey campus and community. Specific areas which could contribute to this sense of pride include:

- Address the doctor shortage both in Surrey and more broadly.
- Serve the needs of underserved communities and Indigenous people. Encourage graduates to be involved within their community.
- Have a visible impact. “Walk the talk” when it comes to realizing the mission of the school, and be socially accountable.
- Educate through decolonized approaches, produce decolonized graduates, and address a crucial gap in decolonized doctors.
- Design admissions that are not bound by MCAT scores, ensure a diversity of background and experiences among students, and select for those who are motivated by community service.
- Be a leader among institutions through innovative teaching practices, and community impact.

“I would be proud if SFUMS is known for training ‘better doctors.’ The doctors we train are knowledgeable, competent and personable. This is reflective of the SFU community.”

- Offer a program that is distinct from other medical schools, including UBC. Service to the Surrey community is an example of this distinction.
- Become the top choice for prospective medical students. The ‘vibe’ of the campus can contribute to the appeal of the program among students.

“This project is unique to Surrey. UBC is the place currently to study medicine – the whole idea that you must go UBC that there is nowhere else. This is a source of pride in town (Surrey). This is a source of pride. We are proud there will be other options. An option that will be such a unique model.”

Develop the pipeline from school promotion to admissions to student support.

Promotional suggestions include:

- Recognize the need and cost to inform prospective students across the province and country of the school’s non-traditional admissions criteria, and to market the program effectively.
- Promote the school to elementary school students, including Indigenous students, starting their interest in the school at an early age, and “demystifying” medical education. Partner with school

districts to support this promotion. Welcome youth into the school through events, camps, and programming.

- Create visibility for medical school students and graduates from underrepresented and underserved communities and their community impact. This will inspire youth from these communities. This visibility can be created through communications products, through student / graduate ambassadors and mentors, and through the student placements in communities.

“We could send out a PR package of sorts; a ‘seed’ that could be sent to elementary schools, so that we keep it in the consciousness of students.”

Admissions suggestions include:

- Recognize that admissions processes themselves can be a barrier to prospective students. Design processes and pathways that don’t create an undue burden, and are also well-supported by advisors.
- Create tailored admissions processes and clear pathways for SFU students from different faculties, possibly including a nomination program by professors.
- Consider personal character in admissions through tactics such as small group conversations and reference checks.
- Create a streamlined pathway for foreign-trained doctors, and life-long learning opportunities for doctors to upgrade their skills. Both could also serve as significant revenue streams.

Student support suggestions include:

- Provide academic supports for students and services to help deal with stress.
- Reduce costs and debt for students, which will contribute to both retention and academic focus.
- Connect students with valuable, paid, job opportunities through placements, TA positions, etc. Engage family medical clinics to foster entry level opportunities.
- Plan for housing for both students and staff and recognize that high living costs may dissuade applicants.
- Engage retired doctors to become student mentors.

Suggests for curriculum and teaching included:

- Engage communities for input on curriculum design.
- Innovate in teaching practice, which may require some teachers to ‘unlearn’ traditional approaches.
- Teach in small classrooms to foster connections between students and teachers.

- Train students in the different ways that healthcare is delivered, such as telehealth.
- Leverage expertise in the Beedie School of Business to train students in the business of medical practice.
- Ensure there are enough opportunities for placements in under-served communities, and that placements provide high-quality teaching environments. 'Shadowing' does not necessarily produce great learning on its own.
- Ensure teaching staff is diverse. Use guest lecturers to expose students to a diversity of perspectives and experiences.
- Attract great teachers and support them with resources. Recognize the competition with other emerging medical schools across the country. Consider recruiting from other countries that have tried similar models of schools (such as innovative medical schools in Scandinavia).

"Faculty is the lynchpin. Word about bad teachers spreads faster than it does about good ones."

What are your concerns regarding space and infrastructure when the SFU Medical School joins the Surrey Campus? What benefits can the school offer in relation to space and infrastructure of the Surrey campus?

Concerns regarding the sharing of space among departments and faculties included:

- Conflict may arise around available space to support all of the new staff and students. Consider opportunities to expand current buildings and research spaces and create new shared facilities and services.
- The medical school will take precedence over other departments and faculties with regards to allocation of space.
- Parking needs to be sufficient and well-marked.

A high-quality program requires high-quality support from facility, security, and IT staff for space and infrastructure, especially considering the high-tech equipment which may be needed by the medical school. Suggestions for how to ensure this high-quality support included:

- Engage these departments early so they can provide feedback on the design of spaces and infrastructure and can prepare for the eventual space and infrastructure needs (including training on new systems and equipment, where applicable).
- Consider the technological needs of future generations when designing space and infrastructure. Consider shipping, receiving, and security requirements for expensive, high-tech equipment.
- Consider infrastructure to support place-based learning, including data security and bandwidth, and how it may impact teaching and learning.

- Create strong connections between central IT teams and local building IT teams. Do not create a siloed IT system. Build in opportunities for user feedback to maximize effectiveness of IT systems.
- Provide these departments with appropriate resources, including their own workspace.
- Prioritize functionality over aesthetics in building designs.

“[...] services like security, cleaners, clerks, IT, etc. are not the focal point but they are necessary to function. They are easily forgotten and their needs forgotten.”

“A building that functions properly, and not one that just looks good in a photo shoot. We want a place that’s healthy, safe, functional. Sometimes we don’t have the resources to provide services and we can’t help other people be their best if we don’t have those resources to help others. We don’t want to make the same mistakes we’ve made before.”

Create community through the design of space:

- Avoid designs that create silos. Design spaces to encourage interaction across faculties, departments, and with the Surrey community, building upon the ‘Surrey campus vibe.’ Ensure this applies to both the ‘interim space’ and new buildings and spaces.
- Reorganize the campus to have one large campus, rather than a disconnected one, with a common space for everyone to gather, regardless of faculty.
- Create a conference centre that is open to international conferences (not limited to medical topics). This will help increase the profile of the medical school, its purpose, and SFU Surrey, while also establishing more connections with different groups.
- Consider opportunities to design space in a way that invites other business and healthcare professionals to be part of the medical school.

In what ways can the SFU Medical School add value to your group, department, or faculty? What do you see as some of the possible challenges?

Opportunities for collaboration and added value include:

- Educate other faculties on the distinct characteristics of medical education and practice so they may be more aware of potential synergies.
- Develop a ground-up fundraising strategy for the medical school, and attract donors to Surrey more generally. New spaces and buildings could provide a revenue source through naming rights.
- Develop strong intra-SFU collaboration with the medical school, which will be attractive to donors and external collaborators.

- Create new research opportunities and connections with medical practitioners. These opportunities may also help to attract faculty to the Surrey campus, which can be a challenge. Specific opportunities for research collaborations exist with Big Data, and on issues related to biomedical engineering and machine learning.
- Leverage the experience and connections of [Work Integrated Learning \(WIL\)](#) to create a bridge between the community and medical school through co-op placements, internships or community-based learning opportunities.

Challenges include:

- Identify what the province sees as a priority and is prepared to fund.
- Ensure resources are adequate to support the influx of students and staff.
- Prepare for changing funding, spending, and disbursement needs over time.

How might we successfully engage with the external Surrey community to deepen the sense of connection to the medical school?

Engage the Surrey community in authentic and meaningful ways. Suggestions for engagement include:

- Recognize that many people in Surrey still don't know about the medical school. SFU needs to communicate and engage further with the external community.
- Create clear and welcoming pathways for the community to ask questions about the medical school, both digitally and in person.
- Encourage decision-makers for the school to live in Surrey or have a deep understanding of the community.
- Engage to understand community needs and ensure those needs shape important decision making about the school. Do not limit community input to minor, time-bound aspects of the school, but also be careful not to overpromise on the impact of community input.

“Consultation with the community... don't just pay lip service. Really hear and listen well, address their concerns.”

Specific populations and groups which should be engaged include:

- Underserved communities and Indigenous groups
- The homeless community
- Surrey Memorial Hospital and other nearby hospitals
- Fraser Health

- B.C. Divisions of Family Practice
- Doctors of BC
- Downtown Surrey Business Improvement Association
- Local newspapers
- Surrey Mayor Brenda Locke
- Municipalities surrounding Surrey.

Leverage the location, embedded in Surrey, to connect with the community. Encourage community interaction and connection by enhancing visibility, creating a welcoming space, and offering community programming and services. Specific suggestions include:

- Foster a welcoming space by having doors open to the public, ensuring a safe space for Indigenous and LGBTQ communities, and being cautious that the perceived ‘prestige’ of the school does not make people feel unwelcome (e.g. “That’s not for me, that’s for rich people, I’m just a visitor.”)
- Include amenities (e.g. library, common space, fitness centre etc.) that will encourage both students and the external community to spend time on campus. The community is not as present in the SRYE building. Need to learn from this experience.
- Host community events and programming to invite the community, including SFU Alumni, into the space. Pay special attention to youth programming to build an early connection with the school, and to inspire youth to pursue a medical education.
- Provide a front-line clinic and counselling services to support the community and students. Counselling services are currently insufficient for students at SFU Surrey. Online services and virtual clinics provide more accessibility, especially for those with lower income.

What We Heard Report: SFU Community Survey

Survey Background

The survey, “A new medical school for B.C.” accepted responses from March 2nd to April 28th, 2023 and was promoted to the entire SFU community. There were 226 survey submissions including 66 that provided responses to at least one of the six open-text questions.

The survey shared the following **draft** vision, goal, and mission statements for the SFU Medical School:

- **Vision:** To consistently, continuously and comprehensively improve the health and wellness of the diverse populations of B.C.
- **Goal:** To graduate physicians who have the skills and commitment to provide team-based community-level health care where it is most needed in British Columbia particularly for underserved and underrepresented populations, and Indigenous Peoples.

- **Mission:** To provide inspiring, excellent medical education and training programs that are flexible and adaptable over time to ensure graduates are lifelong learners who achieve the SFUMS vision.

What We Heard

Respondents shared the following key themes in response to the survey questions.

What do you think of the focus of the SFU Medical School, as articulated in the draft vision, goal and mission?

Reactions to the vision, goal and mission were mixed.

- To some, the draft vision, goal and mission of the SFU Medical School are exciting and appropriate to address the public need for primary care, especially for underserved populations and Indigenous peoples.

“I think the focus of the SFU Medical School is wonderful. It is so important to have more family physicians as many individuals don't have one, especially in remote areas.”

“My hope is that it will not only improve the health of British Columbians but will also set a standard to be followed not only within Canada but worldwide.”

- To others, however, the vision, goal and mission are generic, not ambitious enough in impact or scope, and do not do enough to differentiate the SFU Medical School from other schools.

“The vision/goal/mission are very noble, but could use more detail and specificity. I think they are overly generic and broad.”

“These statements seem to aim lower than UBC who will ‘transform health’ through ‘exemplary medical education’.”

Refine or expand the vision, goal and mission of the school by:

- Identifying which specialties will be available to students, and whether this is limited to primary / family practice and Indigenous health.

- Recognizing and addressing the need to prepare for the health effects of climate change.
- Including ‘accessible learning’ as a key element of the school.
- Educating students in high-quality, holistic, person-centred care, including knowledge of and attention to the social determinants of health.
- Strengthening the healthcare system in B.C. by preparing students to take leadership positions in hospitals and clinics province-wide, and ensuring they are well-versed in research and policy.
- Articulating the role of research.
- Addressing how resources will be allocated.
- Stating directly that one goal of the school is to increase the supply of family doctors.
- Identifying the high-level pre-requisites for application (e.g. completed undergraduate program).
- Including content related to “embed and equalize Indigenous knowledge systems” in the vision, goal, and mission, in accordance with the curriculum pillars.
- Defining ‘underserved and underrepresented populations’ in consideration of other groups besides Indigenous peoples (e.g. rural populations, people with disabilities, transgender people, intersex people, people who use drugs, obese people, recent immigrants, and language groups etc., notably including French as an official language). Articulating how this definition differs across locations, and how the school will impact each of these populations.

Concerns about the SFU Medical School project included:

- The goals are too “lofty”. *“We can’t be all things to all groups, be selective.”*
- SFU does not have the capacity to run a medical school, and needs to address current issues with collegial governance and the retention of senior administrators before this expansion.
- The school will be costly and draw resources away from other departments, or underestimate the requirements placed upon other departments to support and collaborate with the school.
- The school should prioritize supplying B.C. with the highest quality doctors with the skills to serve the broader public. Some respondents were concerned that designing student admissions and curriculum with a focus on service to underserved and underrepresented groups could detract from overall quality.

How can we ensure that the SFU Medical School is successful in achieving its goals?

Remain resolute in the vision, goal, and mission, and ensure and demonstrate that the ethical commitments, and high standards, are realized in all aspects of administration and governance.

“You’ve articulated a big audacious and commendable goal. I think it’s important that it doesn’t get compromised over time because these kinds of equity-supporting mandates are

going to be hard to maintain in the real world under budgetary, political, and social challenges that are inevitable. Missions and goals are easy to overlook when one is in the weeds.”

- Evaluate the program regularly, with input from students and professors. Communicate regularly with the SFU community including regular updates on the school’s progress.
- Use the Carver governance model.
- Hire excellent professors and create clear pathways for existing SFU staff to fill new administrative positions, including any necessary training and accreditation.

“Demonstrate valuing and respecting all people in all that the school does - this includes how all employees (faculty through to cleaning staff) are treated equitably and fairly, strive for a culture of respect rather than competition, recognize the value of different types of work (community engagement, community service etc.) in all employees and students.”

- Secure sufficient funding to support the school’s goals. Ensure that funding can accommodate the school’s growth over time, and ensure other faculties are not compromised.

Ensure admissions, curriculum, and placements are designed to accept and train diverse students, and produce graduates who can meet the needs of diverse communities.

- Secure sufficient funding to reduce the financial burden on applicants and students.
- Develop holistic admissions criteria that select for those who are qualified for person-centred and community-serving care.

“Having a Black applicant stream that truly emphasizes equity in admissions and promotes the medical field to youth through different programs is really needed if Black representation is to be taken seriously.”

- Develop an undergraduate pre-med program that is available at SFU Surrey that includes a focus on person-centred and community care.
- Provide pathways for international students and for recognition and up-skilling of foreign-trained medical workers.
- Consider what language skills are necessary for graduates to serve B.C.’s multi-lingual population and how admissions can select for these skills.

- Create a strategy for ensuring students continue to practice in service of underserved and underrepresented communities across different locations with consideration of financial and social incentives.
- Ensure curriculum incorporates Indigenous frameworks and includes training in public health and communication of risk.

**See the next question regarding continued community engagement by both SFU and students with the public and health communities to understand real-world health care experiences and patient needs.*

How could the SFU Medical School enhance the university's commitment to community engagement?

- Provide medical services including free or subsidized clinics, and public wellness and education programs virtually, on-campus and in community. Design the medical building with space to host the public. Connect with SFU's health care program to provide services to international students at a reduced cost.
- Engage regularly with communities and community organizations across Surrey and in the broader region, to better understand and address community health needs and patient experiences, especially those of underserved and underrepresented groups. Reserve board seats for members of these communities. Ensure diverse representation among faculty.

"Ask the communities about their vision for primary care and follow their priorities."

- Prioritize student engagement with community members and community health practitioners, both in-class and in real-world medical settings, to understand community needs and the realities of medical practice. Build relationships with clinicians to develop fruitful and educational placement opportunities and ensure they are champions of the school.
- Partner with the [Canadian Organization for Rare Disorders \(CORD\)](#) to pair students with patients who have rare diseases/disorders to better understand their needs and experiences.
- Ensure research includes community participation and considers the lived experience of patients.

How might you contribute to the SFU Medical School? / Please suggest resources (capacity) that are available within Simon Fraser University to contribute to the SFU Medical School.

**The two questions above were asked separately, but responses are consolidated below.*

Examples of personal involvement and contributions included:

- Attending the school as a student.
- Providing feedback about the school and holding the school accountable to its goals and vision.
- Donating and paying taxes.
- Promoting the school in the community.

“I wish to be a student at the school, hoping to be one of the first graduates of the school. I then want to actually carry out the goal of serving rural communities ESPECIALLY Indigenous ones. I’ll even sign a 10-year contract that says I can only work rural to ensure my admission into the school. I will do whatever it takes to get a seat.”

Opportunities for contributions and resources to support the school included:

- Leveraging other departments and faculties to support the administrative needs of the school including Canvas modules or workshops, EDI advisory, development of residency programs, IT, room assignments, and fundraising.
- Collaborating with other faculties (both within and outside STEM) on research, teaching and curriculum development including content on anatomy, social determinants of health, medical ethics, biological anthropology, Indigenous-based education, health sciences, health technologies and their responsible use, mental health and substance use, health science communication, and knowledge mobilization.
- Leveraging the health-related networks and relationships of other departments and faculties.

“Oh, my goodness, when I think of all our faculties and disciplines [...], we collectively have SO much to offer.”

- Engaging with patient community, the public, student groups such as the [SFU Pre-Med Society](#), [SFU350](#), the [SFU Students of Caribbean and African Ancestry \(SOCA\)](#), [Disability and Neurodiversity Alliance \(DNA\)](#), and the professional health community including [Black Physicians of BC](#).
- Collaborating with ImageTech to educate students on medical imaging, WearTech on opportunities to test, validate or design wearable health technologies, and Circle Innovation to connect with industry partners developing new health technologies.
- Leveraging existing spaces, classrooms, and labs across campuses, buildings, and faculties.

What other comments or suggestions do you have?

- Engage with high schools to develop interest in the program among potential students at a young age.
- Address possible perception that embedding First Nations, Inuit and Métis knowledge systems and perspectives could mean the school will teach medical methods that are not scientifically proven.
- Ensure enough residency placements are available for students, and ensure students are paid fairly for work completed.
- Ensure sufficient supports, services, and amenities are in place for medical school students, especially considering the needs of a diverse student body which includes those from underserved and underrepresented communities. Recreational facilities can also directly contribute to the health and well-being of students and the surrounding community.
- Learn from the experiences of other medical schools including the [Latin American School of Medicine \(ELAM\)](#) in Cuba.

SFU Collaborators and Resources

The following list contains units at SFU that were specifically named as potential collaborators or resources by survey respondents:

- Big Data Hub
- Centre for Educational Excellence
- Department of Archeology
- Department of Biomedical Physiology and Kinesiology
- Department of Psychology
- Faculty of Education
- Faculty of Health Sciences
- Faculty of Applied Sciences
- Faculty of Science
- Medical Computing and Analysis Lab
- Meeting, Event and Conference Services
- Morris J. Wosk Centre for Dialogue
- Office of Francophone and Francophile Affairs
- Public Square
- Research Computing Group
- Research Operations
- School of Engineering Science

- Sustainability Office
- TD Community Engagement Centre
- Technology Licensing Office
- Work Integrated Learning

Appendix: SFU Community Questions

As part of the registration process for the SFU Medical School engagement sessions, participants were asked to submit any questions about the medical school planning. During the engagement, participants also had the opportunity to ask further questions.

Below is a summary of the key questions that arose through these inputs, as well as those raised throughout breakout discussions at the sessions, or through the survey.

General questions:

- What is the timeline for the development of the SFU Medical School? When will it launch?
- How can one learn more about the SFU Medical School?
- How can one contribute to the planning of the SFU Medical School?
- What will be the research focus of the SFU Medical School?
- How will the SFU Medical School be paid for? Will the school detract from the resources (funding, staffing, and administrative support) for other departments?
- How will the SFU Medical School be governed?
- On which campus and in what space will the SFU Medical School be located? What labs and teaching spaces will the school use? Will new ones be built, and what shape will they take? How will existing labs and teaching spaces be impacted?

Questions about admissions:

- What will be the admissions requirements and processes for the SFU Medical School? What are the prerequisites? When will applications be accepted? When will these details be announced?
- Will there be different admissions pathways for undergraduate students from different disciplines? Will preparatory courses or supports be offered at SFU?
- Will SFU students have any advantage in the admissions process?
- What can potential applicants do now to prepare to apply when applications open?
- Will international students be able to apply? What will be the process for internationally trained medical graduates?
- How many seats will be available in the program? How will SFU ensure underrepresented and underserved communities are represented in the student body?

Questions about curriculum and placements:

- Is primary care the only option for students, or will specialist programs also be available? Some other medical schools have struggled to attract students to primary care programs. How will the SFU Medical school attract enough primary care students?
- Will the curriculum train students in new and emerging medical technologies, biotechnology, or the use of artificial intelligence?
- How will the curriculum train students to understand and support the diverse medical needs of communities? How will they provide cultural safety and trauma-informed care? How will they be trained in reconciliation and decolonized medical practice?
- Will students be able to take all courses at the SFU Surrey campus?
- How will the medical program be different than those at other medical schools in Canada?
- How will student placements work? Where will they take place, and how can it be ensured that there are enough opportunities, considering competition with UBC?

Questions about student supports:

- How will housing be provided for students?
- How will student mental health be supported?
- How will cultural safety be provided for students, including Indigenous students?
- What sort of academic supports will be available for students?
- What will be the cost of tuition? What sort of financial supports will be available for students? Will the tuition waiver for continuing SFU staff apply to the medical school?

Questions on collaboration across disciplines and departments, including those outside of STEM:

- How can departments who are not currently a part of the 'working groups' contribute to the planning of the medical school and curriculum? How can those with relevant expertise identify themselves as potential contributors?
- Will any courses be taught by faculty from other departments at SFU? How will this impact the resources of other departments?
- Will interdisciplinary research be encouraged? Will there be mechanisms or funding to support interdisciplinary research?

Questions on faculty and staff positions:

- When will faculty and staff be hired? How many positions will be available?
- How does SFU plan to compete with other medical schools for faculty and staff?

- Will staff and faculty be reflective of the diversity of BC communities including underserved and underrepresented communities? How will this be achieved?



SFU MEDICAL SCHOOL

INTERNAL SFU COMMUNITY ENGAGEMENT SPRING 2023 HIGHLIGHTS

BACKGROUND

In March and April 2023, the SFU Medical School and Morris J. Wosk Centre for Dialogue teams engaged with SFU students, faculty and staff through a series of events and a survey to share updates and gather input on medical school planning. This is a high-level summary of what we heard.

IMPLEMENTATION TIMELINE



SPRING 2023 ENGAGEMENT BY NUMBERS

210

event participants
(SFU students,
faculty & staff)

4

engagement events
(2 in-person, 2 virtual)

1

SFU-wide
community survey

226

survey responses

MEDICAL SCHOOL CURRICULUM WILL BE BUILT ON THE FOLLOWING PILLARS

1

BC'S DIVERSE COMMUNITIES

Prepare graduates to meet the prevention and primary care needs of diverse communities and populations across B.C.

2

PRIMARY CARE

Educate physicians to work in team-based primary care settings that are patient-centered and socially accountable, through research-informed curriculum and pedagogy.

3

COMMUNITY PARTNERSHIPS

Commit to reciprocal community partnerships in the development and implementation of the medical school, its academic programs, and research priorities.

4

INDIGENOUS KNOWLEDGE SYSTEMS

Embed and equalize Indigenous knowledge systems in learning, research and practices.

5

PLACE-BASED LEARNING

Provide community-based learning and research opportunities.

KEY ENGAGEMENT TOPICS

- SFU Medical School vision, mission and goals
- SFU values, assets and relationships
- SFU community involvement and benefits
- SFU Surrey spaces, community and 'vibe'
- Community engagement and impact
- Service to Indigenous, underserved and underrepresented communities
- Pathways to medical education for Indigenous students
- Embedding Indigenous history and ways of knowing
- Implementation updates and timelines
- Community questions and concerns
- Research collaboration and partnerships

WHAT WE HEARD FROM THE SFU COMMUNITY

SUMMARY OF MAJOR THEMES AND COMMUNITY INPUT FROM THE ENGAGEMENTS AND SURVEY

High Standards & Community Impact

- Leverage this rare opportunity to rethink norms and set high standards.
- Attract students, faculty, staff and partnerships through a premier program, exemplary equity standards, and use of cutting-edge health technologies.
- Hire the highest quality faculty who exemplify equitable and culturally safe teaching practices.
- Realize, expand upon and exemplify the decolonization and Indigenization of SFU. There is still much work to do on this front.
- Remain resolute in the school's vision, mission and goals.
- Track success and be socially accountable.
- Learn from the experiences of other medical schools and medical research organizations to inform planning.
- Make the SFU community proud by successfully improving access to primary care and addressing the health needs of underserved and underrepresented communities.*

Community Engagement & Community Needs

- Engage with communities to understand and address diverse health needs across different populations and locations to inform planning and curriculum. Build off SFU's strength in community engagement.*
- Infuse the school with diverse community perspectives by ensuring diversity in governance, faculty, and students.
- Educate the public, not just medical school students, on health.
- Provide regular planning updates specifically about curriculum, program availability, admissions criteria and research focus areas.
- Provide impactful opportunities for community input on medical school planning.
- Expand upon existing SFU relationships within the distinctive Surrey community to develop community connections.
- Welcome the Surrey community into the school through public amenities and businesses, events, youth camps, and medical services.

Teaching & Learning

- Educate students to become person-centred, community-engaged doctors. Select applicants who demonstrate these qualities.
- Educate students on Indigenous history, culture, health practices, and ways of knowing, and embed these elements in the program.*
- Educate students on more than healthcare (e.g. leadership, clinical business operations, government relations, health & risk communications).
- Educate students in modern health technologies and service delivery.
- Create abundant, high-quality placements that provide real-world experience of medical practice and diverse community needs.*

Student Pathways, Admissions & Support

- Develop deep and robust pathways and supports leading to medical education, starting at the elementary school level, especially for those from underserved and underrepresented communities.*
- Provide substantial cost-of-living support to students including housing, tuition waivers, childcare, a continuous program, and paid job opportunities.*
- Support students with mental health resources, academic assistance, and safe learning spaces.*
- Create admissions criteria to support applicants from diverse backgrounds, experiences and education.*
- Invest in the promotion and marketing of non-traditional admissions criteria, and outreach to underserved and underrepresented communities.*
- Recognize the importance of language skills in serving the diverse needs of BC communities, and select for students who can speak multiple languages.*
- Create programs for International Medical Graduates and Lifelong Learners.
- Encourage and incentivize ongoing service to underserved and underrepresented communities, including rural and remote communities, after graduation.*

Space & Resources

- Leverage the broad and deep pool of SFU-wide expertise and resources across faculties, departments and disciplines (including beyond STEM), to collaborate on medical school planning, teaching and administration.
- Increase, don't reduce the resources and opportunities for other faculties and departments.
- Plan for sufficient funding and resources, and changing needs over time.
- Create clear pathways for current SFU staff to fill administrative positions.
- Develop robust and well-integrated facilities services (e.g. IT, security etc.) to support a high-quality, high-tech program, and involve these teams in school planning.
- Expand upon the 'small town' interconnectedness of the SFU Surrey campus in planning spaces and facilities.
- Improve SFU Surrey campus amenities and services to attract students.

Research & Partnerships

- Collaborate across faculties, departments and disciplines (including beyond STEM) to build upon existing SFU research and create new research projects.
- Create programs, funding and events to uncover and encourage collaborative research opportunities and facilitate personal connections among researchers and partners.
- Recognize the importance of personal relationships in building partnerships and account for the cost of personal relationship development and maintenance.
- Be accommodating to the visions and interests of collaborators, which may differ from those of the school.
- Develop relationships with the vast array of health-related community partners in Surrey and across B.C.

* Highlighted as being of particular importance for Indigenous communities

SFU MEDICAL SCHOOL ADMISSIONS FOCUS GROUP

What We Heard Report: February 27, 2024 Admissions Focus Group

Background

The Provincial government has committed to the creation of a new medical school in BC that will train the next generation of physicians to provide team-based, community-level care.

The medical school's Notice of Intent was approved by the SFU Senate Committee on University Priorities (SCUP) and the development of the Full Program Proposal for the MD Program is underway. The working deadline for submission to the SFU Senate Committee on Undergraduate Studies (SCUS) is March 15, 2024.

As part of the Full Program Proposal for, the SFU Medical School is required to include a calendar entry for the program outlining the minimum requirements to be eligible to apply to the MD program (i.e. minimum admission requirements). Future work will establish admissions policies, processes and selection criteria.

Session Details

On February 27, 10 participants gathered virtually for a 90-minute focus group on admissions for the proposed SFU Medical School. Participants included family physicians, specialists, university administrators, current SFU undergraduate and graduate students, and an SFU alum who is currently in their 4th year of medical school at UBC. The central topic of the focus group was on minimum admission requirements.

The session began with SFU Medical School Acting Associate Dean Academic and Faculty Development, Dr. Maria Hubinette, providing an overview of the program mandate, the school's admissions objectives and a summary of what other Canadian medical school have stated as their minimum admission requirements. Following this, participants were given the opportunity to ask clarifying questions and share personal anecdotes.

What We Heard

Throughout the dialogue, participants shared the following key themes in response to the discussion questions.

1. What kind of attributes do we want in the kind of physicians we want to graduate?

Participants expressed that they wanted physicians who:

- Are community connected and minded
- Are understanding and accommodating of the diversity of people
- Have integrity and humility
- Can see the whole person
- Aware of one's own predetermined and/or preconceived ideas of others (i.e cultures, ways of being, histories, contemporary realities)
- Embody the CanMeds competencies of – medical expert, collaborator, communicator, leader, health advocate, scholar and professional

2. What kind of life experiences do we value?

Valuable experiences demonstrate long-term authentic commitment, resilience, service to community and development of interpersonal and communication skills through employment.

- Experiences like employment or volunteering that demonstrate longitudinal commitment are preferred over short-term “high profile” activities that require privilege to acquire.
- Experiences such as those who have been caregivers for loved ones.
- It is important for people who come into the program to have at least some experience or knowledge that not everyone comes from the same background. (i.e. an awareness of, and appreciation for, diversity) This will enable them to authentically engage with others.

There is value in having a cohort of learners with diverse backgrounds to enhance the learning experience.

- Many people work in other health care areas and discover later that they want to become a physician. These individuals tend to be more mature and have a variety of different experiences and we should find a way to value this in the medical school’s admission process.
- There was recognition that building a cohort of learners with diverse academic backgrounds enriches the learning experience as individuals have different strengths (i.e. teamwork, interpersonal and communication skills) that they bring from their own disciplines.

3. How can we evaluate authentic experiences against performative activities? What are ways we can verify application?

We must be mindful of short-term experiences acquired through privilege.

- It is important to remember that certain extracurricular activities require privilege (time, resources and connections) to acquire. We must find ways to value those who are not able to access these activities because of circumstance and, conversely, to value the diverse experiences that applicants with less privilege may have engaged in.
- The rate of medical tourism that happens amongst medical students is a concern.
- Students should be asked to demonstrate what kind of person they are, how committed they are to becoming a physician and what other skills they have developed beyond the ability to get good grades.
- The challenge for the selection committee will be to differentiate people who are respectful and who value others.
- There is a lot of gaming to get into medical school and students say things they do not believe or participate in activities that they are not really passionate about to look good on the application.
- A suggestion was made to consider using a particular requirement to measure experience. “Stanford and a few other Ivy League schools use a second language as a marker for experience.” This likely will not be a minimum requirement but could be incorporated in the application evaluation.
- With the AI tools and commercial services available to students, it is important to be mindful of the ways in which students are asked to communicate their experience.
- Taking a holistic approach in application review is important. If applicants are not taking full course load, the process must allow the selection committee to understand why. An example of how to verify could be the University of Calgary’s top ten experiences.

- The interview is also a key element in the admission process. It was suggested that we explore having more levels of interviews and more people involved per interview.

4. What non-cognitive abilities do we value?

We value qualities like cultural awareness, teamwork, empathy, resourcefulness, trustworthiness and strong interpersonal and communication skills in physicians.

- One of the participants reflected on their own relationship with their family physician. What made that particular family physician great was his approach to his patients. Not only was he respectful and approachable, but he was also a great communicator and an excellent health advocate.
- Our students need to have an openness and commitment to continuously learn, particularly as it relates to Indigenous ways of knowing.
- If the SFU MD program is centred around team-based care, then physicians need to demonstrate they can function as part of a team and work with other allied health professionals. It would be problematic if our students went into every clinical setting expecting to lead.
- It is so important that physicians are respectful to the people they work with and their patients.
- The best doctors find ways to contribute and work tirelessly to advocate for their patients. Nowadays, patients want to be more involved in their own care and a good physician will meet their patients where they are at.
- Creativity is also important, particularly in rural settings, where access to facilities and equipment could be limited.
- From an Indigenous lens, we should be able to trust physicians but we don't. It is so important that a physician can see the whole patient and gives their patient the space to be their authentic selves. In turn, the medical school admissions process should encourage and support students to be their authentic selves, rather than who they think we want.
- Physicians must often take complex information and communicate at the appropriate level to patients, so excellent communication skills are essential.

5. What ways can we measure a student's cognitive abilities to ensure they can be successful in our program?

GPA must be a consideration, but there could be ways that it can be thoughtfully applied to admissions.

- GPA is an important factor in admissions but there was some agreement that SFU could look at removing low scores or look at the final 2 years of student for improvement over time. This will still allow students to demonstrate their abilities while providing them with flexibility.
- SFU has a pretty good sense of what grades mean from institutions within BC, however, this gets more complicated when evaluating grades from other countries or even grades from other graduate programs within Canada.
- While GPA should never be a sole determinant, GPA should still be an important consideration in the admissions process. There is usually a large difference in the cognitive abilities of a student with a 3.8 GPA versus a 3.0 GPA.

A completed degree, with some flexibility on course load could potentially be a measure of cognitive abilities.

- SFU requires a method that reduces bias in a realistic and cost-effective manner. One way to do that may be to require completion of a 4-yr degree within an agreed time frame.
- Students who are not taking a full course load must demonstrate what they are doing with their time. It is important for the selection committee to see that students can handle the workload and stress, even if the workload is not entirely academic.

A science background or pre-requisites are not entirely necessary, but knowledge of biology or having some foundational science courses can be helpful in the pre-clerkship years. It was also mentioned that there is a limited amount of science in medicine, but what is important is the ability to process large quantities of knowledge and to see patterns.

- One of the participants shared from their experience that classmates with arts and humanities degrees and no prior knowledge of biology struggled, whereas the participant had taken some biology courses in their degree and therefore experienced less stress and pressure. It is important to look at the program and ensure adequate support is available for students with diverse backgrounds as they bring a lot to the learning environment.
- MCAT requirement could be used in the place of science pre-requisites.
- We could stipulate either course pre-requisites, degree pre-requisites or some sort of minimum academic background that students should have.
- A background in science, whether obtained through course work or preparing for the MCAT is important. A science degree in some form of the Life Sciences gives students a basic understanding of biology, cell biology, genetics, molecular biology, physiology, etc. A science degree also teaches students quantitative skills, analytical skills, problem solving, ability to think critically, etc.

6. How do we balance traditional metrics while taking an equity approach to admissions? (cognitive variables vs non-cognitive variables and social identity)

It is important to consider diverse life experiences and backgrounds in medical school admissions beyond just cognitive measures. This may mean building flexibility into our requirements or processes to consider those who may not have a direct path to medical school or who have taken longer to decide on medicine as a career path.

- The full-time studies requirement really discriminates against a lot of students who may need to work to finance their education. This should be avoided as a minimum requirement, even though it could be used as an indicator for the ability to manage workload.
- One could say “undergraduate degree recommended” and allow flexibility for the non-traditional route.
- It was recommended that SFU leverage the work that has already been done around self-identification and admissions. There may be an opportunity to use bio-demographic data to create additional admissions streams for a small number of underrepresented groups. This could be a way to provide a more flexible opportunity.
- Consider providing applicants with more than one method to prove cognitive ability, recognizing that people may take different paths to medicine.

There were concerns about the impact of standardized testing and traditional admission requirements on applicants from underrepresented and marginalized groups but also acknowledgement of the bias inherent in GPA's.

- Consider using the minimum requirement as the last 2 years of undergraduate studies. This will allow late bloomers to have an equal opportunity to be represented.
- Be considerate of different backgrounds and how standardized tests might negatively impact Indigenous and underrepresented groups. SFU must thoughtfully construct pathways so that Indigenous students do not have to explain why they deserve to be in the program.
- While there is evidence that the MCAT does measure cognitive abilities, the test is problematic as it creates accessibility and financial barriers for certain under-represented groups.
- It is important to be mindful that students from rural areas may not have the same access to specialized courses and research opportunities to highlight their cognitive abilities.

Barriers to Healthcare Access for Equity-Seeking Groups

- Summary of a Community Engagement Survey

Sponsored by: Joanne Curry

Supervised by: Sobhana Jaya-Madhavan

Prepared by: Darya Berezhnova

March 2023

SFU respectfully acknowledges the Sḵwxwú7mesh Úxwumixw (Squamish), səliłwətaʔt (Tsleil-Waututh), xʷməθkʷəy̓əm (Musqueam), kʷikʷəłəm (Kwikwetlem), Kwantlen, qíćəy̓ (Katzie), Qayqayt, Semiahmoo and Tsawwassen peoples on whose traditional, unceded territories our three campuses reside.

Introduction

SFU's new medical school planning is well underway and community engagement is a critical part. SFU is committed to creating a program where medical students and residents learn in team-based primary care settings, which are patient-centered and consider different factors and contexts that impact health outcomes. Indigenous knowledge systems and equity-seeking perspectives will be embedded throughout the school, including during the planning process.

This external survey is just one part of SFU's ongoing community engagement process. It was designed to engage with members from organizations that work with equity-seeking groups¹ and with Indigenous community members. This was in addition to in-person/virtual dialogues that took place with leads in community organizations early in 2023. The organizational leads had an opportunity to share their experiences working directly with equity-seeking groups. As a follow-up to the community meetings, SFU community engagement lead(s) will be part of upcoming roundtables involving frontline health support workers and navigators working with diversity seeking groups (especially newcomers).

This survey aims to understand barriers to healthcare access that are experienced by British Columbians, especially equity-seeking groups. It also applies a gender-based analysis plus (GBA+) lens² towards understanding these barriers. The insights from this survey will be used to inform the business case for the SFU medical school, and ensure key elements, including curriculum, admissions pathways, accommodations, space/infrastructure, student experience, etc. are evaluated from and informed by an equity-seeking and GBA+ perspective.

Methodology

Over ten organizations were invited to this external survey with nine short answer questions and three opportunities to provide longer comments was sent to community members who work with vulnerable and marginalized populations, and to Health Directors of nine host nations. In total, the survey received 18 responses.

The survey covered many important areas - the needs of diverse equity-seeking groups, barriers to access, physician attributes, and the skills needed to address health inequities and improve quality of care for BC's diverse communities. Additionally, survey respondents were asked to share reports, articles, and other resources that would help SFU to understand the needs of equity-seeking groups and train physicians to respond to diverse needs. The full list of resources shared is available in the [Appendix](#). In-person/virtual meetings with two large social service organizations also took place and they have both agreed to organize site visits and roundtables with their Health Leads to help SFU gather more in-depth information as the SFUMS project evolves.

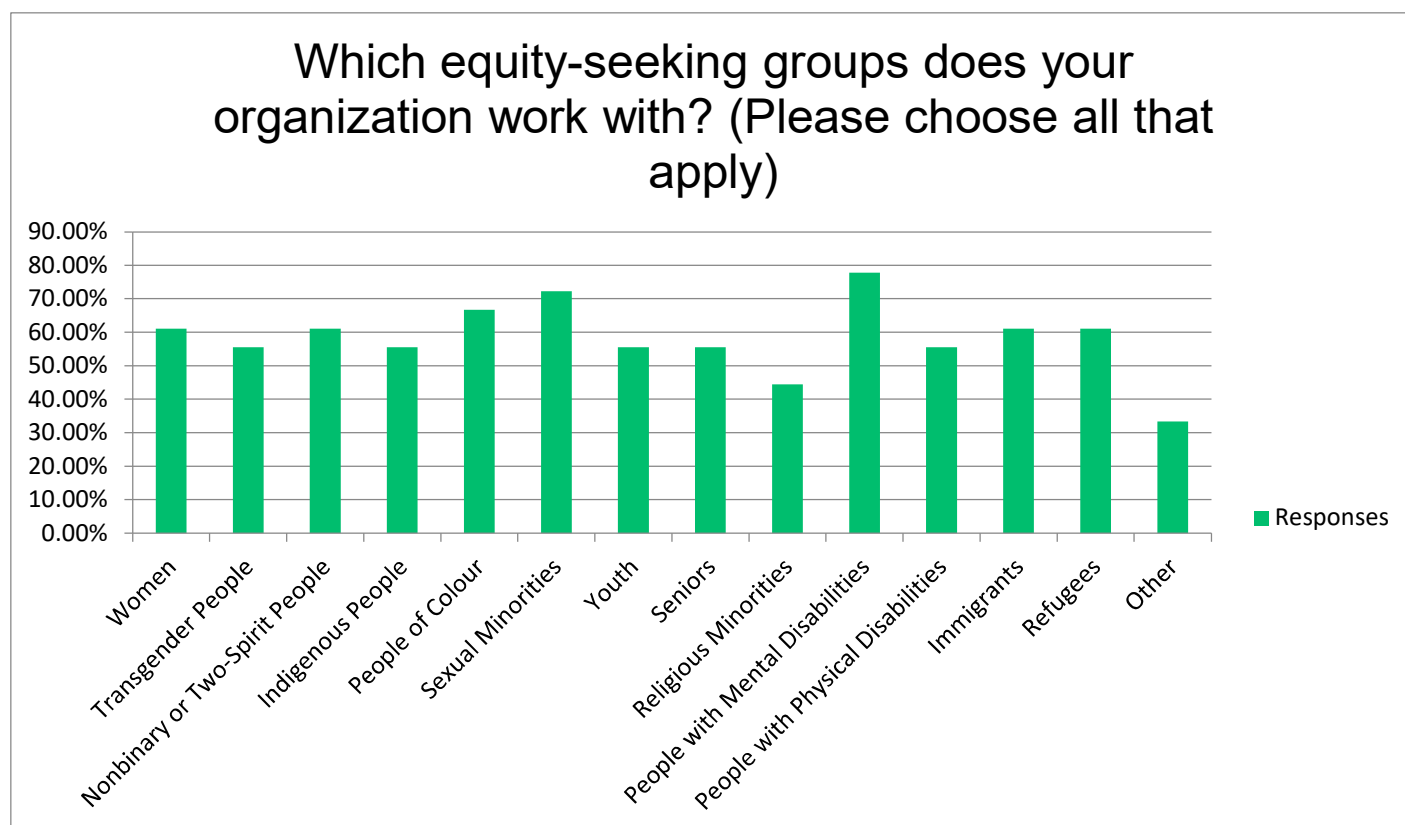
¹ **Equity-seeking groups** are those that experience barriers to equal access, opportunities and resources due to disadvantage and discrimination and actively seek social justice and reparation. Equity-seeking groups are communities that face significant collective challenges in participating in society. Members of equity-seeking groups can have many intersecting identity factors (e.g., sex, gender, sexual orientation, race, ethnicity, religion, age, mental or physical disability, etc.), each of which is systemically marginalized in unique ways.

² **GBA+:** "GBA+ is an analytical tool used to assess how diverse groups of people may experience policies, programs and initiatives." For more information, please click [here](#).

Findings

Demographics

Many intersecting identity factors were represented in survey responses. Survey respondents indicated that they work with women, transgender people, nonbinary or two spirit people, indigenous people, people of colour and racial minorities, sexual minorities, youth, seniors, religious minorities, people with mental disabilities, people with physical disabilities, immigrants, and refugees. As well, respondents indicated that they also work with temporary residents, people with intellectual and/or developmental disabilities, and allies. The full distribution of equity-seeking groups that respondents work with can be seen in the graph below.

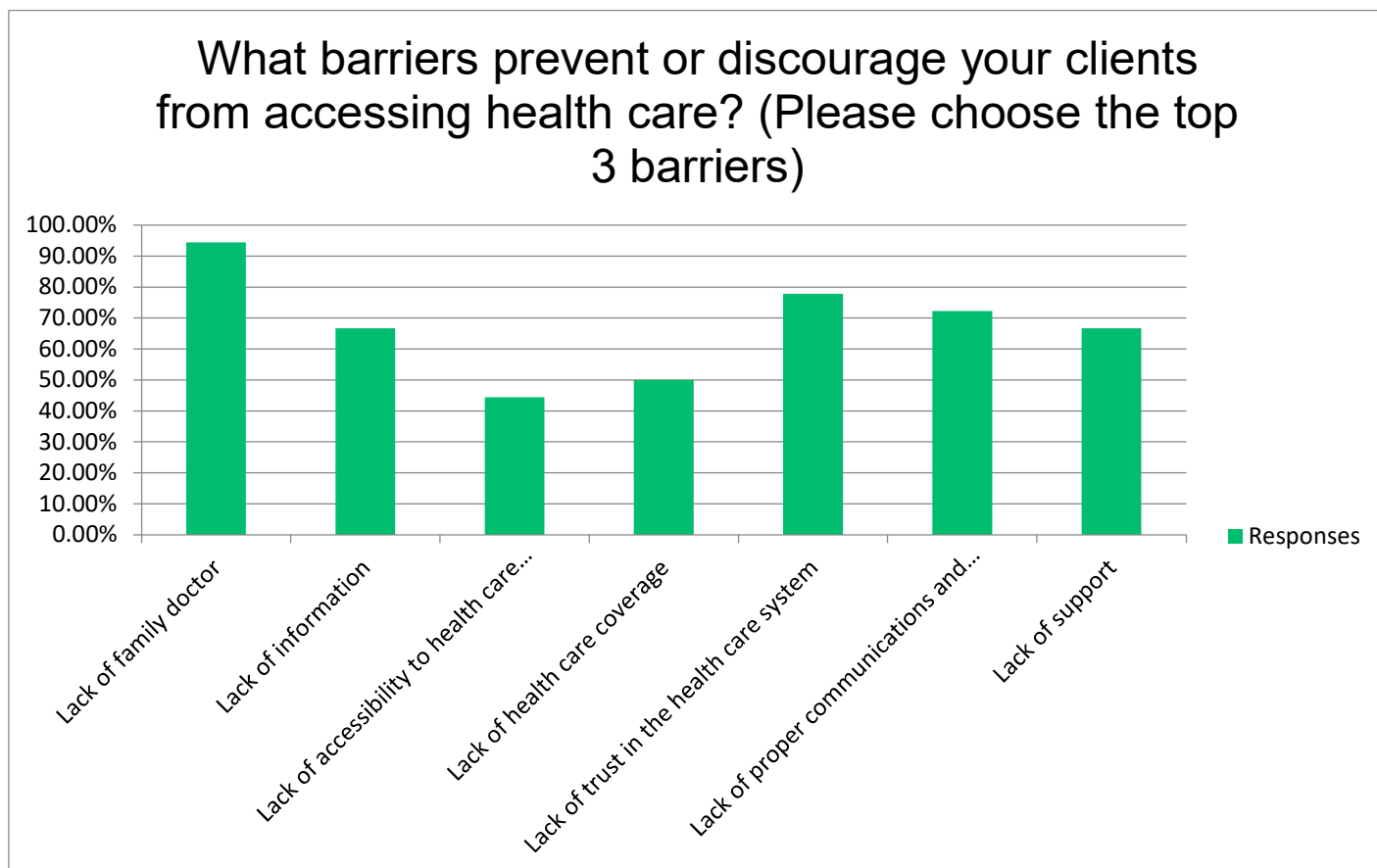


Barriers and Discrimination

Quite tellingly, **100% of respondents indicated that the marginalized groups that they work with all experience marginalization/discrimination at the hands of the healthcare system and all experience diverse barriers to access.**

The **top barrier** to access identified by respondents is a lack of family doctor, with 94% indicating that the clients they serve face this barrier. Some respondents elaborated that when clients without a family doctor, attend walk-in clinics, physicians rush them out of the clinic without listening to their issue, which further leads to a lack of confidence in the healthcare system. Then, 78% of respondents identified a lack of trust in the healthcare system and 72% identified a lack of proper communications

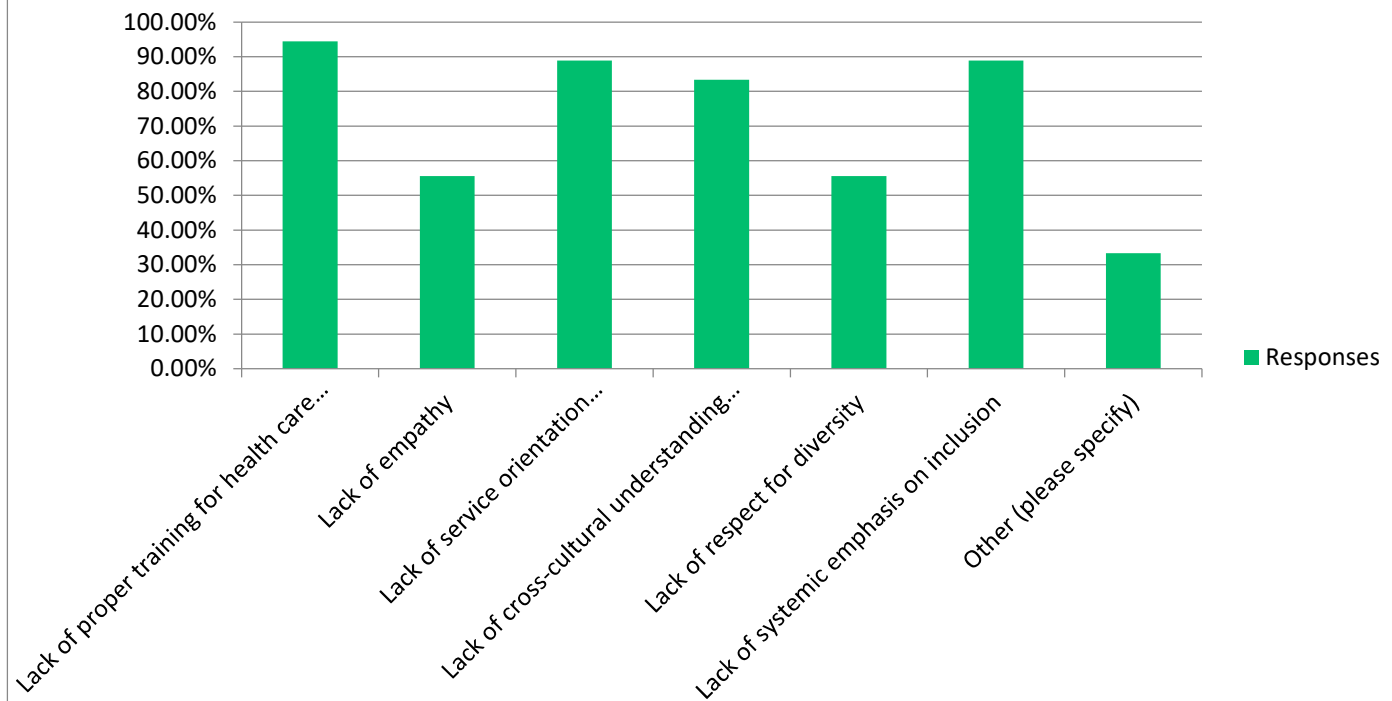
and language issues as the **second and third** most prevalent barriers to access. The full graph describing barriers to access can be seen below.



When asked why such marginalization/discrimination occurs, **94% of respondents pointed to a lack of proper training for healthcare professionals**. 89% identified a lack of systemic emphasis on inclusion and a lack of service orientation, that is, anticipating and responding to diverse needs. 83% pointed to a lack of cross-cultural understanding and sensitivity, and 56% identified a lack of empathy and a lack of respect for diversity among healthcare professionals.

A graph illustrating reasons for marginalization/discrimination by the healthcare system can be seen below.

Why do you think this marginalization/discrimination occurred? (Please choose all that apply)



33% of survey respondents also identified other diverse reasons that contribute to marginalization/discrimination: homophobia, transphobia, racial stereotypes, and patriarchy; a lack of public funding and healthcare professionals; an assumption that people with intellectual disabilities are 'looked after' by alternative systems and thus do not need access to the healthcare system; and finally, a lack of understanding that it is a patient's right to expect adjustments by services and professionals.

Survey respondents noted that individuals with many intersecting identity factors face unique, compounded barriers to access: "if you add other intersections of identities (2SLGBTQIA+ and Developmental Disabilities) you run into potential experiences of discrimination due to one's sexuality, gender identity and expression, and living with a disability. Add race, being a woman, etc. and [there are] more barriers and discrimination that our population experiences." (Anonymous survey respondent)

Respondents also provided examples of discrimination faced by their clients. Some clients experienced overt transphobia, for example, deadnaming and misgendering. Many 2SLGBTQIA+ must deal with uninformed or discriminatory comments from healthcare providers, and often have no clear way, to make comments or complaints. Some individuals have difficulty accessing specific drugs such as pre-exposure prophylaxis (PrEP). Another example of discrimination was experienced by a new immigrant who is HIV positive and a racial minority. During a mandatory appointment for immigration purposes,

they were treated dismissively by the physician who was not trained in trauma informed care and needlessly brought up traumatic memories.

Traits, Skills, and Education

The most commonly mentioned trait was empathy, suggested by 44% of respondents. Multiple respondents also mentioned the following traits: non-judgemental, having cultural understanding and humility, and having an understanding of the historic, social, and legal contexts of diverse marginalized groups. Others mentioned flexibility in service delivery, and a willingness to work in partnership with patients, care teams, and families. Finally, **respondents highlighted that physicians must have not only an awareness of diverse identities, but also a true belief in the dignity and deservingness of their clients.**

A summary of all traits suggested by survey respondents are grouped by theme below:

	• Adjusting communication for specific audiences (e.g., plain language)
Providing Good Customer Service	• Being welcoming and inclusive • Thoroughness • Patience • Timely treatment • Proactiveness • Attentiveness
Being a Leader for Equality	• Advocacy and an attempt to influence systems to reduce barriers for marginalized clients

In terms of what skills should be taught to future medical students, respondents suggested the following be incorporated into the medical school curriculum:

Theme	Examples
Historical, social, and legal contexts	• History of racism in Canada and realities of racism today • 2SLGBTQIA+ rights and legislation under the Human Rights Code • History of institutionalization and current barriers to care for individuals with intellectual and developmental disabilities
Issues and needs of specific minority groups	• Awareness of medical complications associated with certain developmental disabilities (e.g., down syndrome) • Familiarity with the needs of sexual minority groups (e.g., access to PrEP) • Ability to treat long-term and/or lifelong conditions
Skills to promote inclusion	• General awareness of and sensitivity towards diverse cultures • Anti-bias training and diversity education • Patient-centred care
Communication skills	• Knowledge of diverse communication styles, including non-verbal communication, plain language, and cross-cultural communication • People-reading skills
Trauma-informed care	• Knowledge of trauma-informed principles and the ability to apply them to patient interaction
Mental health training	• Knowledge of mental health and experience treating clients with diverse mental health conditions • Conflict management skills
Using external resources	• Awareness of and ability to use external resources, such as collaborating with health navigators and interpreters • Ability to connect clients with appropriate external resources for patient education purposes

Respondents believed that in order to address current barriers to healthcare access for diverse clients, **a new medical school should develop a curriculum that centres the *most* marginalized members of society**, and provides education in cross-cultural communication, anti-racism and equity, diversity and inclusion principles. Crucially, respondents also noted that education on the social, historical and legal contexts impacting the healthcare system and those who access it, including colonization and its specific impact on Indigenous people, should be mandatory for graduation. Even something as simple as providing anatomy resources depicting people of colour, transgender and intersex individuals would go a long way to cementing inclusion within the curriculum. Respondents also shared many useful resources, compiled in the Appendix.

Respondents also shared that a new medical school must hire diverse individuals, and bring individuals with diverse life experiences as educators into the classroom. They stressed that a medical school should not only cater services to diverse individuals, but also depict this commitment in advertising/communications materials, etc. Finally, it was suggested that a new medical school should offer specialization options for physicians interested in treating marginalized populations with complex needs, such as those with intellectual disabilities and mental health issues.

Future Directions

Community members who responded to this survey were supportive of SFU's medical school and the community engagement process thus far. Many offered to support the medical school in the future through consultation, education, and dialogue, providing resources, and connecting the school with potential candidates or dialogue opportunities. Several examples are listed below:

- Connect SFU to leaders with intellectual disabilities to help train and build skill set of new healthcare professionals.
- Re-Imagining Community Inclusion initiative has a health-related working group. There is much opportunity here.
- Can contribute to teaching and content regarding people with developmental and intellectual disability (including aging related changes, Indigenous, dual diagnosis).
- Referrals of skilled immigrants who worked in the health industry and who would like to pursue the same in Canada. Referrals of youth through career guidance programs, who are interested to pursue their career in medical services.
- Take an active role in engaging and advising on the training of new doctors in EDI and trauma informed practice, and resources available in the community to support people of color, immigrants and refugees. Provide community engagement practice opportunity for new physicians.
- Provide information on current needs and barriers from a primary care perspective, on behalf of specific First Nations.

Conclusion

The survey has helped SFU understand not only barriers to health care access by equity-seeking groups, but also very specific ways in which these barriers can be overcome by involving these groups throughout the planning process in a meaningful way, and developing curriculum and training that centres patient dignity and physician empathy. The survey has also helped SFU confirm strong community support for the medical school.

Appendix: Resources Suggested by Survey Respondents

Articles

Addressing health disparities through promoting equity for individuals with intellectual disability:

<https://pubmed.ncbi.nlm.nih.gov/16078552/>

Developmental disability training in Canadian psychiatry residency programs: <https://pubmed-ncbi-nlm-nih-gov.proxy.lib.sfu.ca/11280082/>

Hair Relaxer Use and Risk of Uterine Leiomyomata in African-American Women:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3282879/>

Ignored to Death: Systemic Racism in the Canadian Healthcare System:

<https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/UniversityManitoba.pdf>

Guidelines and Toolkits

Edinburgh Principles: <https://www.alzint.org/u/edinburgh-principles.pdf>

Education Services (FRASER HEALTH): <https://www.fraserhealth.ca/employees/clinical-resources/diversity-services/education-services#.ZAbZvuzMK3J>

Implementing Health Checks for Adults with Developmental Disabilities: A Toolkit for Primary Care Providers:

https://www.porticonetwork.ca/documents/38160/99698/Primary+Care+Toolkit_FINAL_ym2.pdf/dfa654d6-8463-41da-9b79-3478315503eb

Improving Emergency Care for Adults with Developmental Disabilities: A Toolkit for Providers:

<https://www.porticonetwork.ca/web/hcardd/kte/emergency-department-toolkit-v2>

Primary care of adults with intellectual and developmental disabilities:

<https://www.cfp.ca/content/cfp/64/4/254.full.pdf>

Supporting Transgender and Gender Diverse Employees in the Workplace:

<https://www2.gov.bc.ca/assets/gov/careers/all-employees/working-with-others/gender-diverse-workplace.pdf>

Reports

Black Health Alliance, Reports: <https://blackhealthalliance.ca/resources/knowledge-hub/>

Re-Imagining Community Inclusion: <https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/organizational-structure/ministries-organizations/social-development-poverty-reduction/re-imagining-community-inclusion-march-2019.pdf>

TRC Calls to Action: https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

Websites

Chaa Da Cup Project: <https://www.himmat.media/chaa-da-cup> General Medical Council UK, Learning Disabilities: <https://www.gmc-uk.org/ethical-guidance/ethical-hub/learning-disabilities>

Government of Canada, Gender-based analysis plus (GBA+): <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/departmental-plan-2020-2021/gender-based-analysis-plus.html>

My Booklet BC: <https://mybookletbc.com/>

Royal College of Psychiatrists, Learning resources for medical students and trainees: <https://www.rcpsych.ac.uk/members/your-faculties/intellectual-disability-psychiatry/training-resources>

Organizations

Advocate for Service Quality, BC: <https://www2.gov.bc.ca/gov/content/family-social-supports/services-for-people-with-disabilities/supports-services/advocate-for-service-quality>

BC Federation of Labour - Equity Groups: <https://bcfed.ca/equitygroups>

BC People First: <https://www.bcpeoplefirst.com/>

Community Living BC (CLBC), including local offices: <https://www.communitylivingbc.ca/>

Family Support Institute: <https://familysupportbc.com/>

Gender Equity Office, Province of British Columbia: <https://www2.gov.bc.ca/gov/content/gender-equity>

Inclusion BC: <https://inclusionbc.org/>

Provincial Assessment Centre (PAC): <https://www.communitylivingbc.ca/what-support-is-available/provincial-assessment-centre/>

Qmunity: <https://qmunity.ca/>

Sher Vancouver: <https://www.shervancouver.com/>

Programs and Legislation

Community Living Authority Act: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/04060_01

Community Workforce Response Grant, WorkBC: <https://www.workbc.ca/find-loans-and-grants/community/community-workforce-response-grant/grant-overview>

Foreign Credential Recognition Loan Program and Advisory Committee:

<https://www.canada.ca/en/employment-social-development/programs/foreign-credential-recognition-program.html>

Project Based Labour Market Trainings, WorkBC: <https://www.workbc.ca/discover-employment-services/community-and-employer-partnerships/project-based-labour-market>

Settlement Program: <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/transparency/program-terms-conditions/settlement.html>

Supports for Students Learning Program: <https://www.canada.ca/en/employment-social-development/programs/supports-student-learning.html>

Youth Employment Programs, for example at YMCA: <https://www.gv.ymca.ca/youth-employment-services>

February 8, 2023

To Whom It May Concern:

RE: Simon Fraser University – Medical School Development

We write today to provide our support for the development of the medical school proposed at Simon Fraser University. We feel the focus that this school will bring to educating doctors to serve the underserved populations of our province using a team-based care model while considering social, environmental and prevention contexts is one much needed in our province.

The BC Association of Community Health Centres represents 30 member CHCs operating in a variety of community settings in the province. The SFU medical school model is aligned with the principles that govern CHCs which include:

- A community based non-profit organization governed by community;
- A centre that provides primary care services using a team-based care model;
- A focus on social justice and health equity;
- A wrap around approach that includes services focused on the social determinants of health.

It is our experience that practitioners working in the team-based care model provided at CHCs love the model. They are supported to do what they do best – provide patient care that is coordinated to meet the needs of each patient across the spectrum of the social determinants of health. The proposed SFU education model could include practice placements at CHCs around the province to support physician education ensuring students experience success with team-based and community –based patient centred care.

We are excited to support this program and look forward to any collaboration that supports the model proposed. Our Executive Director, Valerie St. John, can be reached at 250-216-1691 or vstjohn@bcachc.org to explore opportunities in this regard.

Sincerely,



R. (Bobbi) Turner-Williams
Interim Board Chair & President, BCACHC

About CHCs – featuring STEPS CHC: <https://youtu.be/tCKG5XnQIW4>

Engage. Advocate. Support.

www.bcachc.org



board@bcachc.org

April 21, 2023

To whom it may concern,

We are pleased to provide a letter of support for the Simon Fraser University Medical School.

The BC College of Family Physicians (BCCFP) is the home of family medicine in BC, supporting family physicians in providing equitable, culturally safe, longitudinal care for all British Columbians. We provide leadership, support, advocacy and continuing professional development for more than 7000 members from across British Columbia.

In our initial consultation with Drs. Roger and Sarah Strasser, we were excited to learn about the ways in which this new medical school supports the BCCFP's vision with its intention to focus on:

- generalism and family practice or other specialties that provide or support community level care;
- immersive, place-based education in community and clinical settings;
- underserved and underrepresented populations including Indigenous peoples; and
- social accountability.

We appreciate the use of an authentic community engagement approach and look forward to further opportunities to collaborate on the development of this new medical school.

Sincerely,



Dr. Justine Spencer, MD, CCFP
President



Toby Achtman, MHA, CAE
Executive Director

27th April 2023

Dear Dr. Strasser,

I'm writing this letter on behalf of the BC Coroners Service (BCCS), in support of the establishment of the new Simon Fraser University medical school (SFUMS).

Our agency is mandated to provide a timely death investigation into any unexpected death which occurs in British Columbia of an individual who is not at the time of death under the care of a registered medical practitioner. We partner with several academic institutions including the University of British Columbia (UBC), Simon Fraser University (SFU) and the British Columbia Institute of Technology (BCIT). Through these collaborative efforts we have created a highly qualified, task oriented and operationally effective death investigation service for British Columbians.

Over the next several years, we would like to expand our relationships with our academic partners, including the new SFUMS. Areas that are not currently covered by our collaborative efforts include the establishment of training for physicians, in particular those who work in rural and remote areas, to provide direct investigative and diagnostic support to coronial investigations. Currently physicians are not trained for this purpose, but I do feel that the mandate of 'cradle to grave' care and the 'generalist' construct of the physicians that you will be training lend itself to our needs in this sense.

We are also facing capacity challenges in terms of body storage and autopsy laboratory space in the Lower Mainland, and I think there is room to collaborate with a newly formed medical school, to have such space jointly managed by SFUMS and the BCCS to our mutual benefit and, more importantly, to the benefit of the citizens of B.C. This will also undoubtedly be beneficial from a training perspective as we are continually challenged to find appropriate training and meeting space to provide courses for our staff.

There is also a 're-think' currently occurring regarding how and where forensic toxicology services are best provided in B.C. As this conversation continues it may well be prudent to link it to the expansion of the autopsy laboratory and body storage space that I have previously spoken to. This will enable the BCCS to partner with an academic partner in a fulsome fashion and will allow us to develop training programs which would be beneficial not just within British Columbia, but throughout Canada and internationally. The added benefit of this is the revenue that will potentially be generated for our province.

In this letter of support, I've outlined several opportunities that exist currently but I'm sure others will become apparent as we travel the path to the opening of the medical school in September 2026, hopefully as collaborative partners. I should also mention that all these areas of collaboration are new and are currently not being undertaken elsewhere. Also of note, these partners, in particular BCIT, are very supportive of collaborating in a more fulsome fashion with

the new SFUMS to further develop all our needs in a mutually beneficial and collaborative fashion.

I look forward to progressing this work with you and your staff over the next few years.

Sincerely,



Dr. Jatinder S. Baidwan
Chief Medical Officer





**BRITISH COLUMBIA
INSTITUTE OF TECHNOLOGY**

School of Health Sciences
3700 Willingdon Avenue
Burnaby, British Columbia
Canada V5G 3H2

bcit.ca

March 14, 2024

Degree Quality Assessment Board Secretariat
Ministry of Advanced Education, Skills & Training
PO Box 9177 Stn Prov Govt
Victoria, BC V8W 9H8

Dear Members of the Board:

Re: Simon Fraser University's Doctor of Medicine, MD Undergraduate Program

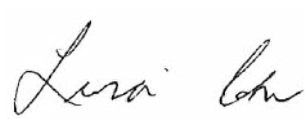
This letter is in support of Simon Fraser University's full program proposal for the MD program. British Columbia Institute of Technology (BCIT) is deeply committed to advancing collaborative healthcare through Interprofessional Education (IPE) and I believe that SFU's dedication to team-based, community-level care offers enriched learning experiences that will benefit students from both our institutions.

By bringing together students from diverse healthcare disciplines, IPE fosters collaboration and promotes a deeper understanding and respect for the roles and responsibilities of varied healthcare professionals. Student engagement in interdisciplinary teams cultivates important skills such as critical thinking, communication, cultural competency, and adaptability. Furthermore, in our post-pandemic world, burnout continues to be a critical issue for healthcare providers across all disciplines. Evidence suggests that work within collaborative teams which are supportive and progressive helps to alleviate stress and fatigue, while contributing to increased job satisfaction. Our collective goal is to train our students for a career in interprofessional healthcare, leading to improvements in patient outcomes and a more sustainable, comprehensive, and holistic delivery of healthcare overall.

Integrating IPE into SFU's MD program presents numerous opportunities for cross-collaboration and innovation, allowing for SFU and BCIT to create immersive and diverse learning experiences, teaching students to apply collaborative practices and preparing them for the realities of the ever-evolving healthcare landscape. I strongly feel that by supporting SFU's MD program, we can enhance the quality of medical education in British Columbia and work towards better addressing the diverse healthcare needs in our province. We look forward to partnering with Simon Fraser University Medical School, to the benefit of our students and the advancements of healthcare delivery in British Columbia.

Thank you for your time and consideration. If you require any additional information, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa Chu". The signature is written in a cursive, flowing style.

Lisa Chu, MBA
Dean, School of Health Sciences
British Columbia Institute of Technology

Simon Fraser University Medical School Letter of Support

May 9, 2023

Dr. Joy Johnson
President
Simon Fraser University

Dear Dr. Johnson,

I am writing to express the Burnaby Division of Family Practice's full support for the establishment of the Simon Fraser University Medical School (SFUMS). We believe that the vision and goals of SFUMS strongly align with Primary Care Networks (PCNs) and Patient Medical Homes (PMHs) in Burnaby, and that this new medical school marks a critical milestone for Western Canada.

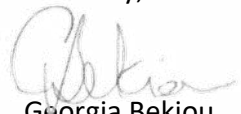
The Burnaby Division of Family Practice is committed to ensuring that Burnaby residents have access to high-quality, patient-centered care that is coordinated across the entire health system. SFUMS's commitment to transforming the health workforce to achieve health equity, with a focus on population health needs consistent with 'social accountability' defined by the World Health Organization, aligns with our core values.

We believe that the establishment of SFUMS is a significant step towards achieving the goal of providing team-based and community-level health care to underserved and underrepresented populations in Burnaby and beyond. The innovative approach to education, including immersive, integrated, and place-based learning for students and residents, will prepare medical graduates to provide team-based community-level healthcare. We also appreciate SFUMS's emphasis on teamwork and collaboration in both the community and clinical settings, which will help to address the shortage of family doctors and other primary care providers in our community and the larger region.

We support SFUMS efforts to establish partnerships with physicians individually and through various organizations, including Doctors of BC and the BC College of Family Physicians. We also appreciate SFUMS's commitment to partnering with communities, including Indigenous communities and their organizations, to achieve authentic community engagement.

In conclusion, we believe that the establishment of SFUMS is aligned with the direction of our PCNs and PMHs, and we appreciate SFUMS's efforts to train doctors who are specifically focused on the needs of our local population, with acknowledgement of the social determinants of health. We thank you for your consideration of our support for the establishment of SFUMS.

Sincerely,



Georgia Bekiou
Executive Director
Burnaby Division of Family Practice

CITY OF SURREY

OFFICE OF THE MAYOR

The Honourable David Eby, MLA
Premier of British Columbia
PO Box 9041 Stn Prov Govt
Victoria, BC V8W 9E1

Dear Premier Eby:

RE: Simon Fraser University Medical School in Surrey

I am pleased to provide this letter of support for the establishment of a Simon Fraser University (SFU) medical school in Surrey's City Centre. SFU President Joy Johnson's vision for Surrey to have a differentiated medical school delivering transformative education including an emphasis on indigenous health, community response and team-based primary health care for the future fits well for our residents.



BRENDA LOCKE
MAYOR

MAYOR@SURREY.CA

604.591.4126

Surrey is a diverse City, growing at a rapid pace with one-third of the population being youth who may benefit from the expansion of this educational opportunity. In addition, it is home to BC's largest population of urban indigenous citizens and serves as a major receiving community for new immigrants. SFU's unique and progressive medical school would have a positive impact on Surrey citizens and people across the British Columbia. This facility will help to address the shortage of primary care providers, support greater access to primary care, reduce reliance on acute care facilities, and enhance the economy through job creation and economic spin off. The benefits to the City and the Province and potentially across Canada would be substantial.

The City of Surrey looks forward to working with SFU to make the medical school a reality. Surrey and SFU enjoy a strong working relationship and have a history of success in partnering to make things happen. An example is the construction of SFU's Sustainable Energy Engineering (SEE) building which opened in 2019. The City's committed support enabled SFU to achieve an extremely ambitious timeline - less than 3 years from funding approval to occupancy.

The City is ready to champion a fast-track process for development and permitting to ensure project success. The wheels are in motion with initial discussions to explore parking requirement relaxation to reduce project costs. The time is right for a new medical school in BC, and Surrey is absolutely the right place for it. I fully support the SFU medical school proposal, and I look forward to helping any way I can.

Sincerely,

A handwritten signature in black ink that reads "B. Locke".

Mayor Brenda Locke



April 21, 2023

Dr. Joy Johnson
President
Simon Fraser University
8888 University Drive
Burnaby, British Columbia V5A 1S6

Sent via email to: pres_office@sfu.ca

Dear Dr. Johnson:

The College of Family Physicians of Canada (CFPC) fully supports the establishment of the Simon Fraser University Medical School (SFUMS), the first new medical school in western Canada in 55 years.

The CFPC represents more than 43,000 members and is the professional organization that establishes the standards for and accredits postgraduate family medicine training in Canada's 17 medical schools. It reviews and certifies continuing professional development programs that enable family physicians to meet certification and licensing requirements. Further, the CFPC certifies and supports family physicians, championing family medicine advocacy and research.

Given the CFPC's unique and essential role in family medicine education, we are delighted with the proposal that SFUMS graduates will either enter comprehensive family practice or specialize in community-based care.

The CFPC also acknowledges that SFUMS education programs will feature community engaged, immersive, integrated longitudinal learning for students and residents with much of their clinical education occurring in community and clinical settings where they may pursue their future careers, therefore increasing the number of family physicians caring for patients in British Columbia and across Canada.

Of particular interest to the CFPC is the dedication of medical schools to the principles of social accountability. We have had the privilege to work with Dr. Roger Strasser when he helped to establish the Northern Ontario School of Medicine and we welcome his, and Dr. Sarah Strasser's leadership as they guide SFUMS's education and research programs to be focused on population health needs consistent with social accountability as defined by the World Health Organization (WHO) and guided by 21st century directions for the transformation of the health workforce to achieve health equity.

The CFPC is encouraged by the direction announced by the Government of British Columbia to establish a medical school at Simon Fraser University, welcoming its first class of medical students in September 2026.

Sincerely,



Christie Newton, MD, CCFP, FCFP
President



Lawrence C. Loh, MD, MPH, CCFP, FCFP, FRCPC, FACPM
Executive Director and CEO

cc: Dr. Roger Strasser, SFUMS
Dr. Sarah Strasser, SFUMS
Dr. Nancy Fowler, CFPC
Mr. Eric Mang, CFPC

May 23, 2023

Simon Fraser University Medical School
C/o Dr Roger Strasser
Interim Dean

To Whom It May Concern,

Doctors of BC is pleased to provide a letter of support for the creation of a new medical school at Simon Fraser University.

Doctors of BC represents more than 16,000 physicians – family doctors and specialists – across the province. The planning for this new medical school aligns with our vision and goals to strengthen and improve access to quality care for our patients.

These include:

Focus on community: We support the focus on training generalists either in family practice or other specialties to provide and support community-level health care. BC has many communities, and populations that are underserved and underrepresented, particularly in rural areas. The focus on immersive and place-based education within community settings will address some major gaps in the health care system.

Team-based care: Doctors of BC is committed to the provision of team-based care as the foundation to provide better access to care for patients, when and where they need it, and with the best practitioner to meet their needs. Team-based care also enables every member of the team to work to their full scope of practice, providing wrap-around care for patients. We are pleased to see that this is an important part of SFU's plan for the new medical school.

Generalism: We appreciate the focus on generalism, as shown by SFU's plans for 'cradle to grave' Facilitated Generalist Career Pathway that will encourage new doctors to work and live in under-served communities where they are badly needed. We are pleased to see the admissions process will favour doctors who want to practice in this way and will facilitate their entry into the new medical school.

Cultural safety and humility: We support the focus on caring for underserved and underrepresented populations, including Indigenous peoples, and the emphasis on social accountability.

Doctors of BC is committed to supporting our doctors of tomorrow. We very much appreciate the willingness of SFU to work in partnership with physicians, in the spirit of collaboration, and its commitment to authentic community engagement to be based on genuine co-operation, co-development, co-delivery, and co-evaluation of programs. In particular, we look forward to

working closely with SFU to ensure physician voices are heard in the development of the curriculum, and to meet the need for clinical training and mentoring.

I am confident that we will work together to help to make the new medical school a success, one that will make a meaning difference for patients and communities in BC.

With gratitude,



PRESIDENT, DOCTORS OF BC

Dr Joshua Greggain
President, Doctors of BC

March 11, 2024

Degree Quality Assessment Board Secretariat
Ministry of Advanced Education, Skills & Training
PO Box 9177 Stn Prov Govt
Victoria, BC V8W 9H8

Dear Members of the Board:

Re: Simon Fraser University's Doctor of Medicine, MD Undergraduate Program

I am writing to confirm Douglas College's support for Simon Fraser University's full program proposal for the MD program. Douglas College is deeply committed to advancing collaborative healthcare through Interprofessional Education (IPE) and I believe that SFU's dedication to team-based community level care offers enriched learning experiences that will benefit students from both our institutions.

Interprofessional education offers many advantages. Bringing together students from diverse healthcare disciplines, IPE fosters collaboration and encourages a deeper understanding and respect for the roles and responsibilities of healthcare professionals. When students engage in interdisciplinary teams, they cultivate significant skills such as critical thinking, communication, cultural competency, resilience, and adaptability. As well, in a post pandemic world, burnout is a significant issue for healthcare providers across the spectrum. An increasingly complex internal and external environment faces health care providers of the future. Evidence suggests that working in collaborative teams, that support and develop team members contributes to job satisfaction, increasing connection and shifting progress towards burnout. A collective goal of our institution and SFU's is to educate students for a place in interprofessional healthcare. This approach improves patient outcomes and leads to increased sustainability, along with comprehensive and holistic healthcare delivery. In this model patients are part of the network not simply consumers of health care.

Integrating IPE into SFU's MD program offers numerous opportunities for cross collaboration and innovation. In addition, partnering with other healthcare providers and community organizations, SFU and Douglas College will create immersive and diverse learning experiences that prepare students for the realities of collaborative practice and the everchanging healthcare landscape. Opportunities for interprofessional scholarship occur in this model which informs future practice and evolutionary health care.



I believe that by supporting SFU's MD program, we can enhance the quality of medical education and subsequently health education in British Columbia which increasingly addresses the healthcare needs of our respective communities. The collaborative efforts between our institutions will not only benefit our students but also contribute to advancements in healthcare delivery.

We look forward to strengthening our partnership and creating a brighter future for medical education in British Columbia.

Sincerely,

A handwritten signature in black ink, appearing to read "Pam Cawley".

Pamela Cawley, BSN, MPhil (Education), PhD
Dean, Faculty of Health Sciences



May 8, 2023

Dr. Joy Johnson
President and Vice-Chancellor
Simon Fraser University
By Email: pres_ea@sfu.ca

Re: Support for new Simon Fraser University (SFU) Medical School in Downtown Surrey

On behalf of the Downtown Surrey Business Improvement Association (DSBIA) Board of Directors and our 1400 plus Member businesses, we are writing in full support for the new SFU Medical School in Downtown Surrey.

As the forward-thinking Downtown Surrey business organization, the DSBIA Board commissioned a study on the ***"Potential Economic & Business Impacts of a new SFU Medical School in Surrey"***. The study, undertaken by Roslyn Kunin & Associates, reviews the benefits and analyzes quantitative models to assess the economic impacts, directly, indirectly and induced. The almost two dozen business and community leaders interviewed for the study were enthusiastic in their support for a medical school and indicated that it would not only provide for better health care for Surrey's Indigenous and diverse communities, but that it would positively impact the Surrey economy. Leaders in indigenous communities looked forward to a local medical school which would provide culturally safe opportunities for Indigenous and Métis.

Surrey's diversity is indicated by the over 100 languages spoken in Surrey and the housing of 22% of Metro Vancouver's Indigenous population. Forty-three percent of Surrey's residents are immigrants and 34% of Surrey residents speak English as a secondary language. The City of Surrey is one of fastest growing communities in Canada with close to 600,000 residents and approximately 1,000 people moving to Surrey each month. By 2040, the City of Surrey is expected to welcome more than a quarter of the region's new jobs and residents. Through collaboration with many players, we are growing into a vibrant network that supports economic development, new technology and numerous spin-off organizations developing solutions for our health care system which will be multiplied and enhanced with a new SFU Medical School.

The commitment of funding for the business impact study was an early demonstration of the DSBIA commitment. A copy of this study is available on request and alternately [Potential Economic and Business Impacts of a New SFU Medical School in Surrey City Centre](#). The DSBIA will organize a committee to work with SFU, the medical community, health related organizations, political bodies, Indigenous peoples, ethnic groups, and business organizations to support and ensure success of the SFU program. We look forward to learning more about the School's development and how business can support its success.

Yours truly,

A handwritten signature in black ink, appearing to read "Elizabeth Model".

Elizabeth Model - CEO

Downtown Surrey Business Improvement Association

March 20, 2024

Dr. David Price
Acting Dean and Special Advisor to the Provost
Simon Fraser University Medical School
8888 University Dr., Burnaby, B.C. V5A 1S6

Dear Dr. Price,

Re: Letter of support for the Simon Fraser University Medical School

I am pleased to write this letter of support in the establishment of the *Simon Fraser University Medical School (SFUMS)*. As the first and only province-wide health authority of its kind, the First Nations Health Authority (FNHA) has witnessed firsthand the shortage of Indigenous medical professionals across the province and the devastating impacts from a lack of culturally safe provision of care. The SFUMS will provide programming through innovative culturally safe, team-based, preventative and community-based approaches, alongside building capacity and professional development opportunities in the recruitment of First Nations individuals.

Across all five regions, we consistently hear First Nations call for increased access and resources for First Nations to participate in and advance their careers in health care, navigation support for students in post-secondary education, and peer mentorship programs. Many First Nations people are reluctant to seek care due to mistreated, discriminated against, or in some cases left untreated, due to racism in the health system leading to significant health disparities.

We applaud the vision of the [SFUMS](#) to embed and equalize Indigenous knowledge systems in learning, research and practices. The FNHA is excited to be a partner in this work to support medical learners to be more effective with First Nations individuals, families and communities in achieving the highest level of health and wellness. FNHA is committed to working with SFUMS to co-develop strategies to identify, recruit and retain more First Nations applicants to meet community needs. Our collaboration with SFUMS also seeks to hardwire Indigenous specific anti-racism and cultural safety and humility into all levels of the program, including evaluation, staffing and curriculum. Incorporating and promoting First Nations knowledge, beliefs, values, practices, medicines, and models of health and healing throughout learning and practice is key to eradicating Indigenous-specific racism and achieving a culturally safe and humble health care system.

The SFUMS is aligned with SFU's values, purpose, and framework for action outlined in its [What's Next Strategy 2023](#), including the commitment to upholding truth and reconciliation. In addition, the SFUMS will support the province in achieving its commitments in the [Declaration Act Action Plan](#), including establishing a health care system that is culturally safe and to increasing Indigenous Peoples' access to primary care. Specifically, SFUMS supports:

- **Action 3.7:** Implement recommendations made in the [In Plain Sight: Addressing Indigenous-specific racism and discrimination in B.C. health care](#) report, striving to establish a health care system in B.C. that is culturally safe and free of Indigenous-specific racism; and
- **Action 4.10:** Prioritize the implementation of Primary Care Networks, the First Nations-led Primary Health Care Initiative, and other primary care priorities, embedding Indigenous perspectives and priorities into models of care to increase Indigenous Peoples' access to primary care and other health services, and to improve cultural safety and quality of care.

As a partner with SFU, the FNHA is excited about the transformational potential that the SFU Medical School represents. The FNHA values our collaboration with SFUMS and looks forward to advancing systemic issues and improving health and wellness services and supports for First Nations in BC.

In health and wellness,



Richard Jock
CEO, First Nations Health Authority

March 14, 2024

Dr. David Price
Acting Dean and Special Advisor
SFU Medical School

Dear Dr. Price,

I am pleased to express Fraser Health's support in-principle for Simon Fraser University's Full Program Proposal for the MD program.

SFU's MD program is well positioned to address a critical need in our health care system by producing physicians committed to delivering team-based, community-level health care. This emphasis on community-oriented care aligns well with the demand for family and primary care physicians in the province.

As the SFU Medical School will be based at the SFU Surrey campus, with the majority of clinical placements taking place within the Fraser Health region, we look forward to collaborating with SFU to place students in a variety of both traditional and innovative new health care settings. This diverse exposure is designed to significantly enhance students' breadth of experience in the medical field. Fraser Health also commits to working with the SFU Medical School in supporting the recruitment, professional development and retention of clinical preceptors and researchers.

Looking ahead, we anticipate a significant increase in demand for physicians in B.C., driven by a growing and aging population. The projected growth in demand for primary care and specialist physicians, as estimated by WorkBC, underscores the necessity for initiatives like the SFU Medical School to ensure a steady supply of qualified physicians to meet the health care needs of the province.

We firmly believe Simon Fraser University's full program proposal will contribute to addressing the physician shortage and enhance the overall health care landscape in British Columbia. By supporting the program, Fraser Health is investing in the future of health care delivery and ensuring better health outcomes for communities in our region and across the province.

Thank you for the opportunity to express our support for SFU.

Yours truly,



Ralph Belle, MD, FRCSC
Vice President Medicine



March 15, 2024

Dr. Evan Adams
Acting Associate Dean, Indigenous Health
Simon Fraser University Medical School

Re: Letter of support for the *Simon Fraser University Medical School*

Dear Dr. Adams,

I am delighted to be writing this letter in support of the establishment of the *Simon Fraser University Medical School (SFUMS)*. As the Chief Medical Officer of Public Health and Chief Science Officer for Indigenous Services Canada, my area of responsibility supports the self-determination of Indigenous communities to narrow the health gaps between Indigenous and non-Indigenous peoples.

The Truth and Reconciliation Commission (TRC) identified the need to address health inequities as critical to the reconciliation process. Specifically, Call to Action #22 urges those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients. Call to Action #23 calls upon all levels of government to:

- Increase the number of Aboriginal professionals working in the health-care field.
- Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
- Provide cultural competency training for all healthcare professionals.

The SFUMS is visionary in nurturing medical trainees to develop culturally safe skills and commitment to provide team-based and community-driven health services where it is most needed, particularly for underserved and underrepresented populations, including Indigenous Peoples.

Responding to TRC Call to Action #22 and #23, the efforts on recruiting highly qualified Indigenous students and committing to Indigenous community engagement towards the co-creation, co-delivery and co-evaluation of SFUMS training programs, drawing on resources developed by the National Consortium on Indigenous Medical Education will ingrain the Indigenous ways of knowing and doing in the core of this new medical school and in health service delivery. This will exemplify what medical school training will be and how Indigenous students will become many of the new medical leaders of the country in the future.

Ultimately, the SFUMS will support our collective efforts to work towards health equity that centers on the voices and leadership of Indigenous and other underrepresented groups. I am honoured for the opportunity to collaborate on this groundbreaking initiative.

Sincerely,

 SIGN

Tom Wong, MD, MPH, CCFP, FRCPC
Chief Medical Officer of Public Health and Chief Science Officer



To Whom It May Concern,

It is with great pleasure that I write this letter of support for Simon Fraser University (SFU) regarding its plans for a medical school at the SFU Surrey campus located on the traditional lands of the Kwantlen, Katzie and Semiahmoo First Nations.

SFU's plans to open a new medical school in Surrey's city centre in collaboration with the First Nations Health Authority and the Fraser Health Authority is very welcomed news. SFU and Kwantlen First Nation (KFN) have enjoyed a respectful and productive relationship for many years. Since 2017, personally attending several events at the Surrey campus with my husband Kevin Kelly and my son Michael Kelly Gabriel. On these occasions we have been asked to provide ceremonial prayers, songs, and drumming to open events in a good way. Kevin, Michael, and I will also provide words of encouragement and teachings drawn from years of ancestral knowledge. The leadership at SFU Surrey knows fully well that these are gifts we offer; that in no way what we are doing is performance. We pray and we teach, and I have experienced the openness of the Surrey campus to receive these gifts in an authentic way.

Yes, the SFU Surrey campus has always shown the upmost respect for KFN's land, its people, our culture, and protocols. Not only do they invite and involve myself, my family, and members of KFN in their meetings and community events, but also work each day to support and care for their Indigenous students and the region's diverse Indigenous communities that call these lands home.

Over the years, it has been a great pleasure to witness the development of spaces to support Indigenous students, their engagement with the region's First Nations artists on a variety of campus projects, as well as their support for Indigenous community groups that make up the Surrey Urban Indigenous Leadership Committee and their collective efforts to address Indigenous public health, poverty, education, and housing needs in Surrey. Simply put, SFU 'walks the talk' and we know the same will be true as the new medical school becomes a fixture of the SFU Surrey campus.

Looking ahead, KFN looks forward to working with SFU in providing advice, guidance, and input into the development of the medical school, be that infrastructure, curriculum or engaging Indigenous communities. I have a strong hope that SFU's medical school will recognize the needs of the region's First Nations people and will be welcoming and inclusive to both Indigenous and non-Indigenous peoples alike. We are also hopeful, given the SFU medical school model being proposed, that students will come join us at Kwantlen First Nation to support and work with our community in our space and place.

As Chief, and behalf on Council, I am grateful for SFU's ongoing work towards truth and reconciliation, and to have SFU's medical school in Surrey that supports Indigenous communities will be transformative, a beacon of hope and a pillar to a strong foundation for so many.

Sincerely,

(Chief Marilyn. Gabriel)



OFFICE OF THE PRESIDENT

May 2, 2023

Dr. Joy Johnson
President and Vice-Chancellor
Simon Fraser University

(via email)

Dear Dr. Johnson,

I am writing today to provide my support to Simon Fraser University's (SFU) Medical School, which is planned for Surrey City Centre. At Kwantlen Polytechnic University (KPU), we agree with your vision to accelerate health innovation through team-based, preventative and community-based care. This new program will surely be a catalyst for change in B.C.

As you know, the location of the new Surrey hospital is on KPU property in Cloverdale, which creates extraordinary synergies between the health and post-secondary sectors. The connection and possibilities between the new hospital, KPU's current and future health care programming and SFU's medical school will be profound and we look forward to further discussions about how we can create a medical ecosystem for the area.

As you mentioned in your proposal, the need for primary care providers is greatest for underserved geographic areas and populations, including Indigenous peoples, new immigrants and refugees, as well as those living in rural and remote regions, and those living in rapidly growing municipalities, such as Surrey. The creation of SFU's medical school, combined with KPU's nursing and other health programs, provides an opportunity to create a team-based care and culturally sensitive training ecosystem, which will greatly benefit our Indigenous partners and communities.

With this in mind, KPU is pleased to explore further partnerships with SFU by providing input and collaboration on curriculum development, as well as finding ways to partner on practicum and clinic placements with support from Fraser Health at the new Surrey hospital. KPU supports SFU's vision of positioning B.C. as a leader in Indigenous medical education to help deliver on the province's commitments to Truth and Reconciliation, UNDRIP and our existing partnerships with Indigenous peoples.

Further to this, KPU is keen to support immigrants and refugees through our unique Graduate Nurse Internationally Educated Re-entry (GNIE) program for nurses, which prepares internationally educated nurses for professional nursing practice and licensure in Canada. As we look ahead, I am confident there will be many more ways for KPU and SFU to partner together to support an accessible primary care education and training facility in Surrey's city centre.

Warm regards,

A handwritten signature in black ink, appearing to read 'Alan Davis'.

Alan Davis, PhD
President and Vice Chancellor

May 29, 2023

Joy Johnson, PhD
President & Vice-Chancellor, Simon Fraser University
8888 University Drive Burnaby, B.C. Canada V5A 1S6

Re: Simon Fraser University Medical School (SFUMS) Business Case

Dear Dr. Johnson,

We are pleased to provide this letter of support for your business case to the British Columbia government regarding funding for the Simon Fraser University Medical School.

We believe that this business case for SFU's new medical school has the potential to enable safer and more culturally appropriate health care for Métis communities and Indigenous people as a whole in British Columbia. It is vital for true reconciliation to ensure future health delivery and care activities avoid creating or exacerbating trauma, and instead empower Indigenous communities and build trust with local health organizations and the BC health system in order to help address health inequities. Developing and delivering culturally safe curriculum that builds on local traditions and teachings is an absolute requirement to achieve this. Through co-creation, co-development, co-delivery, and co-evaluation of SFUMS programs with Métis Nation BC and other Indigenous partners, SFU further ensures community-based healthcare from future graduates will be robust, inclusive, safe, and culturally appropriate. We feel that this project aligns well with our priorities.

Métis Nation British Columbia represents all 98,000 self-identified Métis people and the 39 Chartered Communities in British Columbia. MNBC's mandate is to develop and implement culturally relevant social and economic programs and services. MNBC's Ministry of Health is further committed to addressing the burden colonization has placed on the health and wellness of the Métis, and to developing a robust understanding of the health and wellness needs of our Citizens. It is an aim of MNBC's Ministry of Health to increase the number of Métis physicians in BC to better serve Métis communities, and by including Métis partners in this endeavor, SFU and MNBC can support Métis students to thrive at SFU's medical school.

To ensure success of the project, we will provide the following in-kind support:

- MNBC will work with SFUMS to create reciprocal community partnerships in the development and implementation of the medical school to achieve authentic community engagement.
- The participation of MNBC staff, including leaders from the Ministry of Health, embedded as team members in the five SFUMS Working Groups (Curriculum, Space and Infrastructure, Workforce, Admissions and Learner Experience, and Research). All MNBC team members will have input in these five areas as well as community engagement and protocol and knowledge mobilization.

In summary, we believe SFU's new medical school will lead to the improvement of Métis health and cultural wellness. We are pleased to partner on this initiative and hope it receives appropriate funding, recognizing that the right partnerships and intentions are in place to contribute to reconciliation.

Sincerely,



Louis De Jaeger, MBA
Regional Director – Lower Mainland (Region 2)
Minister of Health
Minister of Economic Development
Métis Nation British Columbia



Tanya Davoren
Executive Director
Ministry of Health,
Mental Health & Harm Reduction,
Elder, Veterans & Abilities
Métis Nation British Columbia



5575 Boundary Rd.
Vancouver, BC V5R 2P9

T. 604 254 9626
www.mosaicbc.org

May 12, 2023

Dr. Joy Johnson
President & Vice-Chancellor
Simon Fraser University
8888 University Drive
Burnaby, British Columbia
Canada V5A 1S6

SUBJECT: LETTER OF SUPPORT – SIMON FRASER UNIVERSITY MEDICAL SCHOOL

Dear Dr. Johnson,

MOSAIC is honored to provide this letter of support, endorsing Simon Fraser University's request for Provincial funding to build a new SFU Medical School to serve British Columbia.

MOSAIC is a registered charity with a mission to enrich communities through services and advocacy and to further the success and sense of belonging of newcomers and individuals from diverse background. One of MOSAIC's key strategic goals is to advocate for holistic approach to addressing social determinants of health anchored in equity-centred design, and for ensuring culturally-safe access to primary care for newcomers. We take a leadership role in public health advocacy through numerous community engagements and programming, including co-chairing the Burnaby Primary Care Network Steering Committee, membership at the National Newcomer Navigation Network (N4) Working Group on International Educated Nurses with CHEO in Ottawa, hosting an Alliance for Doctors Denied by Degree across Canada, mobilizing a PHAC-funded Immunization Project for Underserved Ethnocultural Communities in Metro-Vancouver, and the leading organization for Social Prescribing for Seniors in Burnaby, under the BC Government and United Way.

Our Family and Settlement Team had the opportunity to meet with Sobhana Jaya-Madhavan, SFU's AVP External Relations, for a meaningful roundtable discussion on key considerations in building a new Medical School that prioritizes team-based and patient-centered primary care services, the benefits of community immersion or place-based learning, and strengthening partnerships with BC's diverse communities and MOSAIC.

The roundtable discussion gave us the voice to discuss the challenges in accessing health services especially within the immigrant, refugee, and newcomer communities -- including the systems in place, administrative, cultural, and language barriers. The team was also able to explore the traits of culturally competent family physicians and articulate how a community-immersed curriculum can contribute to the wellbeing of everyone in the community. We truly appreciated the meaningful conversation and are looking forward to ongoing dialogue and partnership.

Specifically, MOSAIC is interested in active participation in curriculum development and research working groups. MOSAIC has the capacity to provide linkage to International Medical Graduates, expert advice in health services to refugee claimants and migrant workers, and student practicum opportunities in our programming, including MOSAIC's Family Center, home visitation program, and community facilities to mention a few.

If you require additional information, please contact Sherman Chan at schan@mosaicbc.org.

Sincerely,



Sherman Chan, MSc, RSW
Director, Family and Settlement



Joy Abasta, MPH, MEd, MN
Senior Manager, Community Health and Specialized Programs



March 6, 2023

LETTER OF SUPPORT

On behalf of the National Consortium for Indigenous Medical Education (NCIME) we would like to offer our support for the newly proposed Medical School at Simon Fraser University.

This project is of particular importance to our organization as it provides a valuable new opportunity for Indigenous students to pursue medical studies. We strongly believe that this new institution with its partnership with First Nations Health Authority offers Indigenous learners a better chance of entering medical professions and graduation with a secure identity and opportunities to serve diverse Indigenous communities in research, education and clinical service. We appreciate the hard work and dedication of the University and its supporters in establishing this new institution. We especially applaud their efforts to make the School of Medicine more diverse, equipping students with the knowledge, skills, and tools they need to excel in the medical field including in providing culturally safe, anti-racist health care. We are excited by the potential of the proposed school and offer our support to ensure its successful launch.

NCIME is the only Indigenous led, designed and operated organization in Canada housing the top Indigenous medical education experts. Our experts bring with them over 30 years of extensive experience in creating programs and leading initiatives to promote Indigenous medical education and recruitment of Indigenous medical personnel and learners. As a consortium we are partnered with the national bodies of medical education in the country. These include the Indigenous Physicians Association of Canada, the Royal College of Physicians and Surgeons of Canada, the Medical Council of Canada, the College of Family Physicians of Canada and the Association of Faculties of Medicine.

NCIME has focused on six priority work streams that include 1. Assessment of Indigenous Studies, cultural safety, and anti-racism. 2. Anti-Indigenous racism. 3. Indigenous admissions and transitions. 4. Indigenous faculty recruitment and retention. 5. Improving cultural safety in curriculum, and 6. Indigenous physician wellness and joy in work. Our work comes from strength-based and distinctions based approaches and from co-creation with Indigenous voices, community and stories through our working groups.

We operate from a wholistic lens from recruitment and outreach to the entire training experience, through to residency certification and in our support of Indigenous learners and faculty.

Key to our success has been our strong stakeholder and Indigenous community relationship building as evidenced by our anticipated Memorandum of Understanding (MOU) with the proposed School of Medicine at Simon Fraser University. This MOU outlines the uptake and implementation of vital and strategic NCIME products arising from our six priority areas. As the voice of Indigenous medical education in Canada we are keen to see the development of a medical school that has meaningfully engaged with Indigenous experts and communities from the local to the national, from the beginning of the process and with partnership throughout.

Thank you for your time and consideration.

Sincerely,



Dr. Marcia Anderson
Chair, National Consortium for Indigenous Medical Education

Cc: NCIME Executive Committee
D Soucy, Executive Director, NCIME

Dr. Joy Johnson, President
Simon Fraser University University
8888 University Dr W
Burnaby, BC
V5A 1S6

March 8, 2023

RE: Letter of Support for Simon Fraser University Medical School

This letter is in support of the development of a unique collaboration of the PEGASUS Institute with Simon Fraser University's new medical school focusing on issues related to equity, underserved and rural populations, planetary health, international partnerships and social justice.

The curriculum of the SFU MD programme is based on "immersive, community-engaged education." This means that trainees can learn in places where there is a need, whether in the community or clinical settings. SFU also wants to help students after they graduate by finding opportunities for them to remain in their community and promote health of that community whether clinical, research, advocacy or education. We believe that the work being done at PEGASUS and the medical school at SFU can complement one another.

[PEGASUS Institute](#) is a non-profit organization which envisions a world in which peaceful interaction ensures long-term global health. Through interactive forums for sharing research, education, field experiences, advocacy, and policy, we hope to promote equity, justice, and global health in their intersection with peace and environmental sustainability.

At PEGASUS Institute, we work to improve health equity for globally and locally marginalised populations by developing academic courses, mentorship programmes, and knowledge mobilisation tools, all while placing human security at the centre of the discussion. It was reassuring to learn that SFU intends to prioritize underserved and underrepresented populations, such as indigenous peoples and refugees.

PEGASUS Institute met briefly with Dr. Roger Strasser, Interim Dean of the SFU Medical School, to discuss the future goals of the SFU Medical School and how PEGASUS Institute could contribute to the common goal of fostering community partnerships in the development of the SFU Medical School.

With funding from the Canadian Medical Foundation PEGASUS Institute is helping Refugee Health Professionals (RHPs) including Internationally Trained Medical Professionals (ITMPs) integrate into Canadian healthcare system. With Dr. Strasser we discussed our plans to assist ITMPs and RHPs learn about pathways and solutions for integration into the system as well as exploring opportunities to use their many skills and assets in Canada and be mentored by those with expertise and who have been through the process. This project will also provide information on alternative health and development careers. We also hope to give established health professional bodies, academic institutions, regulatory bodies, and others the opportunity to develop educational resources to help ITMPs and RHPs practice in various medical fields. A particular avenue of collaboration given SFU's mandate and location in Surrey, near the border and airport where many such professional migrants come to Canada,

PEGASUS Institute

Pegasusinstitute2020@gmail.com <https://pegasusinstitute.ca/>

BIN: 796340743RC0001 Corporation Number: 1254038-0

most recently with large populations from Ukraine, Syria and Afghanistan, is to give special consideration to training, mentorship and placement of such professionals, both in diverse multicultural settings where their language and cultural skills might be an asset, but also with proper support, to potentially assist with the rural health professional shortage.

With the [McGill University Summer Institutes in Global Health](#), we developed short courses on "Peace through Health", "Environment and Global Health" in English and French and, most recently "Migration and Health" in English and Spanish. Each course examines global events and population and individual health, allowing global citizens to consider how peace, migration and environmental factors, each may impact health care and the role of advocate/practitioner to promote social justice and equity. We are also exploring co-developing two courses with the WHO Collaborating Center for Knowledge Translation in Health Equity: Global Health and Health Systems Strengthening and Peace through Health. If there is regional interest, we will adapt such courses in French for francophone Africa and Spanish for Latin America. This partnership mobilizes knowledge and technology. These two courses would give health workers, planners, researchers, academics, and decision makers in low- and middle-income countries (LMICs) essential and accessible tools to build resilience in marginalized global communities. We have proposed some work on these courses to the WHO Academy in Lyon. Having active SFU faculty and trainee participation in such courses could be mutually beneficial.

In 2022, PEGASUS Institute held its first mentorship event for Indigenous and refugee youth, the Creative Arts and Music Retreat for Social Justice. Participants of varied ages listened, learned, and connected through culture, conversation, music, and art. The musical sharing circles allowed young musicians to express their feelings about social justice, mental health, and cultural expression. We are also exploring the use of such arts for other marginalized populations, and could involve trainees, as could our international networks-particularly the francophone and Latin American network could allow international outreach for a new school and our Emerging Leaders Network is attracting younger people from across the country and beyond and we have developed collaborations with other universities on many issues related to global health within and beyond our borders, environmental issues include climate change and peace and health issues.

In short, we see many avenues of potential collaboration and look forward to developing partnerships, much as we have had with several medical schools and universities in Canada and beyond.

With kind regards,



Dr. Neil Arya
Board President
[PEGASUS Institute](#)



Chloé Eward
Interim Executive Director
[PEGASUS Institute](#)

PEGASUS Institute

Pegasusinstitute2020@gmail.com <https://pegasusinstitute.ca/>

BIN: 796340743RC0001 Corporation Number: 1254038-0

Dr. Joy Johnson
President, Simon Fraser University
Simon Fraser University
8888 University Drive
Burnaby, B.C.
V5A 1S6
pres_office@sfu.ca

778-782-4641

April 19th, 2023

Dear Dr Johnson

RE: Letter of Support for Simon Fraser University Medical School

I am writing on behalf of The Rural Coordination Centre of British Columbia (RCCbc) to support the establishment of the Simon Fraser University Medical School. RCCbc brings a rural physician perspective to improving health in rural British Columbia and Canada. The RCCbc as an organization focuses on supporting, educating, and advocating for family practice physicians in rural, remote, and Indigenous communities all across British Columbia. The overall RCCbc network extends out and includes healthcare providers and administrators, community members, policymakers, educators, researchers, and non-profit leaders - all working together to enhance health equity.

Through various programs that the RCCbc helps administer, it is clear to us that many communities in BC are underserved and underrepresented when it comes to team-based community-level health care, and many of these communities are where these services are needed the most. From an equity perspective there is a large gap in care that needs to be filled for rural communities in BC; it is extremely difficult for patients to receive care, have access to, and develop a continued relationship with a family physician that can provide the benefits of longitudinal care. The planned community based training proposed in the SFU Medical School will help in filling some of these gaps by providing providers trained in and for in the places where healthcare is needed the most, this includes rural communities in BC. If for no other reason than 20 % of the population being rural with only 15 % of the physicians being based in those same communities.

Additionally, it is often difficult for younger members in communities across BC to gain the knowledge and skills that they would need in order to even consider entering into a health care career; some people just aren't even aware that this could be an option for them. The SFU Medical School Facilitated Generalist Career Pathway would be extremely instrumental in supporting and encouraging young community members on their path, beginning at the admissions process through to residency programs. This pathway would provide support, professional development, and career progression for medical graduates without them having to leave their community practice setting; it would help fill the gaps in team-based community-level health care in rural, remote, and Indigenous communities.

Providing community engaged, immersive, integrated longitudinal learning beginning at the application process and progressing all the way through medical school and residency, on to graduates future careers, is an extremely beneficial way to support these future physicians and will truly make a difference in health care all across British Columbia.



Dr Ray Markham (OBC) MBChB MRCGP CCFP FCFP FRRMS
Executive Director Rural Coordination Centre of BC



April 24, 2023

Dear President Joy Johnson:

The Surrey Board of Trade as the voice of businesses and organizations in Surrey has been a strong advocate for accessible health care that is critical for attracting and retaining businesses and talent. We are pleased to hear that the SFU Medical School location will be the multicultural City of Surrey, soon to be BC's largest city and home to BC's largest school district.

As a well-established business organization, we understand the business benefits of an innovative new Medical School in Surrey including the health of employees as well as the research potential and associated activities that will focus on addressing the serious gaps and challenges in our health care system.

Given BC's shortage of family physicians, we are pleased to hear that the SFU Medical School will focus on training family physicians in community settings and prepare them to serve underserved populations with empathy and cultural sensitivity.

SFU has a solid track record of being an inclusive community partner committed to working with diverse partners to advance important community goals. SFU's presence in Surrey has transformed this City. SBOT and SFU have a long-standing relationship and we are pleased to support SFU's new Medical School project.

Sincerely,

A handwritten signature in black ink, appearing to read 'A Huberman', with a stylized flourish at the end.

Anita Huberman, President & CEO, Surrey Board of Trade



SEMIAHMOO FIRST NATION

May 16, 2023

RE: Letter of Support – Simon Fraser University's (SFU) Medical School in Surrey

To Whom It May Concern,

I am writing to provide this letter of support regarding SFU's plans to open a medical school in Surrey's city center.

SFU and Semiahmoo First Nation (SFN) have a strong relationship rooted in the respect SFU shows for SFN's land and the region's Indigenous peoples. Over the years, I have had the pleasure to meet with senior leaders at SFU to discuss the needs, interests, and opportunities for engagement with SFN and support Surrey's growing urban Indigenous population. SFU has always been receptive and collaborative in their approach, and with that in mind, I am honored to be asked to be involved in discussions about the proposed medical school and engaging with Indigenous communities south of the Fraser. I would also note that I sit on the space and Infrastructure sub-committee for the medical school.

SFU's medical school collaboration with the First Nations Health Authority provides a significant signal to reconciliation. Over time, I envision a strong partnership between the two organizations that will serve the health needs of not only my Nation, but more broadly, the region's Indigenous and non-Indigenous communities. SFU's reputation of collaboration is well-known amongst the Indigenous community in Surrey – from their support for National Indigenous People Day, the National Day for Truth & Reconciliation, Red Dress and Moose Hide Campaign, to working with the Surrey Urban Indigenous Leadership Committee to help address a variety of Indigenous social and economic issues.

Moving ahead, I look forward to working with SFU to provide guidance and support in developing the medical school in whatever capacity I can best serve. I have every confidence in SFU's ability to work with the local Indigenous communities, and in partnership to improve the health and well-being of the region's population.

Please do not hesitate to contact me should you require any clarification of my comments.

Sincerely,

Chief Harley Chappell

May 8, 2023

Dr. Joy Johnson
President
Simon Fraser University
8888 University Drive
Burnaby, BC V5A 1S6

Dear Dr. Joy Johnson,

SFU's new medical school is welcome news for members of the India Advisory Council and BC's diverse and equity seeking populations.

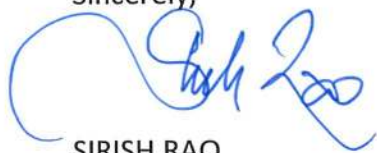
SFU's India Advisory Council, the first of its kind in western Canada, was established in 2006. Comprised of academic, business, government and community leaders, it advises, guides and supports the university's academic, research and community engagement initiatives, including with the local South Asian diaspora. The Council members have a first-hand understanding of the issues facing their community and are keen to be involved in addressing these issues.

Health is a fundamental right and as we know, thousands of British Columbians, especially equity seeking groups, do not have access to a family physician. While accessing the current health care system, this population often faces discrimination and a lack of cultural sensitivity. There is a great deal of research to help us understand this serious problem and its adverse impacts.

SFU, as a community engaged university is well positioned to not only help address the serious gaps in BC's health care system but also develop a medical program that is inclusive of diverse world views and that trains community engaged empathetic physicians. SFU has the track record of very positive community engagement and establishment of this unique model of medical program will be of great value to the community.

Since its inception the India Advisory Council has supported the start of unique community programs and we look forward to establishment of this important project. The Council members listed below fully support SFU and look forward to being involved as this important project moves forward with support from the Province.

Sincerely,



SIRISH RAO
Co-Chair, SFU-India Advisory Council

Dr. Joy Johnson
May 8, 2023

SFU-India Advisory Council Members:

Arvinder Bubber, A S Bubber & Associates Inc.
Barj Dhahan, Sandhurst Group
Arun Garg, Consultant Medical Biochemist
Robin Dhir, Fasken Martineau
Sarup Mann, Ansatel Communications Inc.
Haroon Rashid, Paradigm Ltd.
Anita Huberman, Surrey Board of Trade
Hema Bhatt, Natu'Oil Services
Vivek Savkur, BCIBN
Wally Oppal, Boughton Law
Jas Sandhu, Brixton Properties
Randy Sandhu
Hari Varshney, Varshney Capital Corp.
Sukesh Kumar, KPMG
Dave Hayer, former MLA & MP
Karan Suri, MNP



Joanne Curry
Vice President, External Relations
Simon Fraser University
8888 University Dr. W, Burnaby
BC V5A 1S6

Page 1 of 2

May 18, 2023

**Skwxwú7mesh
Úxwumixw**

Dear Joanne,

Re: Letter of Support – SFU Medical School

Thank you for your letter of April 13, 2023, and the meeting with our Directors of Yúustway – Health and Wellness and Ta7Inewás – Education, Employment and Training, on April 22, 2023, requesting a letter of support and guidance for the SFU Medical school from the Skwxwú7mesh Úxwumixw.

We have reviewed the request, conversation, and supporting materials provided to us. We are encouraged by the commitment to ongoing reconciliation through the establishment of an Indigenous Caucus with five pillars of focus (curriculum, workforce, space, research, admissions, and learner experience), following the recommendations of the *In Plain Sight Report: Systemic Racism in B.C.* We would like to encourage ongoing engagement and collaboration with the Skwxwú7mesh Úxwumixw and other Indigenous communities to further enhance the reconciliation efforts by our shared partner organizations. We are pleased to offer our support for this project.

As the project supporter and First Nation rights holder, we are requesting participation in the development of the business case, curriculum, model of care, and establishment of the pathways for graduates participating in community during and after their training. We feel the best way to undertake this would be for the Skwxwú7mesh Úxwumixw to have a permanent position in the Indigenous Caucus and to have staff and citizens actively participate in the working groups. In addition, we would like to build upon our existing agreement with SFU to have continued dialogue with SFU to formalize a relationship with the medical school and our health and wellness programs under Yúustway.

We also look forward to regular updates to our community, Council, and staff on the progress of the project.

Chet wanáxwstúmi,

On behalf of the Squamish Nation Council

Chair Khelsilem
Squamish Nation Council
Skwxwú7mesh Úxwumixw

Cc: Nexwsxwníwntm ta Úxwumixw – Squamish Nation Council
Sheldon Tetreault, CAO Skwxwú7mesh Úxwumixw



Joanne Curry
Vice President, External Relations
Simon Fraser University
8888 University Dr. W, Burnaby
BC V5A 1S6

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May 18, 2023

**Skwxwú7mesh
Úxwumixw**

Glenda Gibbon, Director Yúustway – Health and Wellness
Paul Wick, Director Ta7Inewás – Education, Employment and Training
Chris Lewis, Director of Indigenous Initiatives and Reconciliation
Sobhana Jaya-Madhavan, Associate Vice-President, External Relations SFU



Tsleil-Waututh Nation

səlilwətał



May 4, 2023

President Joy Johnson
Simon Fraser University
8888 University Drive
Burnaby, BC V5A 1S6

Dear Joy,

I am writing in response to a request for a letter of support for the Simon Fraser University (SFU) medical school (letter of April 13, 2023, from Joanne Curry, Vice-President, External Relations).

We recognize that Tsleil-Waututh Nation (TWN) and SFU have been developing a relationship in various areas, such as education, culture, language, archaeology and environmental science. Our Council has met with you and senior staff to discuss how SFU can increase TWN visibility and representation across the SFU campuses, especially the Burnaby Mountain campus. Our staff have also been actively engaged on developing a Relationship Protocol Agreement, which is in the final stages of review and will likely be approved and signed by this summer.

In the spirit of our relationship and the value a local medical school would bring, TWN would like to offer support for SFU's medical school ("the school"). We request additional information regarding how "First Nations, Inuit, and Métis knowledge systems and perspectives will be embedded throughout the school" (as referenced in SFU correspondence), and specifically how TWN knowledge, perspectives and values will be incorporated.

To help support SFU's objectives of embedding TWN knowledge systems and perspectives throughout the school, we require a seat on the Indigenous Caucus, as identified by SFU as having a key role in the development of curriculum, workforce, space requirements, research, and the learner experience for the school. Please provide us with more information on the responsibilities and structure of the Indigenous Caucus for the school, so we can identify an appropriate TWN representative.

We hope that the SFU medical school is able to bring much-needed knowledge, including Indigenous knowledge, and resources to the next generation of medical professionals, which will also include Indigenous students.

Respectfully,

Chief Jen Thomas, Tsleil-Waututh Nation

Cc: Ernie George, Chief Administrative Officer, TWN
Joanne Curry, Vice-President, External Relations, SFU
Chris Lewis, Director of Indigenous Initiatives and Reconciliation, SFU



March 13, 2024

Degree Quality Assessment Board Secretariat
Ministry of Post-Secondary Education and Future Skills
PO Box 9177 Stn Prov Govt
Victoria, BC V8W 9H8

Dear Members of the Degree Quality Assessment Board,

Re: Simon Fraser University's Doctor of Medicine, MD Undergraduate Program

I am writing to confirm the University of British Columbia's Faculty of Medicine's support for Simon Fraser University's proposal for their upcoming MD program.

We have collaborated on an ongoing basis with SFU personnel in providing information and support to facilitate the development of SFU's new MD program which we believe will be complementary to the health initiatives that the University of British Columbia's Faculty of Medicine are currently undertaking.

Both UBC's Faculty of Medicine and the SFU Medical School (SFUMS) leadership team have demonstrated a commitment to fostering collaboration and cooperation between our institutions. We look forward to working further with SFUMS as it progresses towards its first intake of students and beyond to ensure the ongoing complementarity of our approaches and to ensure the maximum benefit for medical education in British Columbia and for the health needs of British Columbians.

We look forward to strengthening our partnership and creating a brighter future for medical education in British Columbia.

Sincerely,

Dermot Kelleher MB, MD, FRCP, FRCPI, FMedSci, FCAHS, FRCPC, AGAF
Professor, Department of Medicine
Dean, Faculty of Medicine
Vice-President, Health
The University of British Columbia

May 12, 2023

RE: SFU Medical School

To whom it may concern,

The vision for a new medical school in this region is an amazing opportunity to meet the ever-growing needs for family physicians and promote a positive and compelling view of family practice to students, enabling them to discover the rewards and fulfillment of engaging in longitudinal family practice.

As a Division, we have had a history of innovation and leadership within our community, and we believe that the vision for SFUMS is bold, progressive and in line with our spirit and vision of the future. We believe that our partnership will help to create and deliver an excellent student experience. One that can help to foster a culture of innovation and leadership with the next generation of family physicians.

Furthermore, the goal of SFUMS to achieve authentic community engagement, resonates with our intention to foster a collaborative environment where communities, including Indigenous communities, and their organizations are actively involved in partnerships such as these.

We have had strong interest from our local family physicians to work collaboratively on this and therefore on behalf of the Board of the White Rock South Surrey Division of Family practice we extend our support via way of this letter to SFU Medical School (SFUMS), planned for our community.

Please feel free to contact me directly at 236-989-9137 or roganthavarajah@gmail.com.

Regards,



Dr Rogan Thavarajah, Chair
White Rock South Surrey Division of Family Practice



SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Medical Doctor (MD) Program

Appendix 8.5 - Resources

March 15, 2024
SFU Medical School

8.5 Resources

Current and future funding allocated by the Provincial Government and the Ministry of Post-Secondary and Future Skills for the SFU Medical School will be earmarked to ensure it is spent accordingly. Any additional funding required by SFU Medical School, due to unforeseen expenses, will be requested from the Ministries before the expenses are incurred. The governance recommendation is to have the SFU Medical School be a stand-alone, distinct School of Medicine to start. This separation of a faculty/school unit will further support and streamline cost containments within the unit. If there is deviation in future funding approvals, the SFU Medical School will assess the implications and adjust the scope of our plan accordingly. If the funding available requires substantial deviation from the plan, the staffing model may be decreased, seat numbers may be adjusted, or extreme options may be considered (ex: closing the school and executing a ‘Teach Out’ plan, which would allow students from the medical school to transfer to another medical school to complete studies).



MEMORANDUM

ATTENTION	Maria Hubinette, Acting Associate Dean, Academic and Faculty Development, SFU Medical School	DATE	March 12, 2024
FROM	Gwen Bird, Dean of Libraries	PAGES	1
RE:	Resources for medical library		

I am writing to confirm that the SFU Library has been involved in preliminary planning about the resources required to support the SFU Medical School.

The provision of adequate library resources and services will be critical to the success of medical students at SFU, and to the research conducted at the school.

As an input to the business case for the school, the library submitted preliminary estimates of the cost to provide library collections, space, professional expertise, and services. We look forward to continuing to work with you and others involved in planning the curriculum, space design, capital priorities, and services required by the school. The financial support needed to offer a full suite of library services appropriate to a contemporary medical school as well as a comprehensive collection of medical literature will be significant. We look forward to continuing the conversation.

A handwritten signature in black ink, appearing to be "Gwen Bird", is written below the text.



SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Medical Doctor (MD) Program

Appendix 8.6 - Financial Plan

March 15, 2024
SFU Medical School

8.6 Financial Plan

SFU is pleased with the commitments made by the government to continue the funding support for the SFU School of Medicine. The commitment letter received from the Ministry of Post-Secondary Education and Future Skills states that they are in support of the current plan to admit 48 students in the summer of 2026, and the future growth plans to an annual intake of 120 UGME students. The commitment letter also referenced support for the operating, interim capital and permanent capital funding needs of the School of Medicine.

The Ministry has outlined a clear path for the SFU School of Medicine to access the full funding requested in the business case ask upon the demonstration and reporting of the actual operating needs, in addition to providing commitment for the ask (presented in Table 1 below) over the next three years in the Base Operating Budget.

Table 1: Estimated initial start-up and Year 1 operating costs

Nominal \$M	24-25	25-26	26-27
UGME			
UGME Portion of Operating Expenses	27.8	42.4	53.2
Less: UGME Portion of Revenues	-	(0.1)	(1.3)
Less: SFU Self-Funded Salary Increases	(0.1)	(0.4)	(0.7)
Total UGME Program Costs	27.6	42.0	51.2

8.6.1 Tuition

The overall tuition cost for SFU's MD Program will be equivalent to that of UBC. However, the UBC program cost is amortized over 4 years, while the SFU program cost will be amortized over three years. It is important to note that both programs involve a minimum of 130 weeks of student instruction. In 2026/2027, UBC's annual tuition is forecast to be \$20,802.86 which equates to a starting annual tuition of \$27,737.15 at SFU. Table 2 below outlines the costs over time for a student at the two institutions.

Table 2: Estimated Faculty hiring numbers over initial years by position

Year	26-27	27-28*	28-29*	29-30*	Total Program Cost*
School					
SFU Student	\$27,737.15	\$27,737.15	\$27,737.15	n/a	\$83,221.45
UBC Student	\$20,802.86	\$20,802.86	\$20,802.86	\$20,802.86	\$83,211.44

* assumes no annual tuition increase for ease of illustrative purposes

8.6.2 Faculty Hiring Plan

Faculty hiring is planned to grow over time as the student class intake increases in size, and a phased hiring plan was outlined in the business case submitted to government. The estimated numbers for traditional tenure-track appointments in the initial years are highlighted in Table 3 below. Final confirmation of the proposed categories and position ranks are subject to negotiation between SFU and the SFU Faculty Association (SFUFA), as well as the development of policies covering positions that may be excluded from the Faculty Collective Agreement.

Medical Research Faculty (tenure-track)

Funding has been secured for the appointment of up to 38 FTE tenure track/instructional faculty positions (including those who will hold senior leadership roles within the School of Medicine). As the curriculum development and instructional delivery needs become more explicit, funding may be shifted from the Medical Research Faculty “lines” to Medical Education Faculty lines.

Table 3: Estimated Faculty hiring numbers over initial years by position

Year	23-24	24-25	25-26	26-27
Position				
Leadership*	4.0	13.0	2.0	6.0
Professor	0.0	0.0	0.0	1.0
Associate Professor	1.0	0.0	2.0	1.0
Assistant Professor	1.0	0.0	1.0	1.0
Lecturer/Instructor	0.0	0.0	3.0	2.0
New Hires Annually	6.0	13.0	8.0	11.0

* Assumes 60 per cent of leadership positions filled by professors, 35 per cent of leadership positions filled by associate professors, and five per cent of leadership positions filled by lecturers

Medical Education Faculty

We anticipate a greater need for Medical Education faculty members, especially in the earlier stages of program development and implementation. However, in addition to the flexibility afforded by the broad faculty hiring noted above, we have also built in additional budget flexibility for the hiring of both Medical Education Faculty and Clinical Education (Stipendiary) Faculty as needed.



SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Medical Doctor (MD) Program

Appendix 8.7 - Abbreviated Curriculum Vitae for Faculty

March 15, 2024
SFU Medical School

8.7 Abbreviated Curriculum Vitae for Faculty

The MD Program will be taught by faculty members who will be new to the SFU School of Medicine. The hiring plan will begin in the Summer of 2024 and will be overseen by a committee comprised of key university and program stakeholders and contributing medical education experts. Hiring will comply with the stringent requirements of the Committee on Accreditation of Canadian Medical Schools (CACMS) and will conform to policies and collective agreement terms at SFU.

8.7.1 Faculty Categories

The cohort of faculty members required to deliver the medical education curriculum are proposed to fall into four general categories: Medical Research, Medical Education, Clinical Faculty, and Adjunct Faculty.

Medical Research Faculty:

Faculty in this category will be tenured/tenure-track and will mainly have a research-driven workload, along with a combination of teaching and service duties. They are normally required to have a PhD, or an MD with a substantial track record of securing externally-funded grants and demonstrated contributions to research. These roles may be full- or part-time, term or continuing (e.g. tenure-track/tenured), but the majority are expected to be full-time and continuing (e.g. tenure-track/tenured). It is expected that a majority of these faculty members will have research, service, and teaching requirements. These positions will be at the ranks of **Instructor/Lecturer/Assistant/Associate/Professor of Medicine**.

Medical Education Faculty:

Faculty in this category will normally be practicing clinicians who belong to a regulatory college that enforces practice standards and ethical conduct, and/or voluntary medical employee associations. They are normally required to have an MD or other recognized clinical designation. There may be additional individuals in this faculty category which hold specific cultural knowledge that will enhance the medical education program (e.g. Indigenous Elders or Knowledge Keepers). These appointments may be term or continuing. These faculty will be primarily responsible for program delivery and may hold leadership positions. These positions will be made at the ranks of **Instructor/Lecturer/Assistant/Associate/Professor, Medical Education Faculty**.

Clinical Faculty:

Faculty in this category are normally practicing clinicians or subject matter experts responsible for delivering case-based learning, clinical skills labs, and supervising students and residents on-site with patients. They are required to have an MD or other recognized clinical designation. They are independent contractors engaged by SFU; physicians receive stipends or honorariums as negotiated by the

Ministry of Health and Doctors of BC. The stipend amounts for teaching are equivalent to those provided to clinical medical faculty at the University of British Columbia. They are ineligible to hold senior academic leadership positions but may be in roles such as site directors or clinical leads. These positions will be made at the ranks of **Clinical Instructor/Assistant/Associate/Professor**.

Adjunct Faculty:

Distinguished, qualified persons whose professional work leads them into a close working association or a community of professional interest with the research or other academic pursuits of some faculty members or of an academic unit at the University may be appointed as Adjunct Professors, Adjunct Medical Educators or Adjunct Clinical Educators

Final confirmation of the proposed categories and position ranks are subject to negotiation between SFU and the SFU Faculty Association (SFUFA), and to the development of policies for roles not covered within the Collective Agreement.

8.7.2 Credential, Licensing, and Other Requirements

Credential Requirement:

Education credential requirements for each of the faculty categories are as follows:

- Medical Research Faculty are normally required to have a PhD, but may have an MD and related research expertise. Proof of degree is required prior to an initial appointment.
- Medical Education Faculty and Clinical Faculty are required to have an MD or other recognized clinical designation (e.g. RN, RPsych, RSW, etc.). Medical Education Faculty may be required to provide proof of degree as well as proof of clinical designation.
- Clinical Faculty are not required to provide proof of degree as they are required to provide proof of an active medical license, through which completion of degree is implied (e.g. MD).

The following options are accepted by SFU Faculty Relations as proof of degree. One of the options listed, at minimum, must be provided. The unit may use their discretion to decide which of the following items will be required from the faculty member:

- An original transcript sent directly from the degree-granting institution to the hiring unit at SFU
- University degree confirmation service (from the degree-granting institution)
- Third party degree confirmation service (e.g. AuraData, CeCredential Trust, Parchment, Student Clearinghouse, World Education Services)

- A letter of completion can be requested from the institution's central office of student records but must be sent directly to the Dean's or School/Department office contact (include documentation that the institution sent the transcripts/letters directly to the hiring unit).

Licensing/registration/professional membership requirement:

Clinical faculty must provide proof of an active license from the relevant licensing organization. MD Clinical Faculty will be verified via College of Physicians and Surgeons of BC (CPSBC) in the registrant directory. The following information can be found in the registrant directory:

- Clinical faculty must have a Registration Status of "Practicing"
- Clinical faculty must have a registration Class "Full"
- Clinical faculty must have no practice conditions

The verification of the clinical faculty on the CPSBC registrant directory will occur at the faculty member's first appointment and every three (3) years following the initial appointment. If a physician has a change in their registration status or practice conditions (e.g. restrictions), they will be required by their contract to notify SFU. If a physician fails to notify SFU of changes in their registration status or practice conditions, their clinical faculty appointment may be terminated immediately.

Letters of reference:

Candidates for Medical Research Faculty and Medical Education Faculty positions must provide at least three letters of recommendation, typically from academic sources. Letters must be received directly by the hiring unit from the referee.